Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Board of Directors Public Meeting

09.00, Wednesday 4 December 2024

Uffculme Centre

AGENDA

Ref	Item	Purpose	Report type	Time
	Service User Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 2 October 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 2 October 2024**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Service and Site Visits Annual Report** *Phil Gayle, Chair*	Assurance	Enc	09.45
8	**Staff and Service User Stories Annual Report** *Phil Gayle, Chair*	Assurance	Enc	09.50
9	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Director of Operations*	Assurance	Enc	09.55
10	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	10.15
11	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	10.25
	Quality and Clinical Services			
12	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.35
13	**Safeguarding Annual Report** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	10.45
14	**Medical Directorate Annual Report** *Fabida Aria, Executive Medical Director*	Assurance	Enc	10.55
	People			
15	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	11.05
16	**Guardian of Safe Working Q2 2024/25 Report** *Hari Shanmugaratnam, Guardian of Safe Working Hours*	Assurance	Enc	11.15
	Sustainability			
17	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.25
18	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.35
19	**Trust Strategy Update Report** *Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships*	Assurance	Enc	11.45
20	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.55
	Governance			
21	**Modern Slavery Statement** *Kat Cleverley, Company Secretary*	Approval	Enc	12.05
22	**Committee Terms of Reference** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	
23	**Risk Management Policy and Risk Appetite** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	
	Reflections			
24	**Living the Trust Values** *Fabida Aria, Executive Medical Director*		Verbal	12.15
25	**Board Assurance Framework reflections**		Verbal	12.20
26	**Any other business**		Verbal	12.25

27	**Questions from Governors and members of the public**

Close by 12.30

Date and Time of Next Meeting: Wednesday 5 February 2025, 09.00-12.30

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

Members	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	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
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnerships
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Monica Shafaq	MS	Non-Executive Director
	Winston Weir	WW	Non-Executive Director
Attending	Kat Cleverley	KC	Company Secretary (minutes)
	Zalika Geohaghon	ZG	Lead Nurse Consultant for Infection Prevention and Control (item 12 only)
	Emma Randle	ER	Freedom to Speak Up Guardian (item 14 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	Sharon Watkins	SW	Head of Spiritual Care (item 1 only)
Observers	Two governors and three members of staff/the public observed the meeting in person.		

Ref	Item
1	**Staff Story** The Board welcomed SW to the meeting, who attended to share her journey and experiences within the Trust. SW noted that she had been in the Trust for twelve years in a number of roles, with a background in Occupational Therapy and was appointed as Head of Spiritual Care eighteen months ago. SW noted that her faith was earth-based spirituality, and this had led to the team considering alternative faith needs for service users and staff. She confirmed that she was undertaking training to become a Pagan Priestess and Druid, which had given her the opportunity to reflect on the training needs of the team to ensure they were fully inclusive and encompassing of all service user and staff. Feedback for the team had been very positive with staff and service users feeling listened to through a non-judgemental approach which focused on supporting both staff and service users to find hope, meaning and purpose. The team continued to evolve and there was excitement to embracing nationally recognised faiths and religions through SW training for Psychospiritual Care and to continue to strive to be the leaders for change. The team were recruiting new staff and considering additional skills, including yoga and creative arts. To date, feedback from wards had been positive with service users and staff embracing the alternative activities. SW confirmed Friends and Family Tests and spiritual care surveys had been crucial in highlighting the areas for improvement and focus. Spiritual Care team members had been granted access to RiO and there were now options to record contact with the team that supported the reporting data that highlights the offer of support within secure care and seclusion. The Board was advised that the team had seen a significant increase in staff seeking support, including wellbeing sessions, coffee mornings, relaxation sessions and group therapy. SW noted that the team were keen to continue

	this support, however she highlighted that the team was the only resource available and recognised the need for additional staff to ensure current staff maintained their wellbeing and, in turn, maintained and retained the team. SW confirmed she had been informed of funding available through the submission of a bid to Caring Minds and confirmed this would be explored with a vision to be able to recruit a member of staff to develop and deliver a database for recording support given to staff as this continued to see a significant increase. MS thanked SW for sharing her inspiring story. MS asked how SW's initial joining of the Spiritual Care team with no faith translated with service users. SW noted that she had been supported by her line manager to find a faith, and it had allowed staff and service users to relate to her. SW reflected that although not everybody was religious, everyone was spiritual, and the team supported staff and service users to find what connected for them to aid their recovery. MS commended the modernised approach to spiritual care. PN advised that he had recently attended a national conference for faith and recovery and noted the importance of recognising and embracing the opportunities available as partnerships develop and links with voluntary sectors are strengthened; support was offered to the team in making connections with critical friends. SW thanked PN for his offer of support and confirmed that the team do connect with partners through forums where possible as resources remained limited. She confirmed that the vision for the team remained to drive national change for spiritual care; bids for funding were being explored to support the expansion of the team. SW noted the immediate focus for the team continued to be support the Trust's staff and service users. LSG thanked SW for her dedication to the team and the Trust, recognising the additional support being delivered by the team to support staff as they became overwhelmed. She highlighted the importance of the team linking in with internal colleagues and teams who were offering staff wellbeing support for a holistic offer to staff and to ensure the Spiritual Care team were not overwhelmed with demands. SW confirmed that the team continued to link in with colleagues and teams for signposting and support. PG thanked SW for sharing her passion for spiritual care and her continued dedication and commitment to the Trust. He confirmed that the Board would continue to support the development of the team.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
3	**Apologies for absence** Thomas Kearney, Non-Executive Director and David Tita, Associate Director of Corporate Governance.
4	**Declarations of interest** No new interests were declared.
5	**Minutes of meeting held on 7 August 2024** The minutes were agreed as a true and accurate record.
6	**Matters arising from meeting held on 7 August 2024** All matters arising were updated.
7	**Chair's Report** The Board received the report for information, noting the following key points: • PG thanked colleagues for their condolences and well wishes following a recent family bereavement, which meant PG had been unable to attend the AGM. • The recent Darzi report had been referenced as it set out some challenges for the NHS, which the Trust would need to consider. • PG had recently visited Tamarind for Family, Friends and Carers Day and had heard a lot of positive feedback from families and carers about the service.

	• PG had also visited Reaside, and HMP Birmingham. • Mustak Mirza was congratulated for his nomination for a Patient Advocate of the Year award.
8	**Chief Executive and Director of Operations Report** The Board received the report and noted the following key points: • The Trust was supporting Freedom to Speak Up month during October. • The Trust was celebrating Black History Month during October, with the theme "reclaiming the narrative". • The Board noted that there had been reduced turnover recently, and momentum was required to continue the good work. • Pay awards would be reflected in pay over the next few months. The Board was advised that there was likely to be further industrial action following the rejection of the pay deal by the nursing union. • Both BSMHFT and Birmingham Women's and Children's NHSFT Boards had made the decision in principle to move towards a single provider of an all-age mental health service, where BSMHFT would be the single provider. • The complaints team continued to manage the backlog. • Two draft CQC reports had been received and would be published once finalised. • This year's flu campaign had been launched. • RFW thanked everyone for the support that was given during the period of social unrest that was experienced. It was acknowledged that there was ongoing racism and trauma being experienced and that the Trust had a key role to play in supporting, along with partners, to create greater social cohesion. • The Trust had launched a White Allies Network during September, with the first formal meeting due to be held in November. • The Trust had received two ministerial visits. • The Trust was undertaking some focused work on staff vacancies, looking at how teams could work differently and how to develop staff. RFW noted that some positive conversations had taken place so far. • Neighbourhood mental health teams had become embedded within the community and closer working relationships with primary care colleagues were being developed. • The community collaborative was focusing on joined up physical and mental health. • Clinical services were very busy, but there was a lot of work underway to work in partnership. • Two additional Healthcare Assistants had been employed at Reaside to support capacity. • A quality improvement project was underway in the forensic intensive support team. • Acute and urgent care teams were focused on improvement around out of area placements, including increased locality work and clarity around accountability and clinical leadership. Key performance indicators had been established to ensure out of area work was on track. BC asked about out of area and clinically ready for discharge processes, querying the patient flow and patient experience. BC queried how a smooth journey was ensured for service users and what was different now from a year ago. BC noted that the performance and journey appeared to quite variable, and asked if there had been a fundamental change. VD acknowledged the fair challenge, and noted that the key difference was a more joined up approach with partners across the system, particularly primary care and local authority colleagues. Together colleagues were reviewing frequent attendees at A&E to determine a collaborative approach to the pathway. An Innovation Fund had been set up through the Mental Health Provider Collaborative, with the majority of funding awarded to voluntary sector colleagues. FA commented that the whole pathway of the service user was being reviewed to support early help and intervention before crisis points were reached. RFW noted that out of area was an indicator of how the system managed supply and demand, and confirmed that there was ongoing work to understand pathways of care, early help and preventing admissions. BC noted his agreement with the comments made and stated that detailed discussions continued to be held at Finance, Performance and Productivity Committee. BC commented that it would be useful to see key performance metrics to monitor improvements.

	WW queried work around health inequalities and whether collaborative work around ICCR was addressing this. VD commented that there are many projects ongoing to address health inequalities, which was a key driver for the work. VD assured the Board that this was a collaborative piece of work, particularly in relation to access. WW asked about shared patient records between the Trust and partners as part of this piece of work. VD assured the Board that the database supported the patient journey for better outcomes; there was more work to do but the joined-up approach was beginning to have a positive impact. PN commented that there was consideration around telemedicine and digital capabilities for mental health and how these could be utilised to reduced health inequalities. PG asked if there was any data available to measure the impact of Right Care Right Person. VD noted that the final phase was due to go live on 31 October, but positive impacts included the operational street ambulance, and access to the CAD system. The Board agreed that a focused session at Finance, Performance and Productivity Committee on Right Care Right Person would be useful. **Action**
9	**Board Assurance Framework** KC advised that the report set out a culmination of work that had been undertaken over the last year to reframe the Trust's strategic risks so that they were clearly linked to strategic priorities within a modernised, streamlined reporting mechanism. The newly devised risks were set out within the report along with the timeline for when the new BAF would be approved and embedded. KC advised that new risks would be reviewed and approved at Committee meetings during October and November, in preparation for approval at Board in December. The current BAF had also been included as a holding position, and the Board noted the current risks. WW asked that the risk related to becoming an anti-discriminatory and anti-racist organisation was reviewed as part of a deep dive session, as the risk score had not changed for some time. RFW acknowledged the good challenge and recognised that the Trust should ask itself if staff were feeling any difference, and whether it was tangible throughout the organisation. SB commented that the Trust was beginning work on the Race Access Code which would help to determine progress. PN reflected that this could be a deep dive at Committee, and a focused strategy session held for Board. Committee Chairs acknowledged that the focused piece of work on the Board Assurance Framework was driving conversations at meetings and supporting clearer discussions.
10	**Integrated Performance Report** DT presented the Integrated Performance Report, for information and assurance. WW commented that the deep dives demonstrated grip and control, and felt that the waiting times deep dive in particular was very significant. Both the Quality, Patient Experience and Safety Committee and the Finance, Performance and Productivity Committee had raised concern about the waiting times and sought assurance on the actions in place. BC commented that discussions continued to elevate the Integrated Performance Report so that it was more strategic. RFW noted that the report should be used to encourage local teams to use their data more effectively. DT advised the Board that the report would be used to provide clarity around the Trust's current position, and links to the refreshed Board Assurance Framework.
11	**Quality, Patient Experience and Safety Committee Report** LC advised the Board on the key issues discussed at the September and August Committee meetings, as follows: • The Committee had received a report into the two-day CQC inspection that had taken place at Reaside, where significant issues had been escalated in relation to leadership and culture. A single improvement plan had been discussed in September, and the Committee had acknowledged the work in progress. LC assured the Board that the Committee would continue to have oversight of this issue.

	• The Patient Safety Report had identified a number of open Eclipse reports that required closure; a trajectory was in place to monitor these incidents. • A positive report had been received into governance improvements for the Clinical Governance Committee. • The Committee escalated concern in relation to waiting times, particularly in relation to first contact and time taken from first contact to assessment for ADHD and Solar services. • The Committee had taken assurance from the CQC report into Community Mental Health Teams. • The Committee had been assured by the Safeguarding Annual Report. • The Patient Experience and Recovery Group would report directly into the Committee to ensure a clear link to the patient voice. PG asked how the Mental Health Act Legislation Group reported through. HS confirmed that a quarterly report was received at the Committee. KC advised that the corporate team was reviewing forward planners for 2025/26 to ensure they were aligned with the Board Assurance Framework and frequency was appropriate.
12	**Infection Prevention and Control Annual Report 2023/24** The Board received the report and noted the following key points: • The report highlighted the challenges that the team were facing, with contributing factors including ongoing issues since the pandemic; population growth; health inequalities; global warming and climate change resulting in more viruses; vaccination resistance, antimicrobial resistance. All of these factors contributed towards a greater workload and highlighted a need for a larger team. Some recruitment had taken place to increase capacity. • The team was supporting greater ownership of IPC by clinical areas, with areas below 85% compliance receiving dedicated time to identify issues and discuss support needed. • Heads of Nursing continued to be very supportive in highlighting the importance of hand hygiene. • The Trust continued to see outbreaks of Covid19, but they were managed well. • ZG advised that FFP3 fit testing results had historically been low, however a new programme was now in place which was seeing significant improvements. • A high consequence infectious disease procedure was being put in place in line with NHSE guidance, particularly with the increase in cases of Mpox. PG asked ZG if there was one thing that the team would benefit from and what the Board could support with. ZG advised that the team wished to be more proactive and attend educational programmes that were accredited for the organisation and represent the Trust at Infection Prevention and Control events. The Board was assured by the context provided around the report, and received additional assurance that the Quality, Patient Experience and Safety Committee received regular reports on IPC; risks and issues were highlighted to Board through the usual assurance reports.
13	**People Committee Report** SB advised the Board on the key issues discussed at the September Committee meeting, as follows: • Concern had been raised in relation to the levels of depression/anxiety/stress that had been cited as sickness absences. Training and coaching support for managers was available to increase effective management of absence, including return to work conversations. • The Committee was advised that staff were required to undertake training in order to access the e-rostering system. • The Women's Network updated the Committee on its activities, including the Menopause Project, and the supportive conversations taking place around baby loss and caring for elderly relatives.
14	**Freedom to Speak Up Guardian Report** The Board received the report and noted the following key points:

	• The team continued to be busy, with 110 contacts during the quarter. ER advised that this was positive, as it demonstrated FTSU as a trusted route to raise concerns. • The Board was advised that the team had supported two colleagues into the Values in Practice route within the Trust during the quarter. • The breakdown of staff groups within the report showed the staff that sought the most support from the Guardians; data showed that it was representative across roles, but the key areas of concern remained inappropriate attitudes, behaviours and incivility. The team was also reporting a high number of concerns around worker safety, depression and anxiety as a result of bullying and harassment. • 70% of concerns during the quarter featured an element of quality and patient safety. • Bullying and harassment concerns reduced during the quarter, making up 16% of contacts for the Trust against 22% national average. RFW thanked ER for all of the work that had been undertaken by the Freedom to Speak Up team, particularly the Champions who were representative across the organisation. RFW noted the balance shown in the report between the corporate levels and individual services taking action to ensure wider ownership. PG asked if there was anything more the Board could do to support the Freedom to Speak Up work. ER reflected on the healthy speaking up culture that managers and leaders would need training and support in to promote this at all levels. SB advised that there was a FTSUG app that might be a helpful tool for staff. ER would consider this with the team.
15	**Finance, Performance and Productivity Committee Report** BC advised the Board on the key issues discussed at the September and August Committee meetings, as follows: • Two key areas of focus for the Committee were inappropriate out of area placements, and bank and agency spend. • The Committee had been encouraged by the good work that the Trust was doing to reduce bank and agency spend. • There were ongoing discussions about the Integrated Performance Report and the metrics used. • The Committee had received a deep dive into waiting times as part of the Integrated Performance Report and had escalated concern in relation to the number of people waiting for first assessments, and the number of people waiting for further assessments after first contact.
16	**Finance Report** The Board received the report for information, noting the following key points: • The month five consolidated Group position reported a deficit of £249k, mostly driven by significant out of area expenditure and slippage on savings delivery. The reported position was £1.2m adverse to plan. • It was forecast that the planned surplus of £2m would be achieved, based on sustained improvement on agency expenditure, no further increase in out of area run rate, and use of balance sheet flexibility. • Out of area expenditure continued to be a significant challenge, with year-to-date expenditure reported at £9m against a plan of £14m for 2024/25. The current full year forecast was £22m. • The savings target for 2024/25 was £17.8m. At month five, the savings achieved was reported at £4.6m. • Temporary staffing was £1.9m underspent at month five, and was driven by agency reduction ahead of plan. DT noted that the position was slightly off plan but was expected to recover by year-end. The Board noted that there was a BSOL system deficit of £61m. WW queried whether the 'unidentified' savings target had been clarified. DT advised that the Trust was looking ahead to next year's proposal with a clear need to ensure sustainability.
17	**Emergency Preparedness, Resilience and Response Annual Report 2023/24**

	The report was provided for information. The Board noted that the organisation was substantially compliant with the core standards, however a key risk remained in relation to sufficient resource in place to meet all standards.
18	**Terms of Reference** The Board approved the terms of reference, subject to a minor amendment to Caring Minds.
19	**Living the Trust Values** BC advised the Board that he had visited Youth First and Prosper teams, noting that it was fantastic to see these teams who deliver such important services and strongly demonstrate the organisational values. BC noted that the AGM held in September was an inclusive event, and he had been very encouraged by the presentations provided as it was clear that the organisation was doing the best it could for its service users and families.
20	**Board Assurance Framework reflections** The Board reflected on how the Integrated Performance Report could better link to the Board Assurance Framework, with a particular focus on supporting the Trust's well-led journey.
21	**Any other business** MS advised the Board of a Caring Minds Committee workshop that had been held on 30 September. Key topics included strategy, governance and criteria in relation to donations and application processes. The corporate governance team and the charity team would work closely to make sure the right processes and protocols were in place. FA noted that three teams within the Trust had been nominated for awards.
22	**Questions from Governors and members of the public** The following questions were posed to the Board: • A question about clinical supervision and how uptake was improved was asked by one of the observing governors. This had been raised at Clinical Governance Committee, particularly in relation to the quality of clinical supervisions and the need to increase compliance. The Board was asked if job planning and protected time for nurses could be considered. LSG commented that this linked to how rostering systems were used, which was under discussion at the Safer Staffing Group meetings. The Group was reviewing what a good day, week and month looked like for staff when considering skills and competencies. LSG acknowledged that protected time needed to be built in for teams and individuals to hold high quality clinical supervisions. • The Board was asked about the prominence of staff sickness which had been raised at People Committee and queried the available Occupational Health therapy offer for staff. SB confirmed that this was currently under review.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Chief Executive and Director of Operations Report	A deep dive session into Right Care Right Person would be held at Finance, Performance and Productivity Committee.	KC/VD Feb 25	In progress
Terms of Reference	The Board approved the terms of reference.		

Report to Board of Directors							
Agenda item:	**6**						
Date	4 December 2024						
Title	Chair's Report						
Author/Presenter	Phil Gayle, Chair						
Executive Director	Phil Gayle, Chair	**Approved**	**Y**	✓	**N**		

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

Summary of Report

Alert		**Advise**		**Assure**	✓

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.

The Board is asked to receive the report for information.

Enclosures

N/A

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

BOARD OF DIRECTORS

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.

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. Recently NHSE produced further guidance for Boards to consider as part of their ongoing assessment of best practice NHS England, The Insightful Provider Board. I am asking each of the Committee Chairs to reflect on our performance against this guidance and we will then consider as a Board whether there are any changes that we need to make.

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

On a slightly different note, I am pleased to announce that I have been appointed to the interim post of C hair of Black Country Healthcare NHS Foundation Trust from 1st December 2024 until 31st March 2025. I will continue as BSMHFT Chair whilst the Black Country Healthcare NHS Foundation Trust undertake a full recruitment campaign for their permanent Chair.

Additionally, I am pleased to announce that we have recruited Nick Moor as BSMHFT's newest Associate NED. Nick has extensive senior executive experience particular in relation to children and young people mental health. He also undertook in his former role extensive amounts of governance work and was a key client liaison with NHS England.

3. SERVICE VISITS

3.1 Visits to our Trust services are continuing to be scheduled with the NEDs, although I mentioned this in my last report but 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.

Each and every Trust site will be visited in the lead up to Christmas. The dates and information have been shared with NEDs and Governors who can take up the opportunity to accompany members of our Executive Team on these visits at Christmas time.

LISTENING TO STAFF

3.2 My visits to the different services continue. I visited our Solihull Integrated Addiction Services, based in Marston Green where it was a pleasure to meet staff, service users and experience a tour of the facilities.

3.3 I was pleased to visit Small Heath Health Centre where I experienced staff in their MDT meeting and it gave me an opportunity to speak with them and respond to questions posed to me.

3.4 I look forward to visiting other services across December and into the New Year. These visits 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.

3.5 Separately, I attended BSMHFT's memorial service on 20th November at the Uffculme Centre to remember Staff and patients.

4. PARTNER AND SYSTEM DEVELOPMENT / STAKEHOLDERS

4.1 I attended the Midlands Leadership Engagement Workshop, focusing on the 10 Year Health Plan for the NHS. The event was one of seven face-to-face engagement events happening across England to support the development of the 10 Year Plan and it will be a vital part of the process, bringing together NHS leaders from ICBs, NHS trusts, and senior system partners to gather insights, feedback, and ideas.

The meetings capture the challenges and opportunities facing the health system today, but also generate innovative solutions that will help shape its future.

4.2 I continue to attend the BSOL Chairs meeting every month with a varied agenda.

5. CHILDREN'S AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION PROGRAMME – NEW "ALL-AGE" OPERATING MODEL ANNOUNCEMENT

As part of the CYP Mental Health Transformation Programme, BSMHFT and BWC Boards have now approved in principle to move to a single provider approach for the Birmingham and Solihull community and inpatient mental health provision that would be led by BSMHFT, endorsing the views of the Clinical Reference Group and enabling a strong, united foundation to take forward the transformation required.

We are jointly working with BWC to ensuring that staff are well-informed, engaged and can contribute to the process.

We are at the start of this transition process and there will be many questions that colleagues will have.

As we work through the detailed approach to mobilise this change, we will be able to respond to questions, suggestions and concerns with relevant information.

We are proud of our dedicated teams in mental health services and the progress that has been made against a backdrop of significant challenges. Our teams in Solar have been working in an integrated way for some time and this transformation is designed to build on that good work. Thank you for your commitment to further supporting the mental health and wellbeing of children, young people and families across Birmingham and Solihull.

6. **BSMHFT MENTAL HEALTH PROVIDER COLLABORATIVE**

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

A draft model of care for children's and young people's mental health has been published on the ICB website for comments. The closing date is the 20 December 2024 and will provide an opportunity for people to share their views on the proposals. This draft model of care describes an integrated and graduated approach to care and support for children and young people across Birmingham & Solihull. It aims to increase access to care and deliver improved outcomes for all children and young people, enabling them to be healthy, fulfilled and achieve their full potential by preventing mental ill health, supporting early intervention and enabling them to thrive into adulthood. The provider collaborative has completed a review on intensive and assertive community treatment for people with severe mental health problems, identifying areas of good practice, gaps and barriers/challenges to delivery of the model. Action plans are now in development in response to this review.

A Strategy working group has been established with partners to take forward a plan for the co-production of an All-Age Strategy for Mental Health. This Strategy will set out the vision and priorities for mental health over the next five years and include the findings from the Experience of Care Campaign and all age mental health needs assessment.

Following the development of the 3-year strategic vision for inpatient beds across Birmingham and Solihull, the provider collaborative is now reviewing implementation plans developed by partners to take forward the key ambitions set out in this strategy.

A Board Strategy session focused on the delivery of Learning Disabilities & Autism priorities across Birmingham and Solihull took place on 6 November 2024 with representation from across both Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust.

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 I have been involved in two AAC interview panels over the past few weeks, for the appointment of Consultants within the Trust, as well as chairing the interviews in the recruitment process for the new ANED. This is a fantastic opportunity to meet inspiring and talented people who would like their future to be BSMHFT.

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

7.3 I also meet with the Trust's Governors to maintain regular communication and working relationships and to discuss ongoing developments.

7.4 Roisin and I met with Johnathan Brotherton Chief Executive of UHB and Yve Buckland UHB Chair, to discuss previous and current UEC challenges at the QE and how BSMHFT and our Psychiatric Liaison Team are to supporting them with a number of initiatives to manage the flow at A&E with identified mental health patients.

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

7.6 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.

7.7 It was a great experience to have our QPES Committee at Reaside on 30th October to connect with staff and service users and ensure visibility around the Trust as Chair.

PHIL GAYLE

CHAIR

Report to Board of Directors

Agenda item:	**7**					
Date	4 December 2024					
Title	Service and Site Visits Annual Report					
Author/Presenter	Hannah Sullivan, Corporate Governance Manager Paige Harrison, Business Partner/PA to Chair and CEO Phil Gayle, Chair					
Executive Director	Phil Gayle, Chair	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**		**Assure**	✓

The report details the increased focus on visibility for Board members who have been on site at least once a week with Governors joining when available.

The Corporate Governance team have strengthened the process for arranging visits for Board members and Governors with a robust schedule supporting the increased visibility across Trust and partnership sites.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

Service and Site Visits Annual Report

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD SITE AND SERVICE VISIT ANNUAL REPORT

1. INTRODUCTION

I am pleased to offer the Board of Directors a summary of the Board service visits throughout 2024.

As a Board we remain committed to ensuring we are visible across all sites throughout the year. This year we have developed a schedule to ensure all Board Directors and Governors have the opportunity to visit sites.

I am pleased to be able to confirm that this year with an increased focus on visibility Board members have been on site at least once a week with Governors joining when available. This time has allowed us to see firsthand the challenges that our staff are facing on the front line and has allowed teams the time to showcase the delivery of excellent services.

Some of the key highlights have been noted as:

- *PICUs are notoriously difficult environments but the fact that this unit is almost fully staffed is a testimony to how stable it is.*
- *Staff reported supportive ward management and that they are an are which has constantly sought to push and improve patient experience with a number of environmental "firsts in country".*
- *There were a number of innovations in reducing restrictive practice which were very good to see.*
- *It was clear to see that the Ward Manager was respected and valued by staff colleagues and patients. There was a sense of community amongst the staff and it was good to see two young nurses embarking on their nursing careers in Mental Health.*
- *There are a number of international nurses being utilised and supported on the unit but there are concerns at the level of qualified nurses.*
- *A fundamental area of concern is bed management and patient discharge is delayed due to the lack of integrated working practices and the referrals process in place.*
- *There is a recurring theme relating to system-wide huge challenge in the delay in discharge due to lack of resources within social care and therefore placing a significant impact on patients that are well enough to go back into a community/home setting are being deferred and potentially reversing their readiness to be discharged.*
- *Tour of Avon ward with the ward manager and was impressed with the gym on site funded by caring minds. The Gym Manager shared the impact the gym was having on the service users, physical health in weight loss and mental wellbeing improvements.*
- *Workshops and crafts sessions are accessible to those suffering from mental health challenges and encourage community engagement in art and creative therapy workshops.*
- *Staff were happy to work on the ward and that despite the challenging environment and patients' needs.*
- *Witnessed an excellent medical/health centre that is accessible and led by medical professionals from the community background on a voluntary basis giving back to community as part of the Sikh faith values and commitment.*
- *Really impressed by the facility, in particular the amount of quality outdoor space our resident patients have access to. It was great to hear staff speak so positively about the Trust and it was heart-warming.*
- *I was really impressed by the calm and happy atmosphere of the place and it was also great to meet some of our resident patients.*
- *The closure of B1 was raised and the consequential impact that has had on staff (eg stranded without a 'home' and demotivated).*
- *It was also great to hear about the work the team is leading on around family therapies.*

All visit feedback is reviewed with the relevant Executive Director and appropriate actions taken. The teams are informed of all actions taken and this is regularly reported through the Board Committees for assurance purposes.

Following feedback from 2023 I am pleased to note that Committee members have been visiting sites on a monthly basis and will continue this into 2025. This allows a focused visit following concerns or challenges that have been escalated to the Committee via regular reporting.

The Board have reflected on the need for increased visibility out of core hours and will ensure visits will be scheduled for evenings and nights.

The visit plan for 2025 has been developed alongside the proposal for Board members to go ‘back to the floor’ where we will all be scheduled to work alongside staff on shifts. This time will allow us to determine the challenges and recognise our hard-working colleagues.

I have personally been privileged to be able to visit a site a week and this has been humbling. I am very pleased to be the Chair of Birmingham and Solihull Mental Health NHS Foundation Trust.

PHIL GAYLE
CHAIR

Report to Board of Directors

Agenda item:	**8**					
Date	4 December 2024					
Title	Staff and Service User Stories Annual Report					
Author/Presenter	Hannah Sullivan, Corporate Governance Manager Paige Harrison, Business Partner/PA to Chair and CEO Phil Gayle, Chair					
Executive Director	Phil Gayle, Chair	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**		**Assure**	✓

The report details an overview and summary of both the staff and service user stories received at Board of Directors meetings throughout 2024.

The report highlights the feedback received and follow up on actions taken following any concerns raised for assurance.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

Staff and Service User Stories Annual Report

Birmingham and Solihull Mental Health NHS Foundation Trust

STAFF AND SERVICE USER STORIES 2024 REPORT

1. INTRODUCTION

I am pleased to offer the Board of Directors a summary of both the staff and service user stories we have been privileged to hear throughout the year.

We have heard from a range of individuals throughout the year with salient points summarised as:

- Induction programme challenges including access to ICT equipment
- Improvements in the services delivered in the North of Birmingham
- Staff shortages
- Trust values and how these are observed by service users, carers and families
- Continued improvements at HMP Birmingham in relation to staffing, concerns in relation to the estate ongoing
- Use of restraints
- Lack of variety of food options for inpatients
- Spiritual care support across service users and staff received positively
- Positive feedback from a range of staff groups being supported to develop within roles

As a Board we have supported staff through a range of opportunities to address the concerns that were raised throughout staff stories.

Following the challenges raised in relation to the Trust Induction programme the Board commissioned a full review which was undertaken over the summer. This was co- produced with a wide range of staffing groups to identify routes of improvement. A number of suggestions have been taken forward for 2025 including access and support for ICT and ESR services.

The Board of Directors recognise the ongoing staffing pressures within the organisation and nationally across the NHS. The Board have been pleased to support colleagues in international recruitment over the past 12 months and have welcomed over 60 nurses. In addition, the Trust continue the focus on recruitment to vacant posts and are pleased to have been part of regional events promoting the Trust. The Board are pleased to report the vacancy rate over the last 12 months has reduced.

It has been positive to note the ongoing improvements at HMP Birmingham with staff feeling supported as integral changes have been implemented. A number of Board members have visited HMP Birmingham over the last 12 months and myself and Roisin have been onsite to meet staff and the Governor to continue establishing positive working relationships.

The Board have been please to support the expansion of the Spiritual Care team. It has been positive to welcome a new Spiritual Care lead who is driving change with an inclusive approach for both staff and service users.

The positive feedback received has been inspiring and has allowed the Board to review areas of good practice and feed these into other areas across the Trust.

As part of the focus for the Board we also receive stories from service users, this allows the Board to reflect on how the services delivered impact those receiving our services. Katheirne Allen,

This year we have heard from two service users who were able to share their experiences of our services, following the feedback the Board have reflected on:

- The importance of living the Trust values and how this can be observed and perceived by others. The Board have reinstated 'living the Trust values' as an agenda item on the Board of Directors meetings and welcome members to share their feedback on how they have lived the values and witnessed staff living the values on visits across the sites. This is a positive reflection and provides focus for the Board of Directors.

- The Trust continue to monitor the use of restraints and continue to align with good practice in reducing the use of restraints. The Trust have an established 'Reducing Restrictive Practice' working group who are leading on this through a multi-disciplinary approach.

- The Trust have escalated the feedback in relation to catering with Summerhill Services Limited (SSL) who are the suppliers. The Board of Directors welcomed Shane Bray, Managing Director, to a Board meeting to discuss the concerns raised and have been assured a review is underway to ensure alternative options are available and cultural needs have been considered and are catered to.

As a Board we look forward to continuing to receive these stories to allow us to focus on key areas that require our support.

PHIL GAYLE
CHAIR

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	9					
Date	4 December 2024					
Title	Chief Executive Officer and Director of Operations Report					
Author/Presenter	Vanessa Devlin, Executive Director of Operations Roisin Fallon-Williams, Chief Executive Officer					
Executive Director	Roisin Fallon-Williams, CEO	**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

To provide the Board of Directors with an overview of key internal, systemwide and national issues.

The report to the Board provides information on 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 note the report.

Enclosures

N/A

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

Learning and Development

BSol wide coaching and mentoring framework

The Trust's Learning and Development (L&D) team have been identified as the lead for the implementation of a coaching and mentoring framework across the Birmingham and Solihull (BSoL) Integrated Care System (ICS). This work will feed into the wider Talent management agenda.

The ICS consortium coaching and mentoring Framework is now available, statutory organisation partners within the system will be able to onboard to the West Midlands employer's platform in December 2024 and voluntary sector and Primary partners in the new year.

Statutory and Mandatory Training

Following a letter from NHSE Re; Statutory and Mandatory Training Rationalisation in November 2024, the team are planning our implementation of the recommendations. A review of the frequency of our refresher training against the national guidance is already in progress and should be completed by December 2024.

Workforce Transformation

Our Trust vacancy rate continues to drop with a rate of 11.1% in October. We have made considerable progress with appointing to our nursing vacancies, primarily via our international nurse's recruitment and the excellent supply of student nurses to the Trust. The final cohort of nurse's joining us from international locations will do so in December.

Turnover also continues to remain stable, with 321 individuals leaving the Trust in the last 12 months. In support of continuing to stabilise and improve, our focus remains on flexible working, piloting "stay conversations" and our monthly career conversations for colleagues. We are also part of a system-wide People Promise2 group, focusing on health, wellbeing and engagement.

Bank and agency usage remains a focus. In October, our agency usage dropped to 1.8% of our total pay bill which is well below target. We are below our workforce plan target for both bank and agency usage. The next area of focus is around stopping over price cap shifts and some work is being done to negotiate with the agencies and individual workers around this.

Operational People team

New Occupational Health (OH) Service Provider

On 1st April 2025 the Trust will move to a new OH Provider – Optima. A mobilisation team has been established to ensure a safe transition of this service.

Sexual Safety Policy

The People Team is supporting the Trust's commitment to make the BSMHFT a zero-tolerance to any unwanted, inappropriate and, or harmful sexual behaviours within the workplace.

Following BSMHFT signing the Sexual safety Charter in April,2024 the People Team have been leading on adopting the NHSE Sexual Safety Policy. The Trust Sexual Safety Policy has now been drafted and has commenced its journey through the Trust policy ratification process. The People Team will also be providing a Listen Up Live session dedicated to discussing the Sexual Safety Policy.

Medical Staffing

Medical Agency Locums

The reduction in the use of medical agency locums continues. In February 2024 we had 32 doctor locums in post, our current level is at 13 in post. Plans are in place to continue this reduction.

The BSOL system target is to reduce total agency spend to less than 3.2% of the total pay bill by 01/04/25. As a Trust we have already achieved this as spend in October was at 1.8%.

Doctors' rotation – 04/12/2024

We are preparing to welcome 47 new doctors on 4th December as part of their Foundation Year 1, Foundation Year 2 and GP Training placements. They will be with us for four months as part of their full training scheme.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

DIALOG+ training has now been rolled out across the Neighbourhood Mental Health Teams and this is now being put into practice. Work is also underway to develop joint referral meetings in each locality area, with the aim of collaborative discussions to allocate cases to the most appropriate pathway dependent on need. Discussions have also commenced in relation to Peer Support Workers and how these roles may be embedded into some of the Neighbourhood Team workstreams and interventions.

Steps to Recovery has made progress rolling out the Peer Review process around Quality Standards the delivery plan is being finalised with additional service user surveys around reducing restrictive practice and user experience to be rolled out over the coming 4 months. Waiting lists are low, particularly for Rehab Unit's, the interface with Integrated Community Rehab Team (ICRT) is having significant impact. It has successfully diverted inpatient stays and shortening the LoS through early discharge to ICRT enabling bed capacity to effect step down from out of area (OOA) high dependency unit's placements. It has also reduced the number of independent OOA spot purchases from 101 to 78 with a further 7 service users on imminent discharge plans.

Recovery Near You's (RNY) recent focus has been on the retendering of the service. Despite the extension of services to Sept 25, the expectation of the new provider will be start from October 1st, 2024. Trust Business Development Teams are engaged and supporting with our partnership bid.

COMPASS Dual Diagnosis Team - COMPASS have commenced reorientation to their original model of training and supervision within acute care. Practitioners are supporting acute wards with the new referral criteria and process where required progress with be reviewed in January 2025. COMPASS have completed their first year of delivering training to Year 1 and Year 3 Pre-registration nursing students attending Applying Theory and Practice Pathway (ATAPP) training and have received overwhelmingly positive feedback from the students. The Level One Dual Diagnosis E-Learning is now ready to go live as mandatory training on an annual basis for all patient facing clinicians.

The Homeless CMHT, The Homeless Health Exchange, and The Rough Sleeper Mental Health Teams continue to work collaboratively with partners across the city for people who are homeless and rough

sleeping. The homeless CMHT is on target for their wait times and no person exceeds the waiting time to be contacted for an assessment. We will be seeing some changes with partners sadly closing their services from December. Both Washington Court and Salvation Army hostels will no longer be operating from December 2024 due to funding withdrawals. The Health Exchange who are based in the William Booth Centre, which we have been notified will close, are currently completing a quality impact assessment and working with GP partners to scope suitable alternative buildings to deliver the service from.

We are pleased to announce that members of our Allied Health Professional teams have recently been recognised at the Allied Health Professionals Day:

- Pete Watson - Sustainability award
- Shanelle King – Apprentice of the year
- Marta Godyn – AHP professional of the year
- Sukhi Kaur – Leadership Award
- Both West and South teams received recognition for their commitment

We are incredibly proud of the teams' achievements, well done all!

Secure Care & Offender Health (SCOH)

Staffing has significantly improved across the division with more qualified nurses taking up positions. In the women's service we have seen reductions in incidents of self-harm, violence and aggression over the last few months. Development of the outreach provision within the women's service remains positive with good connections now established. Low Secure Child and Adolescent Mental Health Services (CAMHS) young people have engaged in Halloween activities, such as pumpkin carving, Halloween party, cake baking and decorating and lots of spooky themed activities. The whole CAMHS service has achieved their Autism Spectrum Disorder accreditation for another 3 years.

Tamarind Centre had an outstanding peer review and CQC MHA compliance for Sycamore ward. The CQC reviewer stated, "I have never walked out of an ICU happier", recognition of the exceptional care delivery and leadership, despite the challenging environment. The service has welcomed the new policy and framework on sexual safety in the workplace working with staff to familiarise themselves. We successfully appointed Aluya Ikenya to the clinical inequalities lead role as the current lead (Jasmin Benjamin-Raj) was successful in securing a matron role at Reaside. In addition, Lynsey Wier has been successfully appointed to the substantive service manager role at Reaside. Continuous improvement has been noted in the uptake of Enhanced and Immediate life support training. Reaside was rated 'Requires Improvement' following the unannounced CQC inspection in the summer and the reports was published during November. The team continue to work on their improvement plan and are pleased that some urgent immediate estates improvement works has already been completed. The capital review group has also set aside £800K for estates improvements for the next 12 – 18 months and the Trust is actively looking for long term plans to address the environment challenges.

HMP Birmingham healthcare had a good quality network review of mental health services, meeting 85% of the standards. A Caring Minds bid of £21k has been submitted for the staff area to improve the environment. We are working collaboratively with HMP Birmingham towards an NHSE bid for improved shower areas in healthcare wings and refurbishment of two medication dispensing hatches. We continue to work closely with our Birmingham Community Healthcare Trust (BCHC) colleagues, and we are pleased to note their recruitment to vacancies is improving.

The Health and Justice Vulnerability Service (HJVS) have successfully recruited three peer mentors, which is the first in-house peer mentor recruitment for the service. Our Support Time Recovery

Workers are now supporting within the custody environment, ensuring that service users who are unable to be seen within custody are advised about the service and how to access support. The Youth Pathway have received a proposal from a VCSE partner (Voluntary, Community, and Social Enterprise sector) who is keen to offer mentoring through digital/creative arts and boxing, to our young people aged 10-18.

Forensic Intensive Recovery Support Team is working closely with estates to enable their move to their new offices at Main House. Service users who are members of the trauma informed care working group are advising on the plans to improve the environment. The service user forum continues to pick up momentum and the service are looking at ways in which to communicate information to service users within the service they are working with Accurx colleagues to identify how this platform could be used to support messages sent at mass. The service is looking at ways to focus on staff wellbeing and following the launch of the FIRST events planning committee, several local events have taken place to enable staff to feel valued, appreciated and reminding them of the importance of looking after themselves.

Our psychology service has successfully recruited to a number of psychological profession roles across the division. The Prosper team along with their service users conducted a car wash to raise money for charities, including Caring Minds. The Enhanced Reconnect service is up and running with over half of their team recruited. A submission to the market engagement event in respect of the Offender Personality Disorder psychologically led services has been made in reference to the Cameo, Affirm and Prosper services. The new contracts will be decided for April 2025.

The division excelled in some of the key performance indicators including clinical supervision uptake (85%) and appraisal uptake (90%). This is the first time the division has achieved 90% appraisal uptake after the introduction of ESR platform for appraisals.

Our Clinical inequalities project on 'Addressing Inequalities through effective co-production' reached the finals of the Nursing times award (Elizabeth Anionwu award for inclusivity).

Acute and Urgent Care

The Out of Area Steering Group has now been refocused and launched as our newly branded 'Patient Flow Improvement Programme'. The weekly meeting reviews locality level data with highlight reports presented by each locality Clinical Nurse Manager. Early feedback on the new format has been positive, however work continues to improve representation by the locality Clinical Leads, to support and enable clinical decision making and aid patient flow.

The Out of Area Standard Operating Procedure is currently being updated in partnership with the Provider Collaborative, which will include processes and standards if a placement out of area is made. Additional work is required to agree roles and responsibilities for tasks identified, noting the need to further integrate and collaborate between our Integrated Community Care and Recovery services (ICCR) and Acute and Urgent care division to aid a wider pathway approach to admission and discharge.

The clinically ready for discharge deep dive meeting has been launched with strong engagement and leadership from our Birmingham City Council social care colleagues. Recruitment of additional social workers, over winter, to support flow and the discharge process, is currently in train, with the expectation they will take up the positions in the forthcoming weeks. The aim of the group is to support and unblock complex discharges taking a red to green approach, and fully utilise all the available resources and pathways which have been put in place.

An NHSE audit of 72hour breaches in A&E has indicated areas of good practice and improvement. As a system, urgent emergency care is focusing on the implementation of provider winter plans with a key focus on admission avoidance and improving flow at the front door. This includes the focus on

improving gatekeeping and the 'call before you convey' (CbC) offer. Additional CbC staff have been recruited and introduction of the Liberty phone system which allows for better data collection and analysis.

The Right Care Right Person (RCRP) program launch of phase 3 and 4 (Transportation and 135/136) was rescheduled and commended on November 18. This has allowed for additional preparation within Urgent Care, along with training, which was facilitated by Dr Dinesh Maganty, with around 100 attendees. The session has been recorded and will be made available for all to access across the Trust. Throughout the launch week regular touch point meetings with police colleagues had been diarised, enabling partners to come together to share any concerns and seek any further clarity on the approach. We are also finally in receipt of the '*Guidance on implementing the National Partnership Agreement: Right Care, Right Person* '. The RCRP task and finish group will review and benchmarking our approach, to highlight areas of good practice as well as any gaps we need to consider.

Active recruitment is currently underway for our home treatment teams. The division is promoting professional growth opportunities within the teams, including a Band 5-6 development framework, to attract and retain talent. Additionally, they are making progress in addressing clinically ready for discharge (CRFD) and length of stay (LOS) targets, with a plan to reach the national median for both by the end of quarter 3.

Furthermore, the Repetitive Transcranial Magnetic Stimulation (RTMS) and Ketamine clinics are progressing well, with preparations on track to launch these clinics in the new year, enhancing our treatment offerings for patients across the directorate.

Two of our wards on our north site have been positively stepped down out of Enhanced Monitoring Implementation Plan (EMIP). We are pleased to report that there have been positive service users experience reports for both wards following visits by the Service User Council with Experts by Experience. Regular reviews of the Enhanced Monitoring Implementation Plan for Eden PICU show some progress in the light of recent concerns. All 3 wards still actively participate in daily touchpoint meetings focused on patient safety and care quality, which staff are reporting is very helpful.

There is an encouraging improvement in staffing across the directorate with substantive and over recruitment of graduating student nurses and additional Internationally Educated Nurses filling Band 5 vacancies.

Primary Care, Dementia Services & Specialties

The Rare Dementia Service Team have been shortlisted for the Psychiatric Team of the Year: Older-Age Adults Award in this year's RCPsych Awards. The team have been invited to attend the RCPsych Awards ceremony on 7 November 2024.

The Memory Assessment Service (MAS) have commenced 'waiting well' sessions jointly run with the Recovery College. Since May 2024, 10 group sessions have been delivered face to face and 200 people have attended virtually. The sessions were designed to provide support to both the person referred and their family whilst awaiting a MAS assessment, the sessions included practical support, tips for preparing for an assessment and signposting. This is in full collaboration with our local VCSFE partner the Alzheimer's society**.** Recent feedback from people who attended the session is extremely positive "*The staff hosting the session were amazing, helpful and respectful. They did a fantastic job of holding space for everyone's comments and feelings".*

Our Birmingham Healthy Minds (BHM), contracting arrangements have changed from a block contract to cost per case. BHM continue to increase the number of treatment contacts, achieving 712 2+ treatment in September, against a target of 806 despite workforce challenges. Five candidates

from the recent Band 7 psychological therapist interviews, which took place in May, have now commenced in post and we have further interviews planned for the month of November. The service is also establishing strong working relationships with NHS Trust Professionals Bank services, which we will utilise to reduce our waits, whilst we recruit into the remaining vacancies. A compliment via friends and family test to Birmingham Healthy West Minds was recently received "*BHM were very helpful throughout the whole process and listened to my worries and gave me solutions and guidance on how I can improve my mental health.*"

Sage, one of our older adult wards is participating in the rolling out the Culture of Care programme, which is part of NHS England's Quality Transformation Programme. It aims to improve the culture of care within inpatient mental health, learning disability and autism wards, for both service users and staff, ensuring that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work.

The Perinatal Community Service senior leads met for its new quarterly in-person meeting. Updates from teams were shared and a particular focus held on developing the Perinatal Lived Experience Pathway, Peer Support Pathway along with our ongoing work, focusing on staff wellbeing, in response to last year's staff survey results. A considerable amount of work has taken place to prepare the service for the staff survey, with service manager team briefings, highlighting the benefits of staff survey along with work to realign staff in ESR to ensure all 4 community teams receive results this year. Maternal Mental Health Services service delivered a number of events within the Trust and Local Maternity System to mark Baby Loss Awareness week, including a very successful Listen Up Live webinar. This coincided with the launch of a video co-produced with third sector partners Lily-Mae foundation, to raise awareness of the impact on partners of baby loss: https://www.youtube.com/watch?v=23DqI-twWMA This has been done to support the Partner's offer for families receiving care from our Maternal Mental Health Service.

October was a significant month for the Arts Psychotherapies Service, with local and national awards being presented to Arts Psychotherapists working within BSMHFT. Monika Muthi, Drama Therapist was awarded the BSMHFT Allied Health Professions award for Innovation and Development. The award acknowledged Monika's commitment to broadening access to psychological therapies by integrating drama therapy into the psychological offer for women and young people receiving care within Ardenleigh Women's and FCAMHS Services. Dr Jed Jerwood, Advanced Clinical Academic Art Psychotherapist within the Community Art Psychotherapy team was awarded the Inaugural Chief Allied Health Professions Officers, Gold Award for Excellence. The national award, developed by Suzanne Rastrick to acknowledge, reward and celebrate excellence, where a significant, outstanding and exceptional contribution has been made by individual members of the AHP community in England in their work; consistently leading by example, demonstrating strong NHS values and high levels of commitment and quality throughout their role. Suzanne Rastrick stated: '*For the first round of these awards, I have had the privilege of personally identifying individuals who have, often in their own time or unseen by others, strengthened significantly and supported the work that I or my wider team have undertaken during the last ten years. We are extremely proud of both colleagues who hold service users, carers and families central in their practice, evidencing our trust values of compassion, inclusive and committed in all that they do'.*

SUSTAINABILITY

Funding and Finances

The financial position of the wider NHS, and our local BSOL system, continues to be very challenging. Additional controls and oversight are now in place and the Trust continues to take an active part in ensuring any controls are proportionate and minimise the impact for our patients, carers and staff. We are still waiting for further details of how the additional funding for the NHS

announced in the Budget by the Chancellor will flow. We will update in due course.

Community Care Collaborative

Following approval of the Collaborative's Implementation Plan by the ICB Board, the Steering Group received and approved the final version of the deliverables for 2024/5 against each of the five work programmes which are set out within the Plan.

The Group received a comprehensive update on the evaluation of the initial two Integrated Neighbourhood Teams (INTs), which were launched in the east and west localities in 2023. The development of the evaluation has been a multi-partner exercise, with feedback from a range of key stakeholders, including all five integrated neighbourhood teams currently operational.

- The report draws out a number of recommendations to be considered as part of the wider INT roll-out.
- It is acknowledged that there are some constraints with the evaluation, which were highlighted
- The critical success factors for the programme include:

    1. Appropriate investment in the overall model and programme
    2. Data and digital solutions
    3. The need for appropriate infrastructure and wider Locality Operating Model
    4. Integration with BSMHFT's Mental Health Neighbourhood team.

The Mental Health Neighbourhood team and the Integrated Neighbourhood team continue to meet to develop options for further integration. A key piece of work moving forwards will be to define the ARR's roles and liaise with PCN's who do not currently have an ARR's worker in place to address barriers for implementation.

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:

A draft model of care for children's and young people's mental health has been published on the ICB website for comments. The closing date is the 20 December 2024 and will provide an opportunity for people to share their views on the proposals. This draft model of care describes an integrated and graduated approach to care and support for children and young people across Birmingham & Solihull. It aims to increase access to care and deliver improved outcomes for all children and young people, enabling them to be healthy, fulfilled and achieve their full potential by preventing mental ill health, supporting early intervention and enabling them to thrive into adulthood.

The provider collaborative has completed a review on intensive and assertive community treatment for people with severe mental health problems, identifying areas of good practice, gaps and barriers/challenges to delivery of the model. Action plans are now in development in response to this review.

A Strategy working group has been established with partners to take forward a plan for the co-production of an All-Age Strategy for Mental Health. This Strategy will set out the vision and priorities for mental health over the next five years and include the findings from the Experience of Care Campaign and all age mental health needs assessment.

Following the development of the 3-year strategic vision for inpatient beds across Birmingham & Solihull, the provider collaborative is now reviewing implementation plans developed by partners to take forward the key ambitions set out in this strategy.

A Board Strategy session focused on the delivery of Learning Disabilities & Autism priorities across Birmingham & Solihull took place on 6 November 2024 with representation from across both Birmingham & Solihull Mental Health NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust.

QUALITY

CQC Reports

During November two CQC reports were published following focused inspections of Reaside Forensic Services and our CMHTs.

The Reaside report sets out a number of areas of concerns and rates the service as Requires Improvement.

The CMHTs report sets out a number of observed improvements and moves the rating for the services from Requites Improvement to Good.

BSMHFT learning from Greater Manchester Mental Health and Nottinghamshire Healthcare NHS Foundation Trust Reviews

BSMHFT's responses to the Greater Manchester Mental Health Review, the CQC Review of Nottinghamshire Healthcare NHS Foundation Trust, and the NHSE Review of Outreach and Community Services demonstrate the trust's commitment to improving patient safety, workforce engagement, and governance.

To support the validity of the actions taken and their impact on organisation wide safety, success outcome measures will be agreed by the CNO and CMO reported on as part of our regular governance processes. This underpins our ability to remain dynamic in our approach and consistent in our focus.

Culture of Care Programme

The Trust has commenced the Culture of Care Programme in four areas across the Trust with the ambition of the CEO to take across all inpatient areas during 2025.

The Culture of Care Programme is part of NHS England's Quality Transformation Programme.
The aim of the programme is to improve the culture of care in inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work. Tried and tested QI methodology approach used to support organisations to implement the Culture of Care standards in order to achieve the programme aim.

LOCAL NEWS

Children's and Young People's Mental Health Transformation Programme – New "all-age" Operating Model announcement

As part of the CYP Mental Health Transformation Programme, BSMHFT and BWC Boards have now carefully considered the options for the management and organisation of mental health services going forward.

Both Boards therefore approved in principle to move to a single provider approach for the Birmingham and Solihull community and inpatient mental health provision that would be led by BSMHFT, endorsing the views of the Clinical Reference Group and enabling a strong, united foundation to take forward the transformation required.
We are jointly working with BWC to ensuring that staff are well-informed, engaged and can contribute to the process.

We know there are overly complex arrangements in the way we currently provide mental health services for children and young people in BSol. This makes things difficult for our teams and requires significant duplication of effort.

It is particularly challenging within a context of increasing need to support young people's mental health and wellbeing, and the stark health inequalities that exist within Birmingham and Solihull.

We are working with system partners to develop an integrated and graduated model of care that will provide support for children and young people at the earliest point of need.

This means integrated with other services – giving children and young people access across a range of services, and the graduated element is recognising different people need different levels of support. This will be an "all-age" model, in line with national policy.

We are at the start of this transition process and there will be many questions that colleagues will have.

As we work through the detailed approach to mobilise this change, we will be able to respond to questions, suggestions and concerns with relevant information.

We are proud of our dedicated teams in mental health services and the progress that has been made against a backdrop of significant challenges. Our teams in Solar have been working in an integrated way for some time and this transformation is designed to build on that good work. Thank you for your commitment to further supporting the mental health and wellbeing of children, young people and families across Birmingham and Solihull.

National Psychological Professions Week 11th-15th November 2024

The Trust supported the celebrations for National Psychological Professions week 2024 with a focused Listen up Live with Psychological Professions colleagues.
The Psychological Professions are a group of professionals with over 21 different roles, whose work is informed by psychology and psychological therapies. They work with people to alleviate psychological and emotional distress, to improve mental and physical health management and empower individuals and communities to improve their health and wellbeing. Within our Trust, we employ and are actively training colleagues from 17 of these roles, which are broadly categorised as psychologists, psychological therapists and psychological practitioners.
The Trust's focused commitment to support the expansion of psychological therapies for our patients and communities, to widen access to professional careers by creating career paths that

address entry and retention and to boldly innovate and transform with new roles that deliver evidence-based interventions to enhance the quality of our patient outcomes and experience, has meant that the Trust's psychological professions workforce has grown from 459 in July 2022 to over 560 in August 2024.

The Listen Up Live event celebrated this growth and shared the amazing achievements across our 4 Clinical Divisions and Corporate Psychology teams, many have which have been recognised by local and national awards. These include focused attention on:

1. addressing health inequalities through community engagement with our Birmingham Healthy Minds community champions, Ardenleigh Women's' Community Wellbeing group and LGCTQ+ and Dementia awareness days
2. transparently sharing how we deliver our evidence-based interventions through the Solar focused intervention pathway work and the Mood on Track animation developed by our Bipolar service
3. developing cultural competency training and resources trailblazed by our ICCR community services with this learning actively being shared across the Trust
4. initiating new service provision for communities affected by systemic failings that are being supported by our Clinical Health Psychology provision in the new Regional Infected Blood Service
5. introducing new roles such as Mental Health Wellbeing Practitioners and Clinical Associate's in Psychology who have actively supported the reduction in waiting times and increased both access to and capacity for psychological interventions across several teams in the Divisions
6. ensuring that our evidence-based activity that aligns with national guidance on the delivery of psychological practice is accurately captured in RIO as we know that there is a 40% underreporting of activity in some areas.

Our Corporate Psychology teams have also actively clinical delivery through programmes linked to education and training and staff support. These teams have further developed internships programmes for people aspiring to psychological professions training, growing career paths and career ambassadors, maximising new roles through apprenticeships and growing our own workforce and supporting coaching for clinical leaders, to enhance their leadership skillsets. We have also enhanced the co-production within our NHS Talking Therapies Low Intensity Psychological Interventions training programme and successfully retained the provision of our BSol Staff Menatl Health Hub for a further two years who are supporting the delivery of trauma informed psychologically led provision.
All in all, a wonderful celebration

NATIONAL NEWS

10 Year Plan
A new 10-year health plan for the NHS is under way. Amanda Pritchard commented in an NHSE bulletin dated 14th November 2024:

'I also set out five key tasks for every part of the NHS in the immediate future:

1. *Living within the money – in a challenging fiscal environment the Government have had to make difficult choices to support the NHS in the recent Budget. Nonetheless, budgets are likely to be tight in 25/26, so we need to continue the excellent work colleagues have done on improving productivity – as recognised this week by the Institute for Fiscal Studies - and ensuring money is*

well spent, including things like driving down agency spend.

2. *Embedding improvement – taking the resources we've made available through NHS IMPACT and best practice from across the NHS to empower teams to sweep away the things that needlessly get in the way of good care and good outcomes, and that waste their time and effort – and that of patients.*
3. *Maintaining quality and safety – particularly in urgent and emergency care as winter begins to bite, but looking beyond, including those services which are on the margins – like the recent example of paediatric audiology - to spot signals, and act, before they let patients down.*
4. *Working better with primary care – addressing the friction points which frustrate colleagues and patients alike and laying the foundations to move to a neighbourhood health service.*
5. *Making the most of the opportunities we have – fully exploiting tools we've already invested in - like the FDP and the NHS App - to make services better for patients and more productive, and ensuring we are using our collective buying power to drive down spend on everyday products.*

Doing all that will be tough – but keeping the show on the road, and continuing to reform now, is vital if the 10 Year Health Plan is to succeed and deliver an NHS truly fit for the future.'

There are a number of ways people can get involved and contribute including via **Change NHS**
Specific events in localities across the country for the public and staff are also being planned in the new year, we will share these via our communication channels as and when we receive information.

Regulation of NHS Managers

The Secretary of State for Health and Social Care announced on 24th November 2024 that a 12-week consultation will be launched for the regulation of NHS managers. This is part of a programme of work to meet the Government's manifesto commitment to introduce professional standards for, and regulation of, NHS managers, and enhance whistleblower protection.

It states: 'It *is essential that managers are also supported with the skills they need to deliver transformation and increase productivity in the NHS, which is why today's consultation forms part of a wider programme of leadership and management development work to equip the NHS with the leaders needed to deliver our 10-year plan. This includes establishing a college of executive and clinical leadership to champion and enhance the support available to NHS leaders, and asking Sir Gordon Messenger, through the 10-year plan process, to look at how we can accelerate efforts to develop more systematic talent management in the NHS.'*

David Tita, Associate Director of Corporate Governance, will be taking a lead coordinator role on behalf of the Trust to enable our enable our involvement in the consultation and provide our feedback.

State of Health and Care 2023/24 – Care Quality Commission report

The CQC published a report on the state of Health Care and adult Social Care in England for the period 2023/24. The report highlights some areas of concern such as: difficulty in obtaining GP appointments, the need for adult social care still on the rise, after care needs required when individuals are discharged from hospital, and ever increasing numbers needing help and support from mental health services.

You can read in more detail about areas of specific concern, evidence and the local system response using the following link: The state of health care and adult social care in England 2023/24 - Care Quality Commission

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Report to the Board of Directors						
Agenda item:	**10a**					
Date	4 December 2024					
Title	Current Board Assurance Framework: Recommendation to Archive					
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 current Trust Board Assurance Framework since it was last received, reviewed and scrutinised at the RMG on 24th October and at Board Committees on 23rd October and 20th November and the Audit Committee on 24th October 2024. In reviewing the current BAF, the RMG and Board committees are satisfied for it to be closed, archived and replaced with the new BAF which is more succinct and streamlined and have thus recommended this position to the Board for ratification.

2. **Introduction:**

The BAF sets out and brings into one place all the key risks linked to the delivery of the Trust strategy while providing assurance that such risks are effectively and efficiently mitigated and managed in line with the Trust`s risk management policy and best practice. The BAF thus reflects risks to the achievement of the Trust`s strategic objectives while setting out the controls in place to mitigate and manage such risks, evidence to demonstrate assurance that controls are working effectively as well as actions to address any gaps in controls and assurance and to enable attainment of target risk score.

3. **Key issues and risks:**

- The key issue here is to ensure that comms on archiving the current BAF is sufficiently populated to all staff across the Trust to ensure a smooth transition to the new BAF and avoid any confusion.
- Although most outstanding actions on the current BAF have been transferred onto the new BAF where appropriate, it is expected that leads of BAF risks with support and oversight from their Executive Director will continue to implement any outstanding actions that haven`t been transferred.

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 of Directors *is requested to:*

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE*** *and* ***RATIFY*** *the recommendation by Board Committees for this current Trust BAF to be closed, archived and replaced with the new one.*

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.

QPES 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 Committee: Quality, Patient Experience and Safety Committee (QPES)

Table 1a: QPES 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 Quality & Safety	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 Quality & Safety	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 Quality & Safety	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 transforming its	Executive Director of Strategy, People &	People Committee	AD of EDI & OD	12	02/06/ 2023	

	workforce culture and staff experience.	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**	
		Inherent Risk Rating	4	4	16	Quality, Patient Experience and Safety Committee	
Title of risk	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	**Current Risk Rating**	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**	**16th October 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.

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	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.	31st March 2025	Implementation of action will enable likelihood of risk crystallising to be mitigated.	

target risk score.	BAF01/QPES /002	Better integration of Community engagement and patient experience.	AD for AHP and Recovery/ Head of Community Engagement.	31st Jan. 2025	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.	31st March 2025	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 16 Oct 2024	BAF Risk has been reviewed. BAF reviewed and updated with regard to review of data use underway.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	3	4	12	Quality, Patient Experience and Safety Committee	
Title of risk	Failure to focus on the reduction and prevention of patient harm and at enhancing its safety culture.	**Current Risk Rating**	4	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**	**16th October 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.) <u>External</u>: • 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. New agendas set out for Divisions to report via triple a into CGC, CGC TOR updated

	• *poor management of the therapeutic environment.*	Capital prioritisation process SSL Service Agreement Forum CQC well-led and unannounced visits.	Gap in MHA Action Plan oversight arrangements from CQC inspections	Quarterly reporting to Trust CGC on overall MHA 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	Trust focus on MHA compliance at CGC is 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.	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	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

		QI resource and draft strategy PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data tracking/themes and trending and adoption of a QI approach to resolution.		committee planning structures. 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.	(outside of QI Team)- to be confirmed which Executive Team as 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	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	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.

		EBE consultation and participation in specific trust-wide groups/forums		• Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board.	
	• *insufficient staff with the correct skill set*	Improvement Programme Improvement Plans 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. Trust safety huddle established now as an example, guidance for Divisions to be completed, safety team to drop in to Divisional meetings to support

	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	29/11/2024	• 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	29/11/2024	• 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	29/11/2024	• 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	29/11/2024	• 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. October 2024 -CNO has taken direct leadership of the programme. Clinical supervision rates increasing, policy due for ratification December 2024, review of position paper for Executive Team in November 24	

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

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

	TOR for Governance Review has been prepared including options appraisal for delivery. Cohesive working arrangements between Safeguarding and Patient safety have been strengthened including shared learning as a standardised agenda in PSAG.
18/012/23	**Progress** **Additions** Multiple additions made to controls, gaps in controls, assurance, and gaps in assurance. 3 further actions added to BAF action plan to support progress around current gaps **Changes** Dates amended on the following actions; BAF02/QPES /002 – Changed from October 2023 to February 2024. This is a new agreed implementation date from PDG. BAF02/QPES /003 – Changed from February 2024 – April 2024 – In line with approved TOR BAF02/QPES/008 – Changed from November 2023 – January 2024. This was due to PDMG being cancelled. Group will re-sit in January with 1st upward report presented then. **New Actions** BAF02/QPES/009, 010, 011 have been added to the BAF **Closed/Completed Actions** The following actions have been closed/completed; BAF02/QPES/005, BAF02/QPES/006, BAF02/QPES/007 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT.
Feb 2024	Updates on progress with mitigating and managing this BAF risk.

10th April 2024	**Progress** **Additions** Multiple additions made to controls, gaps in controls, assurance, and gaps in assurance. This is following a BAF Review Meeting with all of the heads of corporate services. **Changes** Dates amended on the following actions; BAF02/QPES/004 – Action Plan Amnesty Outputs - Changed from March 2024 – September 2024. Change of date for this action requested to enable QI Projects to be robustly set up, implemented and early data reviewed against success measures. BAF02/QPES/010 – Trustwide Workstreams Clinical Supervision and RMS - Changed from April 2024 – September 2024 – Change of date requested as both projects have been defined as complex and having cross-organisation dependence. It is anticipated that the increased timeline will enable meaningful updates and improvements. BAF02/QPES/011– Customer relations KPI Plan Changed from January 2024 – May 2024. Increase in date requested as Part 1 plan for timeline of completion of historic complaints (greater than 6 months) has been submitted to QPESC for April. Part 2 of the plan will be submitted in May. **New Actions** No new actions have been added. **Completed/Embedded Actions** 7 Actions have closed/been embedded as part of the review of the BAF. Embedded BAF02/QPES /001 BAF02/QPES/005 BAF02/QPES/007 Completed BAF02/QPES /002 BAF02/QPES /004a BAF02/QPES/008 BAF02/QPES/012 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below;

	Likelihood: 4: Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB and requires improvement rating from CGC following themed inspection of CMHT.
12th July 2024	**Progress** Additions Following review further changes have been made to controls, gaps in controls, assurance, and gaps in assurance. **Changes** Dates amended on the following actions; BAF02/QPES/010 – RMS and Clinical Supervision Workstreams: The date has been amended on this action due to the Clinical Lead for the Clinical Supervision Project being off for some time on unanticipated sick leave and the Project Lead for RMs having recently left the organisation and it is not evident that clear outputs and timelines have been assigned to this project. QI have worked extremely hard to maintain progress on this project, but further work needs to be taken to establish clarity of outputs. It is anticipated that revised/defined timelines for this work will be established by the next iteration of the BAF. **New Actions** No new actions have been added. **Completed/Embedded Actions** **BAF02/QPES/011:** Customer Relations KPI Improvement Plan will be devised and reported to QPESC on a monthly basis. This has been completed and KPIs are significantly improved. **Scoring** **It is recommended that the scoring is reviewed with a possibility of reduction in scoring. Rationale is detailed below;** Previous Likelihood: 4: Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics.

	Consider New Likelihood: 3: There is mixed evidence in relation to current outcomes with some improvements in sources of evidence and some sustained concerns. Improvements CQC: Recent CQC inspection of Eating Disorder Inpatient Unit rated as "Good". Also evidence of significant and sustained improvement against the recent CMHT S29A's and awaiting formal feedback from re-inspection. Complaints: Complaints KPI's have continued to improve over the last 8 weeks as presented through QPESC and although some historic complaints remain these are being worked through in targeted timelines. Governance KPI's/metrics: Specific metrics within the Patient Safety and Experience Report have remained consistently on or below the mean for the quarter including staff assaults and restraints over the quarter Sustained Concerns PFD's: The Trust has received 2 further PFD's in the last 6 weeks relating to issues of ongoing concern impacting patients safety. External Reviews: The Trust also has 7 ongoing homicide reviews with significant learning evolving through the review processes Consequence: 4: Internal data evidencing staff and patient harm including; patient assaults, a recent in-patient death, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB.
10th Sept 2024	Action: BAF02/QPES /003 31st May 2024 Request extension of due date from 31st May to 31st Oct 2024 to enable completion of action following successful holding of the CGC workshop.
16th October	CNO leading on Clinical and Management supervision, improvements being made.

	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	2	6		
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date added**	2nd June 2023
						Date reviewed	16th October 2024
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
	There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance. This may be caused by: -						
BAF03/QPES	• Inability to effectively use time resource in driving improvements and safety. • Failure to use QI approaches to develop pathways to improve access to services. • Inability to develop and embed an organizational learning and safety culture.	• SI oversight Group • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity.	Limited assurance from current approach to review of quality and governance metrics at Divisional level. Limited reporting of Divisional quality reviews to QPES and Board.	• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC,		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	

	• 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.	

target risk score.						

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. **<u>Completed/Embedded Actions</u>** Nil **<u>Scoring</u>** **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 **October 2024** October 'speak out, listen up' month of focussed activities, resulting in more staff accessing FTSUG support PSIRF review underway Paper to QPES on learning from Greater Manchester and Nottingham Reviews Masterclass held with the Senior Coroner for Birmingham

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**	**16th October 2024**

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

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

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

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

Actions being implemented to achieve target risk score.	BAF04/QPES /001	Review and refresh of the family and carer pathway	Associate Director for Allied Health Professions and Recovery	31st 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**	**16th October 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF05/QPES	**There is a risk that the Trust may fail to be rooted in communities and tackle health inequalities.** This may be caused by: -				
	Lack of engagement with our local communities. Services that are not tailored to fit the needs of our local communities or aligned to local services. Lack of understanding of our population, communities and health inequalities data. Not working together to tackle inequalities across the BSOL system Inadequate partnership working leading to barriers between services e.g., primary care, social care. Demand for community services exceeding our	• Data with Dignity sessions. • Divisional inequalities plans. • PCREF framework • Synergy Pledge. • Provider Collaborative inequalities plans. • System approaches to improving and developing services. • Community Transformation Programme – now in year 3 of	• Divisional inequalities plans not fully finalized for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day job. • Recruitment and	• Integrated performance dashboard. • BSOL system mental health performance dashboard. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering Group. • Reach Out governance	• Inability to engage with all parts of the Trust. • Local meetings not feeding into higher level. • Relevant people not present at deep dives; includes consistency of how these are carried out and how KPIs are monitored.

	capacity to deliver good quality, timely care. People having to go out of area for inpatient care due to inadequate service provision in area. Failure to have appropriate quality and modern estates and facilities	implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work. • Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighborhood teams. • Development of community collaboratives. • Community engagement team	retention	structures. • Local FPP and CGC meetings. • Highlight and escalation reporting into Strategy and Transformation Board. • Performance Delivery Group “deep dives”. • Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feeds to Inequalities board. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.	
	This may result in: -				

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/QPES /001	Work ongoing to keep down capital costs of major developments, e.g. assessing potential use of a modular build.	Deputy Director of Estates / Associate Directors of Operations	31st Dec 2024	Affordable capital plans with identified funding.	
	BAF05/QPES /002	Quality improvement approaches being embedded to support transformation. Above action modified to read as thus: - Work to address inequalities has commenced on certain parts (e.g. Secured Care & Perinatal Services) of the Trust and is progressing.	Head of Quality Improvement / Associate Directors of Operations	Ongoing process	Enables successful delivery of transformation plans and service developments.	
	BAF05/QPES /004	Support for development and implementation of divisional health inequalities plans from EDI team	Jas Kaur / Associate Directors of Operations	Ongoing process	Services will understand their current gaps and have actions in place to improve access, experience, and outcomes.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Co-produce approach with patients and carers and Voluntary Sectors and have devised a plan to integrate our patients successfully in the Communities.
29/11/2029	Updates on progress made so far.
29th Feb 2024	Updates on various works happening in other parts of the Trust have been considered. Actions reviewed and new one added.
08th April 2024	For BAF05/QPES/001 & Estates and Facilities element proposal completed; Plans proposed for new Highcroft 32 bed ward following Modern Methods of Construction- modular build. Awaiting Business Case approval.
27th June 2024	Risk reviewed and new elements of assurance added. Risk score has been reduced from 4 x 4 = 16 to 3 x 3 = 9 for greater accuracy and to reflect actual potential risk.
16 October 2024	Health Inequalities update report coming to QPESC

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	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**	**16th October 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:
		  ○ Transition workers
		  ○ 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.

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**	**16th October 2024**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
BAF07/QPES	**There is a risk that the Trust may fail to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.** This may be caused by: -						
	Not thinking as a system in developing priorities and improvement plans Lack of appropriate partnerships Ineffective partnerships e.g., lack of trust, collaboration, engagement, being seen as equals etc. Pathways and interfaces that are fragmented not joined up – both internally and externally Not being involved in system wide developments and	• Trust is a representative on key system groups e.g., ICB Board, Place Committees, Inequalities Committee. • Lead provider for BSOL mental health provider collaborative. • Lead provider for Reach Out (secure care) and a partner in CAMHS, eating	• Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about	Reports on system and partnership activity to: • WM Provider Collaborative Board • Provider Collaborative governance structures (BSOL and specialist services) • Operational Management Board • Strategy and Transformation Board • Board Committees • Trust Board			

	initiatives e.g., development of place, wider health inequalities work etc. Not having service user voice to inform transformation and development plans	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.	our population and needs.	• Productivity programme in acute urgent care. • Community care collaboration. • Full community pathway integration – SMI adults (community transformation programme). • CYP transformation programme. • Continuous QI across the trust. • Co-produced Digital transformation – patient portal.	
	This may result in: -				
	• Lack of joined up pathways and care. • Service users falling between gaps. • Poor service user experience. • Poor service user outcomes. • Negative Trust reputation. • Loss of confidence in the Trust by partners. • Potential duplication of effort and services. • Poor value for money.				

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF07/QPES /001	Refresh Partnerships Strategy	Head of Strategy, Business Development and Partnerships	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	June 2025	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.

Appendix 2: Details of the FPP Committee BAF

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

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

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

		and this offers the ability for new ideas to be looked at through a lens keeping digital on the agenda. • The DOF Chairs, CIO is included in the distribution of all new business cases.	Capital Review Group, existing services are not considered unless capital investment is required.		
	• *Teams and services are not aware of digital solutions within the Trust.*	• System strategy group produces an annual update to the Trust (Digital newsletter). • The PMO ensures all digital projects have a case study and project on a page submitted to Connect and the staff briefing as they occur. Individual projects are discussed at FPP in the quarterly assurance update.	• 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.

		• 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
Actions being implemented to achieve target risk score.	**BAF01/FPP/ 001**	Wider communication across the Trust regarding the Systems Strategy Group, including its role.	James Reed / Carl Beet	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	
	BAF01/FPP/ 002	Raise awareness of the ability for the Systems Strategy Group to help in service redesign and re-imagining service delivery. Start with Senior Leadership Team meeting and professional user groups	James Reed / Carl Beet / Shaun Kelly	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
12/06/2023	This is a new risk which has been recently added.
19/09/2023	Updates to FPP have taken place in line with the quarterly cycle, 9 comms articles have gone out in the last quarter lifting the profile of digital projects and services featured in the weekly brief. The Digital strategy is in draft and has been shared with FPP and circulated through wider meetings as part of a general digital awareness. We have dedicated snap comms for all things digital and have used the snap comms to promote campaigns on cyber awareness, general digital updates, and system upgrades. We have expanded the use of the virtual agent / chat bot "Ask Jake" which now covers the majority of password resets in the organisation and we are looking to expand that in to other departments such as HR and Estates.
14/12/2023	Members of the FPP and the various BAF leads at the BAF review meting queried if the lack of a Trust-wide transformation/continuous improvement piece or operational driver for digital shouldn`t be the focus of this risk considering the fact that digital is only an enabler with the aim of maximising the benefits of the transformation agenda. The Trust thus needs to demonstrate clarity around what it wishes to achieve through its clinical services transformation agenda with digital supporting as an enabler. Members agreed that this BAF risk is around failure to maximise the benefits from the investments in IT and that it should be widened to include cyber security and recommended the following new BAF risk for consideration: - • Potential failure to reap the added value of and embed a Trust-wide culture of continuous improvement and transformation. This underpins the risk of not delivering the outcomes linked to the transformation Strategy as reflected in our inability to define how things will look like in say 3years time.
11/03/2024	Digital, data and technology presentations have taken place with exec colleagues and a dedicated session at the senior leaders' briefings. The System Strategy group continues to be the core group for all Digital, data and technology asks within the Trust, we have increased the areas represented and the diversity of the group to ensure greater collaboration and awareness takes place across the organisation. We are moving on to the national tenant for Office 365 to aid with the wider system collaboration piece across the ICS, this should aid with integration across our own organisational boundaries and help with accessing data from other organisations in the ICS. We have published our Microsoft roadmap on connect under the PMO and ICT pages, to aid the wider communications piece. The HR chatbot is under development to help with all Digital HR matters across our teams and we continue to automate the onboarding work for TRAC and ESR.

			Impact	Likelihood	Score	Oversight Committee	
Executive Lead	Executive Director of Finance	**Inherent Risk Rating**	4	4	16	Finance, Performance & Productivity Committee	
Title of risk	Potential failure in the Trust's care of the environment regarding implementation of the Green Plan.	**Current Risk Rating**	4	3	12		
		Target Risk Score	3	3	9	**Date added**	8th June 2023
		Risk Appetite	**Open:** Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements. **Target risk score range 9-10.**			**Date reviewed**	**17th July 2024**

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

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

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

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

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

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

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

target risk score.				Action is redundant giving the lack of funding to address Reaside functional suitability`.	premises supporting safe, and sustainable care environment. Trust responsibility re the prioritisation and provision of capital funding. Given lack of funding then due consideration to the removal of this as risk as it may be beyond direct control.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
11/05/2023	Full review of all 31 Estates and Facilities Risks, 12 Risks accepted and closed these will be reviewed annually to ensure circumstances and mitigation remains in place. The remaining 19 Risks have been re-assessed for content, mitigation, likelihood, and impact.
12/09/2023	Strategic Trust Sustainability/ Green Meetings BAU. Works underway to draft achievement against NHS E MOU. Comms Plan for Autumn/ Winter 23 underway. Liaison with Trade Unions on information and details for Green initiatives.
14/12/2023	Members at the BAF review meeting argued that this risk around the `Green Agenda` and should include the fact that it is driven by three things i.e. standards set by the quality improvement piece, the therapeutic environment and safety of patients. Members then recommended that this risk should be refined with clarity of purpose to include elements around transformation, compliance and the need to maximise benefits to patients and avoid harm.
26th Feb 2024	Risks and controls remain as this represents a long-term strategic approach needed by the NHS to manage its Sustainability and Net Zero challenges. It does not represent a short-term project or programme of works. Indeed, failure to deliver against the agenda in its entirety being a significant risk to all NHS organisations. In terms of long-term planning very significant financial resources will need to be made available to allow for fundament challenges such as Heat Decarbonisation. BSMHFT full Regional and National engagement. SSL/BSMHFT leading the ICB/ICS responses Nationally.
17th July 2024	As February 24 - Risks and controls remain as this represents a long-term strategic approach needed by the NHS to manage its Sustainability and Net Zero challenges, failure to deliver against the agenda in its entirety being a significant risk to all NHS organisations

	Continue to work across ICS and with NHS E re prioritisation of initiatives and joint working Long term planning needed re the refresh of the Green Plan and embedding Green and Sustainability as core to the Trust. Trust Strategic return completed re again the 'embedding' of Green Plan into core strategic organisational SSL/BSMHFT leading the ICB/ICS responses Nationally Low Carbon Skills Fund application submitted for revenue funding towards detailed design for Heat Decarbonisation schemes at 4 sites. Trust Green / Carbon Steering Group held 3 monthly with good corporate attendance, struggle re clinical attendance

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
Title of risk	Failure to operate within its financial resources.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	3	9	**Date added**	09/06/2023
		Risk Appetite	**Open:** Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels. **Target risk score range 9-10.**			**Date reviewed**	**17th July 2024**

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

		ICS expectations and reporting requirements.	Trust has not been able to develop a pipeline for delivery of savings.	statutory financial obligations, including any shortfall in savings delivery.	would improve controls and performance.
	This may result in: -				
	• *Trust not meeting its financial targets limiting available funds for investment in patient pathways.*				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.			
	112	The Trust does not secure the growth funding we require.			

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

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

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

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

01/09/2023	Communications issued to whole Trust re financial position – number of initiatives implemented to increase controls including Vacancy Control Panel and Investment Oversight Group. Work ongoing to identify further opportunities for efficiencies and work by KPMG at system level now being finalised which offers some further options
14/12/2023	Members at the BAF review meeting argued that this risk is around compliance and the need to avoid financial failure and queried in the light of the previous discussions on digital and the green agenda if it has been appropriately framed? They also argued that this risk should specify which year it is referring to and how finance is enabling investments in clinical care and transformational change. Members also agreed that the Trust needs to generate financial efficiency in order to have the financial headroom to invest in the things that we want and to maximise benefits from the investments we make.
12/2/2024	BAF risk title amended to include reference to financial year 23/24 in light of discussions around when the risk relates to. Likely that the score will need to be amended to reflect the outcome of the planning round and certainty in income for 24/25 but position not yet confirmed. Additional element added within controls around utilisation of balance sheet flexibility as this is how the position is being managed in this financial year as reported and agreed by Board as part of the NHSE financial reset. Proposal for Risk Management Group to review how the risk is framed for 2024/25 financial position once there is more certainty around plan for next year.
14/05/2024	The majority of actions are now completed; however, the above two outstanding actions have been added and are ongoing.
17/7/2024	The financial plan for 2024/25 has been reviewed and approved by FPP and Board. It includes elements of financial risk, especially around savings delivery, out of area reductions and programmes around temporary staffing, but the plan is to deliver a £2m surplus for which at Q1, the Trust remains on track to deliver.
17/7/2024	Internal Audit continue to review elements of financial performance and process – during 2023/24 they completed audits on our Cost Improvement Programme (4.2023/24) giving reasonable assurance, and also completed a financial culture review with some recommendations that will be followed up in a further culture review in 2024/25. The audit plan for 2024/25 also includes an audit around financial controls.
15/10/2024	BAF03/FPP/02 – Financial Management Policy has now been adopted by the Sustainability Board and has been in use by the Finance Department since the beginning of October. BAF03/FPP/03 - Finance teams have adjusted their local level reporting, and have a session with an external partner to share learning around Power BI finance tools. The changes to the ledger, and chart of accounts from the imminent changes as a result of BSMHFT receiving services currently provided by BWCH means that all financial reporting arrangements will need to be reviewed.

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
Actions being implemented to achieve	BAF04/FPP/004	Update the Trust Risk Management Policy and Risk Appetite Framework.	David Tita	31/12/2024	Risk Management will provide a framework to underpin effective risk management and prevent the likelihood of risk materialising.	

target risk score.	BAF04/FPP/ 005	Re-design, redefine and re-structure the Trust BAF.	NEDs, EDs & ADs	31/12/2024	This will create a slim down BAF, enhance engagement, understanding and compliance.	

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	This is a new risk that has been recently added and is being appropriately mitigated and monitored.
19/09/2023	ToR for the review of the Trust`s governance arrangements have been finalised and are progressing through governance for approval and implementation. ToR also include a schedule for undertaking the governance review and an options appraisal reflecting potential options that have been considered and a recommendation of the preferred option. Timescales for delivering the various actions have been reviewed to align with the ToR.
14/12/2023	Risk description strengthened to focus on the lack of a culture around compliance and other aspects of compliance. Some fresh causes, controls and assurance have also been added especially around the requirements which underpin the new NHS Provider Licence. Request change of due date for action BAF04/FPP/ 003 to enable aligning its implementation to the ongoing review of the Trust`s governance arrangements.
8th March 2024	A CQC Steering Committee that regularly meets has now been created to monitor and oversee ongoing pieces of work around compliance with CQC regulatory provisions, standards and Notices and safety practices.
17th July 2024	Risk has been reviewed and progress notes added. Completed actions have been turned `green ‘and two new actions added. Recommend reduction in risk score to reflect progress; suggest 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.

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

Risk ID or Number		*Things in place to address the cause*	What are the weaknesses in the controls?	*Triangulated evidence that the controls are in place, being followed, and making a difference*	What are the weaknesses in the assurance?
BAF05/FPP	*There is a risk that the Trust may fail to harness the opportunities and dividends provided by partnership working within the system and collaborative space in delivering high quality patient-centred mental health services to the local population of Birmingham and Solihull.* This may be caused by:				
	• *Inability to embed BSOL Mental Health Provider Collaborative*	• MHPC governance architecture. • Reach Out governance architecture. • Appropriate contractual arrangements – procurement, dispute resolution, suspension and termination, decommissioning, and conflicts of interest policies. • Enhanced relationships with partners. • Multi-partner Hub. • Better engagement with partners and shared governance arrangements. • Establishment of Memorandum of	• *Newly established groups which are working through their interface with the various governance structures.* • *Limited number of policies in place to support contract management, ie decommissioning.* • *Newly relationships take time to nurture, grow and mature.* • *Changes to the translation of the Procurement, Patient Choice and Competition Regs 2013.*	• Procurement Plan • CQC Reports • Other regulatory Reports. • CQRMs enabling effective management, oversight and collaboration.	• *Time to mature newly developing relationships with providers requiring trust and transparency.*

		Understandings. • VCFSE collective and Panel embedded into governance structure in the Collaborative. • Implementation of Data Sharing Agreements.			
	• *Poor Commissioning Committee decision-taking.*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance architecture. • Partnership Agreement • Memorandum of Understanding.	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out Commissioning Sub-Committee • Escalation and assurance reporting from Executive Steering Group • Auditable process for decision-taking • Consistent attendance at CoCo Sub-Committees	• Delays in getting signed agreements.
	• *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	• Time required to commission effective frameworks. • Time to build trust, faith and confidence.

				• Minutes from Executive Steering Group.	
	This may result in:				
	• *Poor quality of services to the local population including poor patient experience.* • Dysfunctional relationships with partners and the potential reputational damage. • Failed collaborative ventures. • *Poor patient outcomes, and increased regulatory scrutiny, intervention, and enforcement action.* • *poor system engagement.* • Lack of trust, faith and confidence in BSMHFT.				
	Linked risks on the CRR-Risk ID	**Brief risk description**			
	N/A	N/A			

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

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

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	Not applicable at this moment as risk has been newly identified.

28/09/2023	• There have been two workshops facilitated by Korn Ferries with the CYP Transformation Boards in both Birmingham and Solihull to support a re-set of the Boards including the positioning within the MHPC Governance Architecture. • Continued engagement with the VCFSE forum. • Multi-agency working groups have been established to take forward the commissioning of the Health Needs Assessment and Campaign to support the development of the BSOL MHPC Strategy.
14/12/2023	Members at the BAF review meeting recognised that partnership working is a means to an end and argued that the risk here is around the inability to land a system-wide strategy for BSOL, with enablers such as the BSOL MHPC, effective commissioning and working across the system and co-producing solutions while delivering health services to our populations in a much more impactful way.
Feb 2024	Updates on progress with mitigating and managing this BAF risk. • All Age MH HNA has been commissioned from the Centre for Mental Health which will be delivered in August 2024. • Experience of Care campaign led by Rethink Mental Illness will underway and due to be completed May 2024. • Interim Strategy for BSOL MHPC to be available in draft end of March 2024. • Co-produced All Age MH Strategy to be developed by end of March 2025. • Ongoing engagement with VCFSE Panel and Collective. • MHPC attendance at Birmingham City Councils Strategic Commissioning Group. • MHPC attendance at Solihull Commissioning Group meetings – monthly. • Review of governance arrangements for the inclusion of Learning Disabilities & Autism. • Determining new arrangements surrounding introduction of Procurement Selection Regime 1/1/24.

Appendix 3: Details of the People Committee BAF

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to shape our future workforce.	**Inherent Risk Rating**	4	5	20	People Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	3	12	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**18th July 2024**

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

			significantly increasing. Still losing staff within first 2 years, some staff groups i.e psychology and pharmacy are above turnover KPI.		• Staff survey results still reflect some gaps.
	• *Less attractive pay for some staff groups.*	Management of the workforce market: • ICS workforce programme to manage demand and competition in the system in collaboration with partners. • Membership of the ICS People Committee. • Assertive recruitment to areas with chronic vacancy challenges. • National payment mechanisms and banding panels. • Remuneration Committee. • Recruitment Policy and processes. • Stabilisation Plan • Retention Plan		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population • Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover • 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	• Falling to reassurance rather than assurance

				engaging with agency workers.	
	This may result in: -				
	• Failure to recruit a workforce that supports the values of the organisation. • Support the progression and development of the workforce. • An underperforming workforce. • Failure to represent the profile of the organisation within the workforce. • Sustained patterns of inequality and discrimination. • High turnover • Non-compliant behaviours. • Employee relations cases.				
	Linked risks on the CRR-Risk ID	**Brief risk description**			
	1058	Shrinking supply of mental health nurses nationally. Additionally, Difficulties in recruiting to and retaining Band 5 Registered Mental Health Nurse and shortage of experienced Band 6 Registered Mental Health Nurses continues to be a challenge (4x4=16)			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/PC/001	Deliver our workforce plan through: Increasing workforce supply to address workforce gaps across the organisation.	Head of Workforce Transformation	March 25	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF01/PC/002	Progressing the retention activities and improve our turnover rate.		Dec 24		
	BAF01/PC/003	Support delivery of service specific recruitment and retention plans.		Ongoing		
	BAF01/PC/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		March 25		

	BAF01/PC/005	Develop and roll out a package of First Line Management (B5-7) training that supports all aspects of the role and is supported by an action learning set infrastructure	Head of People & Culture	Dec 24	Training has now launched although not all modules are up and running, this is being monitored via Shaping Our Future Workforce Committee.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Work predominately in this area is progressing as planned. Volumes in relation to INR has not been achieved as projected, however this is being addressed. Despite continuous IA around junior doctor and consultant pay, recruitment to consultant posts has increased. Retention is healthy within the Trust, priority is with attraction and onboarding. Score remains the same.
12/12/2023	The likelihood score has reduced to a 3 bringing the overall risk score down to a 12, International recruitment is continuing at a steady pace. A full onboarding review has taken place with improvements identified. Work is continuing to move bank workers onto substantive contracts. Working with the ICS on areas of priority such as agency pay. Directly engaging with agency workers. A request for an extension of the deadline for risk BAF01/PC/005 is sought due to the delay in finalising some of the modules, therefore this is being rolled out on a phased approach with a final launch date of March 2024.
7/03/2024	A revised launch date for the first line management training programme has been identified for Apr 24. This will be monitored through Shaping the Future Workforce Committee. There have been significant numbers of Internationally educated nurses arriving who have completed or currently completing their OSCE training and are being inducted into the organisation. The workforce planning round has commenced for 24/25. Staff in post continues its upward trajectory and turnover continues to improve. Head of Workforce Transformation has started in post and will lead on this BAF risk.
18/07/2024	Further modules have been released as part of the FLM programme and a revised model for leadership has been shared at internal committees, INR and student nurse recruitment continues to positively impact on band 5 vacancy rates. Task and finish groups have been established to have a focus lense of workforce initiatives such as grow your own and stay conversations

Updated CRES BOARD ASSURANCE FRAMEWORK

			Impact	Likelihood	Score	Oversight Committee	
Executive Lead	Executive Director of Strategy, People & Partnerships	**Inherent Risk Rating**	4	5	20	People Committee	
Title of risk	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	3	12	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**18th July 2024**

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

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	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	April 25	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

target risk score.	BAF02/PC/003	Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes	AD OF EDI and OD	Dec 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional factors have been highlighted that add to the risk without increasing the score
12/12/2023	Likelihood risk score has been reduced due to a number of activities that have taken place over the last quarter, The HR Toolkit now launched with a number of key policies revised, and language changed to reflect values. Social media policy has been ratified and due to launch shortly. We have reframed values in practice process. Pulling together EDI and OD in relation to restorative learning and Just Culture and there has been the development of the corporate psychology offer.
March 2024	BAF02/PC/002 BAF02/PC/003 timelines may need to be extended as although underway resource to develop the infrastructure for delivery has only been fulfilled in the last 8 weeks.
18/07/2024	Staff survey details have been shared and teams are now developing local engagement plans with the support of the OD team. FLOUISH programme commencing over the next 3 months with the reframe of the leadership offer under a global lens. Colleague Engagement approach confirmed through TCSE Any updates on actions being implemented.

Updated QPES 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?**
BAF03/PC	There is a risk that the Trust may fail to modernise its people practice in ensuring the achievement of its operational objectives. This may be caused by: -				
	• *Inability to deliver digital solutions.* • *Inability to foster a psychologically safe environment.*	• Staff survey • Pulse check • Reflective HR casework • Transforming culture sub-committee • Systems strategy board • A range of digital platforms through which colleagues can escalate and feed in centrally. • QI Projects to address some of the concerns raised by staff.	• Colleagues not completing surveys. • Capacity to undertake this work. • Low trust and confidence. • Lack of digital infrastructure. • Lack of sufficient funding.	• 360-degree feedback for senior leaders • FTSU quarterly reports to committees • HR casework tracker • Staff survey results are improving in some areas. • Improved HR KPI reports. • Audit reports • Digital Staff management system. • New workforce digital group, project tracker on people goals	• Falling to reassurance rather than assurance. • Lack of engagement and buy-in from staff. • Built in evaluations to every large-scale project • Audits are not systematic as they are adhoc at the moment.

		• Research and benchmarking against what good looks like. • Working with ICS partners to identify shared digital solutions. • Use of integrated digital solutions e.g. Digital passports.	• Lack of digital competence. • Lack of digital expertise within existing workforce resources to deliver training. • Digital solutions haven`t been embedded.	• Trust wide audits are conducted in line with a forward planner learning lessons which will be considered for future activities.	• local audits are more sporadic.
	This may result in: -				
	• Poor employer brand limiting recruitment. • Staff feeling vulnerable and unable to speak up resulting in missed opportunities to improve practice. • Increased retention of a valuable workforce. • Compensation costs. • Increased regulatory scrutiny, intervention, and enforcement action.				
	Linked risks on the CRR- Risk ID	Brief risk description			
	N/A	N/A			

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

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

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

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Progress in relation to developing a range of digital solutions for our people processes has been slow due to staffing shortages, however some local work has been completed. Work is underway to address the accuracy within our ESR data and this now will be overseen by an internal workforce systems group. Score has not changed.
12/12/2023	Risk score remains the same as this is the area with least progress. A new workforce digital group has been set up, and trust wide audits are in place for any large-scale changes so lessons can be learned, however as this work has only just started we are not able to assess the impact to reduce the risk scoring.
07/03/2024	Risk score has reduced slightly, due to the work that has been completed since the last update to increase the accuracy of data and demographics of F/W requests, leavers and honorary contract status. We have received a small amount of funding from NHSE to improve ESR data quality and currently reviewing options. Work is underway on a People chat box similar to Ask Jake which will provide automated responses and sign posting for HR related queries, which is due to launch the end of March 24. Other suggested areas of improvement are now being presented and reviewed regularly by internal groups.
18/07/2024	'Ask Ava' HR chatbot has now been fully launched and receiving initial positive feedback. Further work continues to be carried out on our quality of F/W data and leavers analysis. Wider project work around usage of ESR is due inline with national review. Rosters for our medics have now been moved to online through Allocate.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	4	12	**Date added**	**6th July 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**18th July 2024**

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

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being	BAF04/PC/ 001	Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	AD OF EDI	Ongoing	Action will mitigate potential likelihood of risk materialising.	

implemented to achieve target risk score.	BAF04/PC/002	Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust.	AD OF EDI	April 2025	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 the Board of Directors							
Agenda item:	**10b**						
Date	4 December 2024						
Title	New 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**	✓

- **Purpose:**

This report aims to reflect the progress that has been made in developing a new BAF for the Trust.

- **Introduction:**

A 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 Risk Management Group and the Audit Committee at their meetings in October reviewed, scrutinised and endorsed the form and structure of the new BAF which comprises the following overarching BAF risks: - (Please check appendices for details).

- **SR1** - Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.
- **SR2** - Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.
- **SR3** - Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
- **SR4** - Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
- **SR5** - Failure to maintain a sustainable financial position.
- **SR6** - Failure to maintain acceptable governance and environmental standards.
- **SR7** - Failure to deliver optimal outcomes with available resources.
- **SR8** - 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.
- **SR9** - Failure to continuously learn and improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

- **Key issues and risks:**

There are three key issues worth flagging at this moment: -

- The need to sufficiently populate the new BAF once it has been approved by this Committee and ratified by the Board.
- The need to ensure that the new BAF is regularly reviewed and updated.
- The need to align each risk on the new BAF with the relevant risk appetite category once the Board has ratified by the Trust`s Risk Appetite Framework.

The new BAF will be populated through existing governance and management meetings/structures as well as regularly reviewed by relevant Executive Directors and their ADs/Deputies. All BAF risks will be aligned with the Trust`s Risk Appetite Framework once it has been ratified by the Board.

NB: ***SR7 (Failure to deliver optimal outcomes with available resources)*** hasn`t been included in this BAF piece as there are further cross priority discussions planned in the coming days to developed and present it at the extraordinary FPP on 19th December 2024 for approval and then ratification at the Board on 5th February 2025 prior to its inclusion in the new BAF.

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 RATIFY*** *this new BAF for the Board,* ***NOTING*** *that each BAF risk will be aligned with the Trust`s Risk Appetite Framework once it has been ratified by the Board today.*

Enclosures

Appendix 1: Summary of the draft new Trust Board Assurance Framework.
Appendix 2: Trust Board Assurance Framework Heat Map
Appendix 3: Details of People Committee Board Assurance Framework.
Appendix 4: Details of QPES Board Assurance Framework.
Appendix 5: Details of FPP Board Assurance Framework.
Appendix 6: Details of QPES Board Assurance Framework continues

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. 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							
SR1	Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.	June 2024	October 2024	DSPP	**4x3=12**	N/A	**5x4=20**
SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.	June 2024	October 2024	DSPP	**4x3=12**	N/A	**5x4=20**
2. Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve							
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	Sept 2024	October 2024	CN	**4 x 2 = 8**	N/A	**4 x 4 = 16**
SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.	Sept 2024	November 2024	CN	**4 x 2 = 8**	N/A	**4 x 2 = 12**
3. Sustainability: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population							
SR5	Failure to maintain a sustainable financial position.	Sept 2024	October 2024	DOF	**5 x 2 = 10**	N/A	**5 x 4= 20**
SR6	Failure to maintain acceptable governance and environmental standards.	Sept 2024	October 2024	DOF	**3 x 3 = 9**	N/A	**5 x 4= 20**
SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	October 2024	DOF	**5 x 4 = 20**	N/A	**4 x 4 = 16**
4. 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							
SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.	Sept 2024	October 2024	MD	**4 x 2 = 8**	N/A	**4 x 4 = 16**
SR9	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.	Sept 2024	October 2024	COO	**4 x 2 = 8**	N/A	**4 x 4 = 16**

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic				SR5 SR6	
4 Major			SR4	SR3 SR8 SR9	SR1 SR2
3 Moderate					
2 Minor					
1 Insignificant					

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.	• **Shaping our future workforce** • **Transforming our culture and staff experience** • **Modernising our people practice**	• Increased FTSU contacts. • Staff survey results • Colleague feedback	• 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.	People Committee	Executive Director of Strategy, People and Partnerships	SR2

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
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.**			5	5	25
		DATE RISK WAS ADDED	June 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5x Likelihood 4=20	Poor staff experience, low morale, feeling less valued and listened to, unable to speak up and develop trusting relationships with colleagues, all contribute to the Trust's inability to retain its skilled workforce.	**Impact 4 x Likelihood 3=12**	A number of workforce plans focused on improved culture would have a positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL

▪ Robust international recruitment process ▪ Robust workforce plan ▪ Stay Conversations ▪ Grow your own initiatives ▪ Apprenticeships ▪ Values in Practice Framework. ▪ FLOURISH ▪ Data with Dignity ▪ Divisional Reducing Inequalities Plans ▪ Restorative Learning and Just Culture programme ▪ No Hate Zone ▪ Community Collaborative ▪ Training Needs Analysis ▪ First line manager training ▪ Compliance with Trust policies ▪ Staff survey ▪ Pulse survey ▪ Leavers surveys ▪ Stay conversations ▪ Active bystander training ▪ PSRIF ▪ Reducing Health Inequalities ▪ Complaints and concerns	▪ Delays in time to hire ▪ No formalised marketing and attraction strategy / plan ▪ Inability to match recruitment needs (due to national and local shortages) ▪ High dependency on bank and agency staffing ▪ Poor establishment controls ▪ Colleagues not engaging in controls set. ▪ Lack of local accountability. ▪ Not following values and behaviors framework. ▪ Non-compliance with Trust policies ▪ Colleagues not completing surveys. ▪ Non-attendance at training.

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	Ongoing	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.

Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust	Associate Director of Equality, Diversity, Inclusion and Organisational Development	Ongoing	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed.
Take PCREF from pilot to full implementation	Associate Director of Equality, Diversity, Inclusion and Organisational Development	Ongoing	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • 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 Programme • Patient Carer Race Equality Framework • Values In Practice feedback process. • Behavioral framework • Inclusive health & wellbeing offer.	• Diversity gaps in senior positions. • Gender pay gap. • Significant workforce gaps. • Cost of living increases with AfC pay-scales not as competitive as some private sector roles. • WRES and WDES indicators.	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management	

• Improved experience scores on staff survey Improved retention rates. • EDI Improvement plan.			
Update since last review:			
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.	• **Shaping our future workforce.** • **Transforming our culture and staff experience.** • **Modernising our people practice.**	• Increased demand. • Reduced pipeline locally and nationally to fill workforce gaps. • Reduced training commissions. • Hard to fill specialty posts across multiple professions on a national scale.	• Reduced capacity to deliver key strategies, operational plan and high-quality services. • Increased staff pressure. • Continued reliance on temporary staffing. • Reduced ability to recruit the best people due to deterioration in reputation. • High turnover	People Committee	Executive Director of Strategy, People and Partnerships	SR1

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
	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.**		5	5	25
		DATE RISK WAS ADDED	June 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5 x Likelihood 4=20	The pandemic has had a significant impact on the NHS to recruit to its expanding workforce. On a platform of increased operational pressures, rapid demand, a competitive marketplace, reduced pipelines, challenged training places and funding, the risk to the Trust is significant for filling its workforce gaps and developing its services. Staff shortages and deteriorating staff experience will impact further on the Trust's ability to attract and recruit to the organisation.	**Impact 4 x Likelihood 3 = 12**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ International recruitment pipeline. ▪ Safer Staffing model ▪ MHOST ▪ E-Rostering compliance. ▪ Training Needs analysis. ▪ Leaver's questionnaires. ▪ Stay conversations ▪ Staff Survey ▪ Pulse survey ▪ Values and Behavioural framework. ▪ Robust People processes. ▪ Robust temporary staffing processes. ▪ Retention plan ▪ Health & wellbeing offer.	▪ Delays in time to hire. ▪ No formalised marketing and attraction strategy / plan. ▪ Inability to match recruitment needs (due to national and local shortages). ▪ High dependency on temporary staffing. ▪ Poor establishment controls. ▪ Not using E-Rostering to full ability. ▪ Not following values and behaviours framework. ▪ People processes not being adhered to.

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop and implement clear workforce plan.	Head of Workforce Transformation		Just completed a mod year review and on track to deliver against the plan.
Decrease use of bank in line with growth of substantive workforce.	Head of Workforce Transformation	Ongoing	Bank has decreases but at a slower rate than the substantive workforce had increased.
Develop and implement stay conversation process.	Head of Workforce Transformation		Stay conversations will be implemented in high turnover risk areas in Q3.
Placement of International educated nurses and newly qualified nurses reducing band 5 vacancies.	Head of Workforce Transformation		Band 5 nurse vacancies significantly reduced. Focus will move to supporting band 5 to 6 development.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • Values based recruitment	• Diversity gaps in senior positions • Gender pay gap • Significant workforce gaps	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention. • Complaints	

• Flexibility with the targeted use of Bank incentives and Trust-wide reward. • Improving vacancy and turnover performance. • Customer satisfaction survey positively improving. • Values based recruitment • Stay conversation data • Comprehensive health & wellbeing offer. • Increased % of staff recommending BSMHFT as a place to work. • Improved staff engagement scores. • Improved recruitment timeline. • HR KPI reports • Increased use of social media to attract.	• Cost of living increases with AfC pay-scales not as competitive as some private sector roles • WRES and WDES indicator 2 (likelihood of appointment from shortlisting). • Colleagues not adhering to flexible working initiatives. • Non-adherence to values-based recruitment principles.	• Bank and agency • Disciplinary Process • Sickness Absence Management.	
Update since last review:			
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	**Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.**	• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively	• Lack of implementation & embedding of QI processes • Unwarranted variation of quality of care • Insufficient focus on prevention and early intervention • Poor management of the therapeutic environment • Limited co-production with services users and their families	• Failure to meet population needs and improve safety • Variations in care standards and outcomes • Unwarranted incidents • Failure to reduce harm • Poor patient experience	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR4 SR8 SR9

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
	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.***		4	5	20
		DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL

• Process in place to review and learn from deaths • Clinical Effectiveness process including Clinical Audit, NICE • Implementation of PSIRF • Transition to LFPSE • Patient safety education and training • Implement a culture of continuous learning and improvements • Mental Improvement Programme work as defined in the Patient Safety Strategy • Development and application of RRP Dashboard • Process in place to for staff, service users and families to raise concerns • Programme of external audit • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Internal adoption of a transparent Quality/assurance process AMaT implementation • QI Resources and projects in place • CQC Insight Data and regular joint meetings • Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme). • Coroner's Reports • QSIS compliance • Shared Care Platform • Capital prioritisation process • Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation	• Gaps in MHA Action Plan oversight arrangements from CQC inspections • Clinical Governance structures from Ward/Team to Board • 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. • Levels of training and support for supervision • The action plan amnesty thematic review has highlighted a gap in staffs understanding of the importance of RMS/Clinical Supervision • Inability to embed a culture of continuous learning and improvements • Process for communication and information sharing with ICB/NHSE/CQC/MHPC

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of Trust Clinical Governance and implementation of recommendations from internal audit and review to ensure Ward/Team to Board governance is fit for purpose	DQS/CN	31st December 2024	Review and workshop completed. Paper to QPESC, CGC TOR revised and published, agenda updated, and forward planner revised in light of reporting arrangements to QPESC, reported at Audit Committee.
One year in review of PSIRF to ensure the process is meeting statutory responsibilities and ensuring	DQS/CN	30th January 2025	Review of PSIRF started, scope to include reporting, after action reviews, Structured judgement reviews and safety panels, supporting staff, relatives and demonstrating learning. Coroners masterclass held.

continuous improvement in quality through an embedded safety culture			
Development of process to meet requirements of statutory reporting and required reporting	IDCN	30 November 2024	Process in draft shared with external stakeholders for comment
Alignment of policy and audit processes and reporting schedule through CEAG	IDCN	31st December 2024	Completion of review of audit frameworks contained in policies for assurance and reporting arrangements agreed to go through updated Clinical Effectiveness and Assurance Group

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting. • Executive Director's Assurance Reports to QPES Committee and Board • NHS Digital Quarterly Data • Commissioner and NED quality visits • CGC Local review has been completed - Outcome of Clinical Governance Review has informed any areas of inconsistency that will need be addressed	• Reaside regulatory notice environment and governance. • Reaside FTSUG Regional escalation. • Reaside CQC Report • Zinnia Centre CQC Sec 64 Letter. • External Audit Clinical Governance Review (18 recommendations).	• CQC planned and unannounced inspection reports • Internal and External Audit reports • Triple A reporting to QPES from CGC • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting • 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 • Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board • Independent annual assessment against the 68 NHS Core Standards for EPRR. • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation Meeting	• The availability of real time safety data to triangulate information • Strengthening of processes is required for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded • Analysis and triangulation of data across different sources needs is weak and inconsistent • Lack of an accountability framework in place for how actions from Ligature and Environmental risk assessments are overseen/managed at Divisional level with stratification of associated risk at trust level • Gaps in assurance: Safe staffing data for medical and nurse staffing

LINKED TO RISK REGISTERS/CRR RISKS	
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
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.**	• **Quality** ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively.	• Inability to effectively collate, share and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover • Overreliance on bank and agency staff. • 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. • Increased waiting list time affecting care and support for patients and their families and carers. • Families and carers not always engaged in care planning. • Estate /environment not fit for purpose in some areas. • Poor food choices and opportunities in some settings. • Lack of understanding of sphere of influence for clinical facing teams.	• 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 from staff and patients, families and carers • Reactive rather than proactive service model • Increased service demand –	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR3 SR8 SR9

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.***	**INHERENT RISK SCORE**	Impact	Likelihood	Risk score
			4	4	16
		DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Community transformation • The design of a Community Engagement Framework being led by the ICBQI Programmes with our EBE`s/ HOPE Strategy • IPEAR representation • Recovery for all team • Trust induction sessions • EBE educator programme • Recovery College • Participation & Experience team members in each division • HOPE (Health, Opportunities, Participation, Experience) action groups • LEAR action groups • EBE recruitment panel programme	• Changes in the Policy landscape and the creation of ICBs, Mental Health Provider Collaboratives and system working • Challenges around workforce as genuine engagement requires sufficient and consistent staff • Turning off part of CPA where family and carers were being recorded and offered family engagement tool – risk that Dialog + won't always capture family and carers needs / support Ongoing work around preventative needs and stigma 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 use of bank and agency staff can impact on our capacity to build relationships with families

ACTIONS PLANNED

Action	Lead	Due date	Update

Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement	December 31st 2024	Review in scope working with MHPC Definition required for the interface between community engagement and patient experience.
Development of Fifteen Steps Model	AD	March 31st 2025	Coproduction of this in development with EBE's. Model to commence in April 2025 and project plan to be presented at PEAR in December 2024 and shared with QPES in January 2025.
Co-production of Experts by Experience Strategy	AD	Completed	The HOPE (Health, Opportunities, Participation, Experience) strategy is completed and published and launched at EBE celebration event in July 2024. Coproduced with EBEs, stakeholders and strategy team in 2023.
Patient Experience and Recovery Group to be co-chaired by CNO and report directly into QPESC from October 2024	AD	November 30th 2024	PEAR reporting into QPESC directly, review TOR at November 2024 PEAR and agree forward planner

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• FFT • Healthwatch • EbE Observer project • Patient councils in Secure Care. Urgent care, CMHT and D&F.	• Community Mental Health survey	• Monthly reports on participation and engagement presented QPES • QI Reports • Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey. • Executive oversight of the engagement activities. • Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated	• Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance through clinical governance committee. • Inability to integrate and effectively use data in reporting – Inability to integrate and triangulate data from patient experience and PALS/Complainants effectively. • Patient safety partners are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised Clear reporting structure and attendance at safety meetings Project overview available.

		through PEAR.	
LINKED TO RISK REGISTERS/CRR RISKS			
Risk 824	Failure to ensure that patient information leaflets and posters are available in a range of languages would result in a breach of regulation 10(2)(c) and the Equality Act 2010.		
Risk 1023	Risk that families and carers are not consistently involved in risk history, risk assessment and care planning for patients, resulting in the potential for inadequate support and avoidable harm to patients.		
Update since last review:			
11th Nov 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	Failure to maintain a sustainable financial position NB In this context, a sustainable financial position means an in year AND underlying breakeven over next 2 years and sufficient cash headroom.	• **Sustainability** ❖ **Balancing the books**	• *Poor financial management by budget holders.* • *Inadequate financial controls.* • *Cost pressures are not managed effectively.* • *Savings plans are not implemented.*	• Trust not meeting its financial targets limiting available funds for investment in patient pathways.	FPP	Executive Director of Finance	SR6 SR7

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
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.**			5	5	25
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact: 5 x Likelihood 4= 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 5 * Likelihood 2 = 10**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE RISK WAS ADDED	18th October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• 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. • Savings Policy • Sustainability Board review. • ICS expectations and reporting requirements.	• Consequences of poor financial performance do not attract any further review. • Requests for cost pressure often made without following agreed process. • Attendance at Sustainability Board variable. • Trust has not been able to develop a pipeline for delivery of savings.

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**

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	Ongoing	Finance teams have adjusted their local level reporting, and have a session with an external partner to share learning around Power BI finance tools. The changes to the ledger, and chart of accounts from the imminent changes as a result of BSMHFT receiving services currently provided by BWCH means that all financial reporting arrangements will need to be reviewed.
To develop a financial management policy – work is underway to progress this	Deputy Director of Finance	31/10/2024	Financial Management Policy has now been adopted by the Sustainability Board and has been in use by the Finance Department since the beginning of October.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations, including any shortfall in savings delivery.	•	• 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 to 24/25.	• 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. • HFMA sustainability audit has identified a number of development areas that would improve controls and performance.

LINKED TO RISK REGISTERS/CRR RISKS	
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.

Update since last review:

21st October 2024
Risk newly assessed with inputs from the team and presented for Exec sign-off.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	**Failure to maintain acceptable governance and environmental standards.** **NB Acceptable governance and environmental standards means:** ○ **Acceptable levels of backlog maintenance.** ○ **Acceptable levels of unexpected and avoidable deaths, injuries to patients and justified complaints.** ○ **Acceptable levels of injuries to staff and employment claims.** ○ **Acceptable levels of information governance failures.** • **Acceptable CQC rating.**	• **Sustainability** ❖ **Caring for the environment**	• Unacceptable levels of backlog maintenance. • Unacceptable levels of unexpected and avoidable deaths, injuries to patients and justified complaints. • Management of Owned, Retained, PFI and landlord facilities. • Unacceptable levels of injuries to staff and employment claims. • Unacceptable levels of information governance failures.	• The environment does not support delivery of first-class Clinical services. • Increased levels of environmental incidents. • Potential harm to patients. • Regulatory action – penalty, notice etc. • Service User safety, care and ability to receive the best therapeutic care is compromised. • Reputational damage to the Trust. • Poor patient care, safety and experience. • National Green Agenda targets not achieved. • 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.	FPP	Executive Director of Finance	SR5 SR7

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.**	INHERENT RISK SCORE	Impact	Likelihood	Risk score
			5	5	25
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5 x Likelihood 4 = 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 3 x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Shareholder, Liaison, Contractor and Operational Management Team Meetings and Committees are all in place to ensure communication, Service delivery, and physical aspects and priorities are delivered to meet all quality requirements. • Trust Sustainability and Net Zero Group established. • Heat De-carbonisation reviews across sites. • Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme. • Delivery of the Trust Green Plan and the built in Action Plan. • 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.	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan. • Condition Surveys, review of premises statutory standards and compliance assessments / independent AE audits ensure standards are met and maintained. • Operational pressures negatively impacting on staff capacity to fully implement these controls. • Self-assessments, accreditation and self- certification processes aren`t strong. • Governance around compliance is weak.

ACTIONS PLANNED

Action	Lead	Due date	Update
Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL		Helps to mitigate impact on carbon and environment. The Sustainability / Green Group does not impact on major factors in for example 'Failure to maintain

			acceptable operational governance and environmental standards I.e. death / serious injury'.
Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust/ SSL		Mitigation of backlog is progressed via SSBM, Capital programmes and Maintenance regimes where Trust finances allow Replacement of current Reaside facility to address poor functionality, Service user accommodation and environmental system life cycle impacts is a Trust led major project

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc.	•	• Inspection reports. • Compliance audits. • Self-assessment, accreditation and self-certification reports. • External visit reports. • Peer Reviews • Board Assurance Framework Report	• Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • 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. • The culture of BAF not fully developed and embedded.

LINKED TO RISK REGISTERS/CRR RISKS	
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.
85	Non-compliance with E and F statutory standards in external landlord-controlled buildings.
1459	Reaside- backlog condition and clinical functionality.

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.
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES		CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.**		• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience. ❖ Using our time more effectively	• Inability to effectively use time resource in driving learning and transforming services. • Inability to develop and embed an organizational learning and safety culture. • Failure to identify, harness, develop and embed learnings from deaths processes. • Lack of support for and involvement of families and careers. • Lack of effective understanding by staff of what the Recovery Model is about and its expectations. • Services that are not tailored to fit the needs of our	• 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. • 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. • Some communities being disengaged and mistrustful of the Trust. • Negative impact on service user recovery and	QPES	Executive Medical Director	**SR3** **SR4** **SR9**

			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.	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.			
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.***		**INHERENT RISK SCORE**	Impact	Likelihood	Risk Score
					4	5	20
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	**RATIONALE**	**TARGET RISK SCORE**	**RATIONALE**	**RISK HISTORY**
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score).*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
• SI oversight Group • Patient Safety Advisory Group (PSAG).	• 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.

• Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • 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. • BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Implementation of Family and carer pathway. • BSOL peer support approaches. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • 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 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.	• No organisational wide reporting of LFE metrics. • Family and carers pathway not consistently applied or suitable for all services. • Performance in these areas is not effectively measured. • 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.

• BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighbourhood teams. • Development of community	

ACTIONS PLANNED

Action	Lead	Due date	Update
Support for development and implementation of divisional health inequalities plans from EDI team.	Jas Kaur / Associate Directors of Operations	February 2025	Plans will be finalised based on feedback.
Patient Carer Race Equality Quarterly submissions to NHSE – Linked to the activities highlighted in the framework.	Jas Kaur / Associate Directors of Operations	Ongoing	Regular reports to NHSE.
To audit health inequalities footprint within the Trust`s governance and reporting arrangements from `Ward to Board`.	David Tita / AD Corporate Governance	30th November 2025	This will facilitate an evaluation and understanding of the extent to which governance reports are written and presented through the lens of health inequalities.
Review and refresh of the family and carer pathway	AD for Allied Health Professions and Recovery	March 31st 2025	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board. • New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. • Participation Experience and Recovery (PEAR) Group.	• Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	• Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering • Performance Delivery Group "deep dives". • Highlight and escalation reporting into BSOL	• 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 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.

• Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.		MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feed to Inequalities board.	• 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. • Inability to engage with all parts of the Trust.

LINKED TO RISK REGISTERS/CRR RISKS	
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.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments.
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**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.**	**Clinical Services** • Community transformation • Inpatient transformation • Improving access • Patient flow improvement programme • Partnership working • Urgent care transformation • Children and Young People new model of care.	• Demand for services exceeding our capacity including increase in demand for inpatient services. • Increased demand in the community. • Limited capacity in social service provisions. • Lack of partnership and effective system working. • Organisation delivering transformation but not joined-up. • Long waiting times to access services. • Inadequate support for our service users with mental health co-morbidities. • Not thinking as a system in developing priorities and pathways. • Fragmented pathways and interfaces. • Lack of service user voice in informing service transformation. • Lack of support for and involvement of families and careers.	• Service users being cared for in inappropriate environments when in crisis. • Increased OOA and the financial consequences. • Increased pressure on A&E in acute hospitals. • Increased waiting times/waiting list and backlog. • Negative impact on recovery and length of stay/time in service. • Negative impact on service user access, experience and outcomes. • Lack of joined up pathways and care. • Service users falling between gaps. • Inferior and poor care. • Increased risk of incidents. • Provision in the community not available.	QPES	Executive Director of Operations.	SR3 SR4 SR8

			• The difficult financial landscape.				
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.***		**INHERENT RISK SCORE**	Impact: 4	Likelihood: 5	Total score: 20
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	**RATIONALE**	**TARGET RISK SCORE**	**RATIONALE**	**RISK HISTORY**
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Risk newly identified** *(Space for graph showing movements in BAF risk score)*
		DATE OF LAST REVIEW	21st October 2024	

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
• Inpatient Bed Strategy and Inpatient quality transformation programme. • Digital transformation programme. • Partnership working with the Voluntary Sector. • Inpatient flow improvement programme. • Patient initiative follow-up work. • Urgent care and Community transformation. • Better prioritisation and triaging of patients of waiting lists. • System approaches to improving and developing services. • Solihull Children and Young People Transformation. • System approaches to improving and developing services. • Solihull Children and Young People Transformation. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Partnership working re dual diagnosis processes and pathways.	• Not enough beds for population when compared nationally. • Lack of the right model of care that is suitable for our patients. • Capacity within teams to deliver transformation and service developments alongside day job. • Family and carers pathway not consistently applied or suitable for all services. • Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about our population and needs.

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**

Implementation Plan of 1st Phase of Inpatient Bed Strategy.	Associate Directors of Operations	30th Nov 2024	Workshop has been setup to discuss implementation of the first phase of the inpatient bed strategy.
Implementation of 3rd phase of the Community transformation.	Renu Bhopal-Padhiar / Associate Director Specialties (Keisha Dell)	31st March 2025	On track -
Implementation of the 1st phase of the Urgent Care transformation and Winter Plan.	Associate Director of Operations- Acute and Urgent Care	31st March 2025	On track -

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
BSOL MHPC Executive Steering Group. Participation Experience and Recovery (PEAR) Group. Highlight and escalation reporting to Strategy and Transformation Board.		• Two weeks wait review. • Piece of work around Clinical Governance. • Financial plans that have just been signed. • Reports to the Strategy & Transformation Boards. • System trajectory around 104 and 78 weeks wait. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • Reports to QPES Committee. • Co-produced Trauma informed recovery focussed training rolled out (NMHT). • Physical health connectors pilot.	• Having a strong service user/carer voice across all of our governance forums. • Variations in inputs across pathways. • Gaps in the CYP Pathways.

LINKED TO RISK REGISTERS/CRR RISKS	
CRR Risk IDs	**Risk Descriptions**
CRR02/1924	Potential insufficient capacity across Acute Care pathway to manage patient demand.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments
Update since last review:	

21st October 2024
Risk newly assessed with inputs from the team and presented for Exec sign-off.

Key	
Positive assurance	Evidence of good assurance from Peer Reviews/Internal Audits/Corporate functions/External audits & visits/Accreditations/external engagements/ Inspections by regulators etc.
Negative assurance	Evidence of concerns raised by Peer Reviews/Internal Audits/Corporate functions/External audits & visits/Accreditations/external engagements/ Inspections by regulators etc.
Planned assurance	Peer Reviews/Internal Audits/Corporate functions/External audits & visits/Accreditations/external engagements/Inspections by regulators etc planned for the year.
Gaps in assurance	Weaknesses in the assurance that is available.

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	11					
Date	4 December 2024					
Title	Integrated Performance Report					
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance and Information					
Executive Director	Dave 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

Alert	✓	**Advise**		**Assure**	

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.

Building on the service line review meetings, the Director of Finance confirmed at the Performance Delivery Group meeting in November of the introduction of Divisional leadership review meetings on a quarterly basis. These will complement service line review meetings. The Executive Team plans to meet the divisional senior leadership team to allow a focus on team working and management and delivery of the Trust's finance, people, quality and performance priorities and understanding dependencies across the team to do so.

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			Continuing improving trend (97.51%) in last 6 months, above revised improvement trajectory and 95% national standard.	3, 23-24
Talking Therapies – service users seen within 6 weeks			Continued improving trend and meeting national 75% standard at 89.88%.	3, 21-22
Inappropriate out of area Number of placements			Deterioration in last month remains above trajectory	2-3, 11-13
Referrals over 3 months with no contact			Small improving performance in 2 months. Long waits over 18 weeks reduced.	4, 18-20
People				

Vacancies			October at 11.1% deterioration in month but below trajectory	5
Sickness			Deteriorating trend in month at 6.29%.	5, 29-30
Appraisals			Sustained trend in last month at 79.8% and remains below the 90% standard	5, 31-32
Sustainability				
Monthly Agency costs			Improvement in month	5

Table 2: Performance

	On Track	Plan in Place	Progress	Page
CPA 3 Day Follow Up			Improving trend in last month (84.67%) above 80% target	16-17
Talking Therapies - Service users moving to recovery			Improving trend in last month (44.70%) below 50% target	
Talking Therapies Reliable Recovery Rate			Deteriorating trend in last 2 months (40.27%) below target of 48%	27-28
Talking Therapies Reliable improvement rate			Deteriorating trend in last 2 months (58.61%) below target of 67%	25-26
Clinically Ready for Discharge: percentage of bed days			Small improving trend in last month. Oct at 11.63%	4, 14-15
Clinically Ready for Discharge: Number of delayed days			Small improving trend in last month. Oct at 1909	4, 14-15

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Sustained trend in last month (93.6%). Remains below target of 95%	5, 33-34

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incident resulting in harm (patients)			Reducing trend in last month. Reviewed via QPES.	5, 35-36
Incidents resulting in self harm			Increase in last month	5,37-38

Recommendation

The Committee is asked to review and note the contents of the report.

Enclosures

Integrated Performance Report

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 (improvements in reducing long waits)
- 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 October 2024

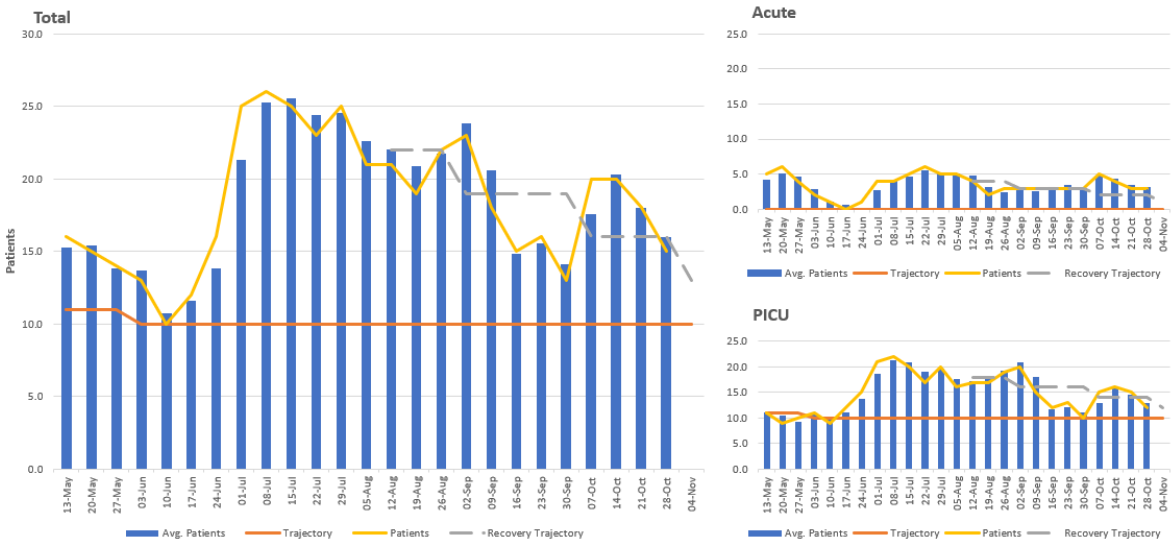
The key performance issues facing us as a Trust have changed little over the last 2 years, although there have been some improvements against some of the metrics in recent months:

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 demand has increased for PICU beds leading to an increased use of inappropriate placements and remaining above trajectory in October. The granular level weekly data is outlined below. As at the end of October 2024, there was 3 acute (target 0) inappropriate placements and 14 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 – renewed action to progress.

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.
- Social worker recruitment agreed via local authority, recruitment process underway.
- **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 consistently achieving the national waiting time standards for 6 weeks and 18 weeks.

6-week position as at October 89.88% (national standard 75%)

18-week position as at October 97.5% (national standard 95%)

The improvements have been due to the successful drive of the action plan including successful recruitment of staff. Recovery plans are heavily reliant on recruitment and retention.

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. The service are discussing these metrics with teams and new starters to enable an understanding about what is required..

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 planning guidance focusing on reducing long waits in adult and CYP services. The initial focus is to review all long waiters over 104 weeks and a trajectory to reduce these has been submitted to the NHSE via the ICB for Adult community and CYP. The CYP trajectory also includes reducing long waits over 78 weeks.

The informatics team have developed supporting waiting times reports to enable teams to manage and monitor compliance going forwards.

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. Progress continues to be made and the improvement trajectory to achieve a 20% reduction in long waits by end December 2024 has been achieved and exceeded.

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, and a further trajectory was set to provide an additional 20% reduction by October. Good progress has been made and the trajectory has been achieved.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 11.63%. The main drivers for this are the delays in both adult and older adult acute services. CRFD in October 2024 in Adult Acute & Urgent Care was at 14.5% (50 patients) and in Older Adult Services at 24.3% (26 patients). The number of delays in Acute and Urgent care has increased this month and older adults has seen reduction. 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 nursing home placements.

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 of Self harm have increased from 218 to 233 this month
- Incidents resulting in harm (patients) has reduced to 26.2% (from 27.5%)

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.

- Bank and Agency WTE reduction – figures not available at time of writing report.
- Staff Appraisals at 79.8% as at October 2024 below improvement trajectory and remains below the 90% Trust standard.

- The appraisal staff survey has been sent Trust wide with over 100 responses received - currently reviewing the qualitative data.
- Further respondents have joined the working together groups and further workshops to support the implementation of the change ideas.
- L&D have confirmed a flowchart with key stakeholders which will support staff experience and clear signposting to support.

- Staff vacancy levels Vacancy data for October 2024 11.1%. The HCA vacancy rate was –1.1%, the band 6 vacancy rate was 23.2% and the band 5 vacancy rate was 12.7% - down from 47% between June and September in 2023.

  Mandatory Training at 93.6% - Has been maintained this month due to improvements in the level of Soft Restraint System Conveyance training now the grace period has ended. Additional training requirements have been added 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 £8,743k against plan of £9,499k. Majority of slippage relates to out of area spend and unidentified savings
- YTD agency expenditure now below NHSE ceiling (££2,940k v £5,458k). Level of medical staff expenditure significantly down on 23/24
- Operating Surplus - YTD surplus of £624k against plan of £1,480k surplus. Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

October 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR | Corporate | Specialties | Secure Services & Offender Health

Performance

Clinically Ready for Discharge: Bed Days	1909 ↓
Clinically Ready for Discharge: Bed Days (%)	12 ↓
CPA 3 Day Follow Up (%)	85
CPA 7 Day Follow Up (%)	93
Eating Disorders: Waiting Time - Routine (%)	100
Eating Disorders: Waiting Time - Urgent (%)	100 ↑
First Episode Psychosis: Waiting Time (%)	100 ↑
Out of Area: Inappropriate Placement Bed Days	560 ↑
Out of Area: Inappropriate Placements Active	17
People on CPA with a Formal Review in last 12 Months (%)	97 ↑
Referrals over 3 Months with no Contact	3671 ↓
Talking Therapies: Reliable Improvement Rate (%)	59 ↓
Talking Therapies: Moving to Recovery (%)	45
Talking Therapies: Reliable Recovery Rate (%)	40 ↓
Talking Therapies: Seen in 18 Weeks (%)	98 ↑
Talking Therapies: Seen in 6 weeks (%)	90 ↑

People

Bank & Agency Fill Rate (%)	91
Fundamental Training (%)	94 ↑
Staff Appraisals (%)	80 ↑
Staff Sickness (%)	6
Staff Turnover: Rolling 12m (%)	7 ↑
Staff Vacancies (%)	11 ↑

Quality

Abscons from Inpatient Units	8
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	2 ↓
Failure to Return	18
Incidents of Self Harm	233 ↓
Incidents Resulting in Harm: 1 - Patients (%)	26 ↓
Incidents Resulting in Harm: 2 - Other (%)	8 ↑
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	25
Ligature with Anchor Point	1
Patient Assaults	37 ↑
Patient Assaults / 1000 OBDs	1.9 ↑
Physical Restraints	343 ↓
Physical Restraints / 1000 OBDs	17.6 ↓
Prone restraints	74 ↓
Prone restraints / 1000 OBDs	3.8 ↓
Reported Incidents	2581
Staff Assaults	88
Staff Assaults / 1000 OBDs	4.5

Sustainability

Agency Staff Spend	£337k ↑
Capital Expenditure	£397k
Cost Improvement Programmes	£1,306k ↑
Group Cash Balance	£98,784k ↑
Info Governance (%)	96
Operating Surplus	£685k
System Oversight Framework (SOF) Rating	3

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Integrated Performance Dashboard

October 2024

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Clinically Ready for Discharge: Bed Days		1559	1546	1689	1603	1933	1909 ↓
Clinically Ready for Discharge: Bed Days (%)		9	10	10	10	12	12 ↓
CPA 3 Day Follow Up (%)	80	83	86	86	74	80	85
CPA 7 Day Follow Up (%)	95	93	92	93	89	91	93
Eating Disorders: Waiting Time - Routine (%)	95	100	86	100	100	100	100
Eating Disorders: Waiting Time - Urgent (%)	95	100					100 ↑
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	100	100 ↑
Out of Area: Inappropriate Placement Bed Days	328	520	384	775	712	536	560 ↑
Out of Area: Inappropriate Placements Active	10	12	17	27	23	14	17
People on CPA with a Formal Review in last 12 Months (%)	95	95	97	97	96	97	97 ↑
Referrals over 3 Months with no Contact		3708	3730	3646	3821	3758	3671 ↓
Talking Therapies: Reliable Improvement Rate (%)	67	63	60	59	61	59	59 ↓
Talking Therapies: Moving to Recovery (%)	50	48	45	48	48	43	45
Talking Therapies: Reliable Recovery Rate (%)	48	45	42	44	45	40	40 ↓
Talking Therapies: Seen in 18 Weeks (%)	95	91	92	93	96	96	98 ↑
Talking Therapies: Seen in 6 weeks (%)	75	81	82	83	88	90	90 ↑

Integrated Performance Dashboard

October 2024

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Bank & Agency Fill Rate (%)		88	90	88	90	91	91
Fundamental Training (%)	95	94	92	93	93	93	94 ↑
Staff Appraisals (%)	90	76	76	79	77	80	80 ↑
Staff Sickness (%)	4	5	5	6	6	6	6
Staff Turnover: Rolling 12m (%)		7	7	7	7	7	7 ↑
Staff Vacancies (%)		12	12	12	11	10	11 ↑

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Integrated Performance Dashboard

October 2024

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Absconsions from Inpatient Units		3	7	1	6	4	8
Commissioner Reportable Incidents		0	0	0	0	0	0
Community Confirmed Suicides		2	0	1	0	0	0
Community Suspected Suicides		0	3	2	2	3	2 ↓
Failure to Return		24	17	20	18	22	18
Incidents of Self Harm		166	230	227	208	218	233 ↓
Incidents Resulting in Harm: 1 - Patients (%)		31	29	28	27	27	26 ↓
Incidents Resulting in Harm: 2 - Other (%)		8	8	8	7	9	8 ↑
Inpatient Confirmed Suicides		0	0	0	0	0	0
Inpatient Suspected Suicides		1	0	0	0	0	0
Ligature no Anchor Point		27	21	36	21	17	25
Ligature with Anchor Point		2	0	3	0	1	1
Patient Assaults		28	39	38	37	43	37 ↑
Patient Assaults / 1000 OBDs		1.5	2.1	2.0	1.9	2.3	1.9 ↑
Physical Restraints		200	315	312	364	285	343 ↓
Physical Restraints / 1000 OBDs		10.4	17.0	16.2	18.8	15.2	17.6 ↓
Prone restraints		49	41	67	35	43	74 ↓
Prone restraints / 1000 OBDs		2.6	2.2	3.5	1.8	2.3	3.8 ↓
Reported Incidents		2236	2545	2713	2524	2277	2581
Staff Assaults		86	87	69	117	97	88
Staff Assaults / 1000 OBDs		4.5	4.7	3.6	6.0	5.2	4.5

Integrated Performance Dashboard

October 2024

Measure	Latest Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Agency Staff Spend		£435k	£394k	£404k	£375k	£389k	£337k ↑
Capital Expenditure		£333k	£557k	-£56k	-£2,102k	£1,080k	£397k
Cost Improvement Programmes		£922k	£850k	£1,292k	£947k	£2,826k	£1,306k ↑
Group Cash Balance		£88,969k	£90,881k	£85,539k	£93,790k	£97,993k	£98,784k ↑
Info Governance (%)		95	93	95	94	93	96
Operating Surplus		£275k	£493k	-£162k	-£432k	£187k	£685k
System Oversight Framework (SOF) Rating		3	3	3	3	3	3

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Out of Area: Inappropriate Placements Active

October 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

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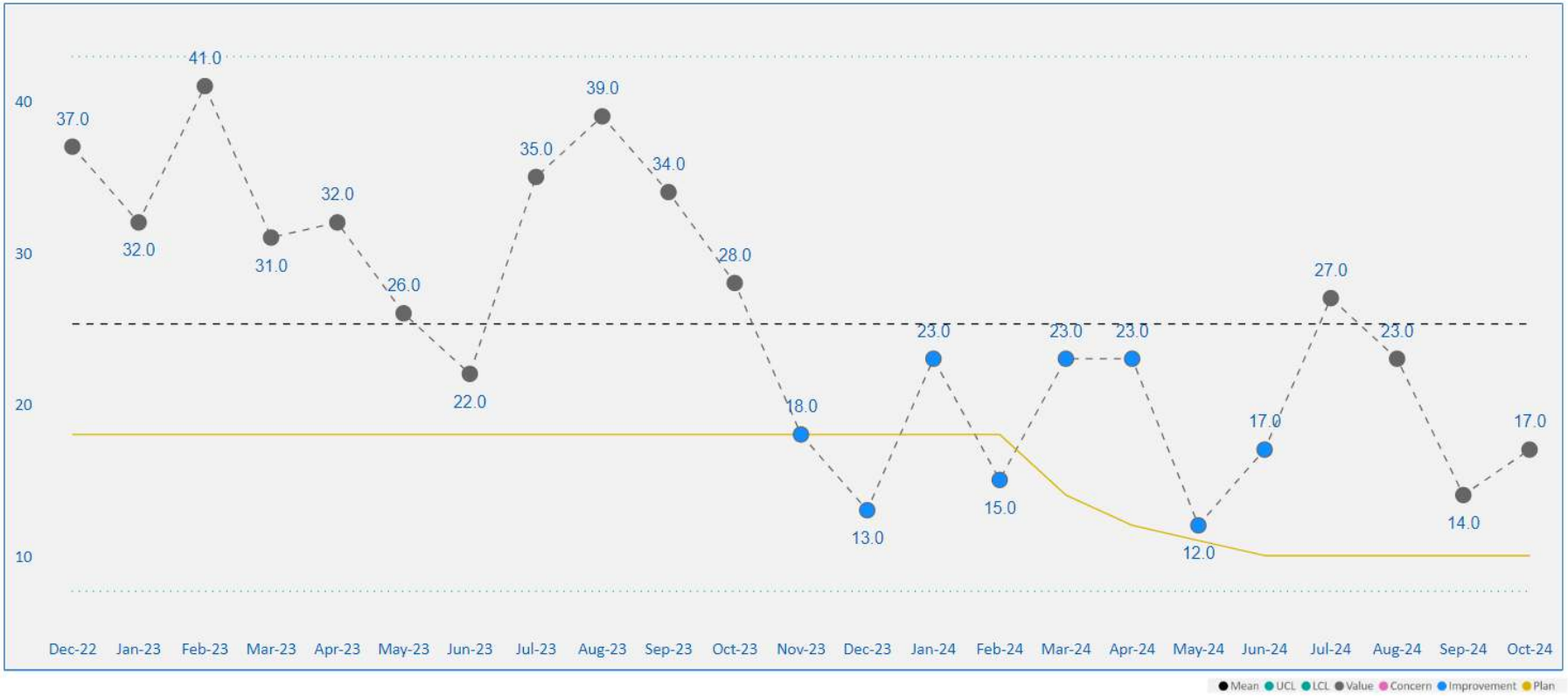
Commentary

*All means and SPC control limit calculations are based on data for the last 25 months



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 October there were 17 Inappropriate Out of Area Placements with 3 in acute beds and 14 in PICU beds above the trajectory of 10 for October 2024. There were 8 inappropriate admissions during October with 2 acute and 14 PICU which is an overall increase of 7 compared to September. 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 1901 overall in October, with adults at 987 lost bed days. Adult bed occupancy reduced slightly to 95.8% and length of stay remained at an average of 111 days in October 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.
E: What do we expect to happen?	Monthly use of inappropriate out of area beds is expected to continue but reducing as the range of actions being taken forward get implemented and embedded and progress is made toward achieving the agreed trajectory of using only 10 or less PICU placements.
F: How will we know when we have addressed issues?	When the numbers of inappropriate OOA placements reduce in line with the trajectory submitted in the action plan. Actions being taken forward by the workstreams begin to impact on creating capacity and flow to support repatriation of out of area placements.

Clinically Ready for Discharge: Bed Days

Birmingham and Solihu Mental Healt NHS Foundation Tru

October 2024

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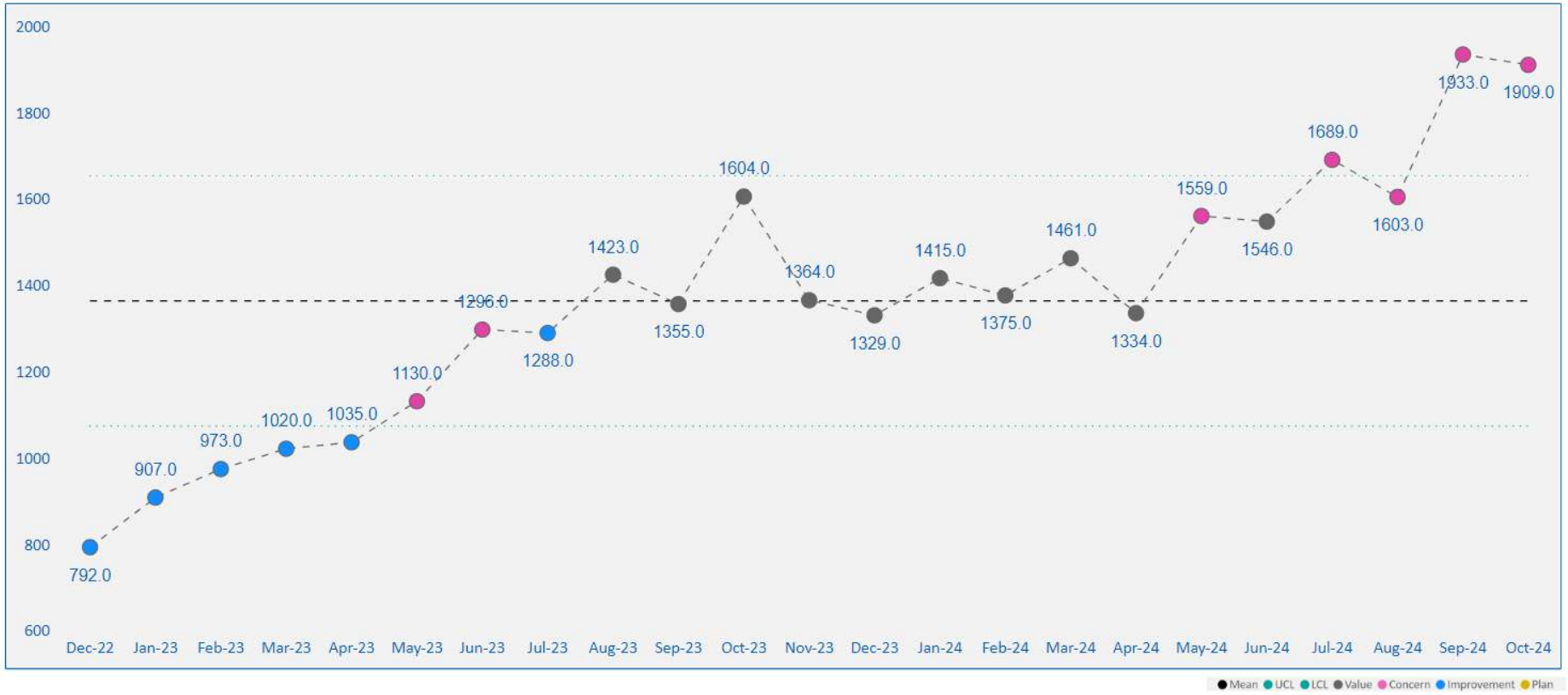
Commentary

*All means and SPC control limit calculations are based on data for the last 25 months



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 increased to a peak of 1933 bed days in September and have reduced in October to 1909. Adults moved from 897 days in September to 987 days in October, which related to 50 patients, with a main delay reason of awaiting supported accommodation and public funding and older adults moved from 622 days in September to 519 in October and related to 26 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 Solihu
Mental Healt
NHS Foundation Tr

CPA 3 Day Follow Up (%)

October 2024

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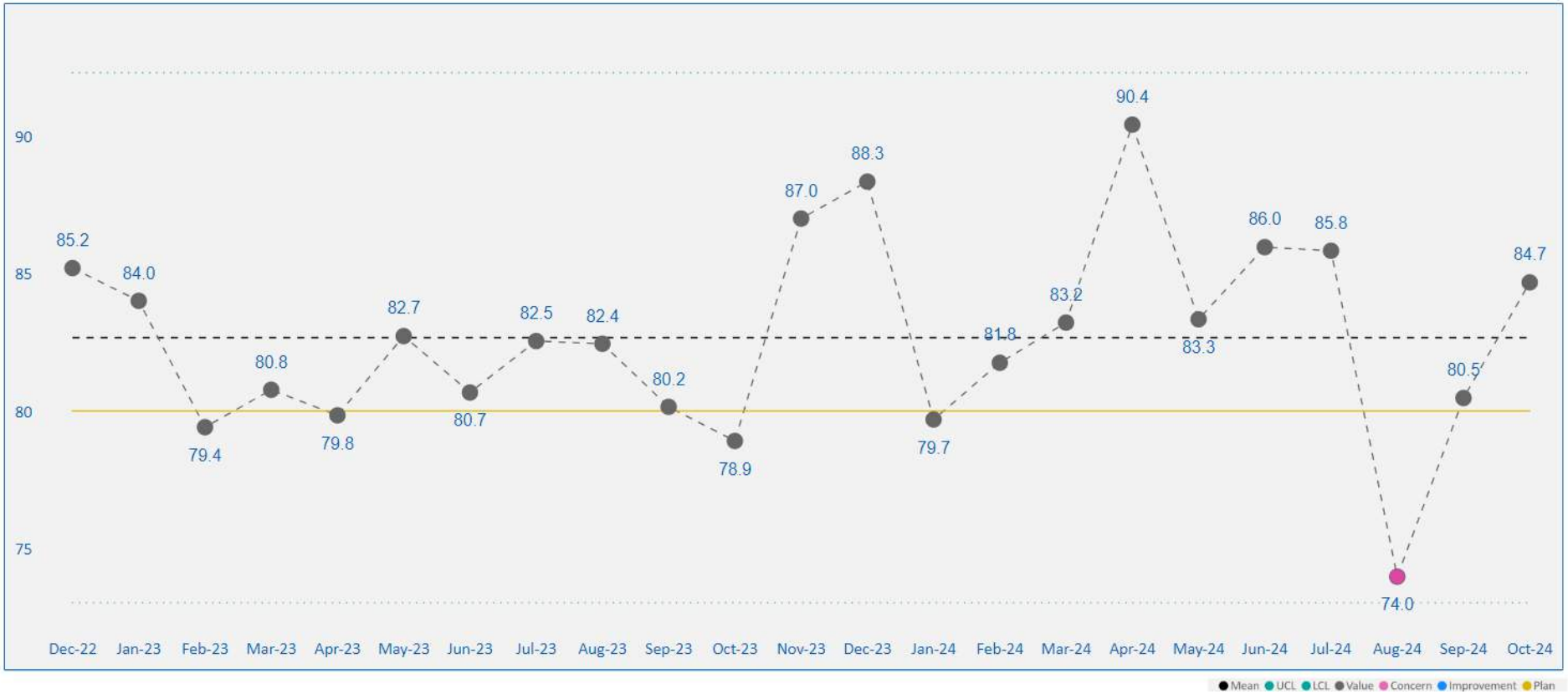
*All means and SPC control limit calculations are based on data for the last 25 months



Question	Answers
A: What has happened?	The follow up rates from January 2024 onwards have been just above the 80% contractual target. October has seen an increase to 84.67% above the 80% target. This relates to 21 service users from 137 discharges in October not being followed up within 3 days, of which, 2 patients were discharged to the care of another MH trust, attempts were made to see 3 patients which were not successful, 1 patient was arrested following discharge and staff had a brief conversation , 1 patient was placed on a CTO after a long period of leave and was seen for follow up on the same day, 8 patients were seen on day 4-7 and 2 patients were seen after 8 days. 4 cases will be a pass when data entry is completed. Of the 21 exceptions 18 were in adult acute and 3 were in ICCR. When data entry is completed, performance will increase to 87.59% 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 October has moved from 25 in September to 21 in October. 2 patients have been transferred to other MH Trusts which requires the staff to check to see whether they have been seen by the local MH team. There were also 8 cases where teams did not see the patient until days 4-7, outside the target of 3 days. 4 Cases will be a pass and are awaiting data entry and when this has been completed will move performance to 87.59%. 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 Months with no Contact

October 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

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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 the last 2 months showing a decrease with October 2024 at 3671 areduction of 87 since last month. The number of referrals not seen within 3 months of referral has increased in MAS, and has decreased in adult and older adult CMHTs, Solar and CAMHS Primary Mental health. Neuropsychiatry has remained at the same level as the previous month Neuropsychiatry service accounts for 25.7% and Adult CMHTs 14.5% 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 was set to reduce by a further 20% by october 2024 and this has been achieved with October with 102 below the trajectory aim of reaching 126. . 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.
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 is being 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 88% since November 2023 from 94 to 11 in October 24. Clinical service managers are ensuring that all patients have a future appointment for those waiting over 52 weeks • Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in. Those waiting for 26-52 weeks has reduced by 9 patients in the last month. • Internal trajectory in place to reduce those waiting over three months for a first appointment by December and then reviewing those awaiting a follow up appointment. • National trajectory has been submitted to ICB and NHSE to reduce those waiting over 104 weeks for second contact Demand: • Establishing a triage Multidisciplinary HUB to include Birmingham Healthy MINDS and NMHTs to direct referrals to the appropriate service on referral. • CMHT caseload validation to identify service users whose needs can be addressed in primary care via the Neighbourhood Mental Health Teams (NMHTs). • 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. Currently undertaking a review of the cohort to see how many would be suitable. Clinic due to commence next year. • Projects are in place in Solihull, Longbridge and East to look at different ways to increase flow.

	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. A national trajectory has been submitted to NHSE via the ICB to reduce those waiting for more than 78weeks. 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 a trajectory to reduce these has been submitted to the ICB and NHSE for Adult community. The CYP trajectory will be based on reducing 78 week waits as they have a small number of 104-week waiters. A waiting times report has been updated to make available a list of those over 104 week and 78 weeks to enable services to identify each cohort. This is based initially on referral to second contact until we move to activity based on meaningful contact. 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. September shows that they are below the trajectory. It should be noted that there are a number of service users are in care homes and have had phone reviews with care home staff only 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. 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 start to work towards this, 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 December 2024. For Older Adults they would have seen a reduction of those waiting for more than 18 weeks by 20% by end October 2024.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies: Seen in 6 weeks (%)

October 2024

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Question	Answers
A: What has happened?	The numbers of service users seen within 6 weeks has been on an increasing trend for the last 11 months and remains above the 75% threshold at 89.88%, for the seventh 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. October2024 performance is at 89.88%, a continued improving trend, above trajectory and continuing to meet the national 75% standard for the seventh 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 October 2024 shows a 11% 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 nine 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 have started 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 previous increase in staff have 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 increase in staff has had a positive impact on the number of patient contacts with October 2024 seeing a 11% increase compared with 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. Work is also being undertaekn to reduce the number of single session contacts and these have been on a declining trend.
E: What do we expect to happen?	The service expects to continue to meet the 75% target as the contacts undertaken by the new staff begin to come through. April -October performance shows that they have reached the target and the focus will be to maintain this.
F: How will we know when we have addressed issues?	The national standard of 75% is met and maintained.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies: Seen in 18 Weeks (%)

October 2024

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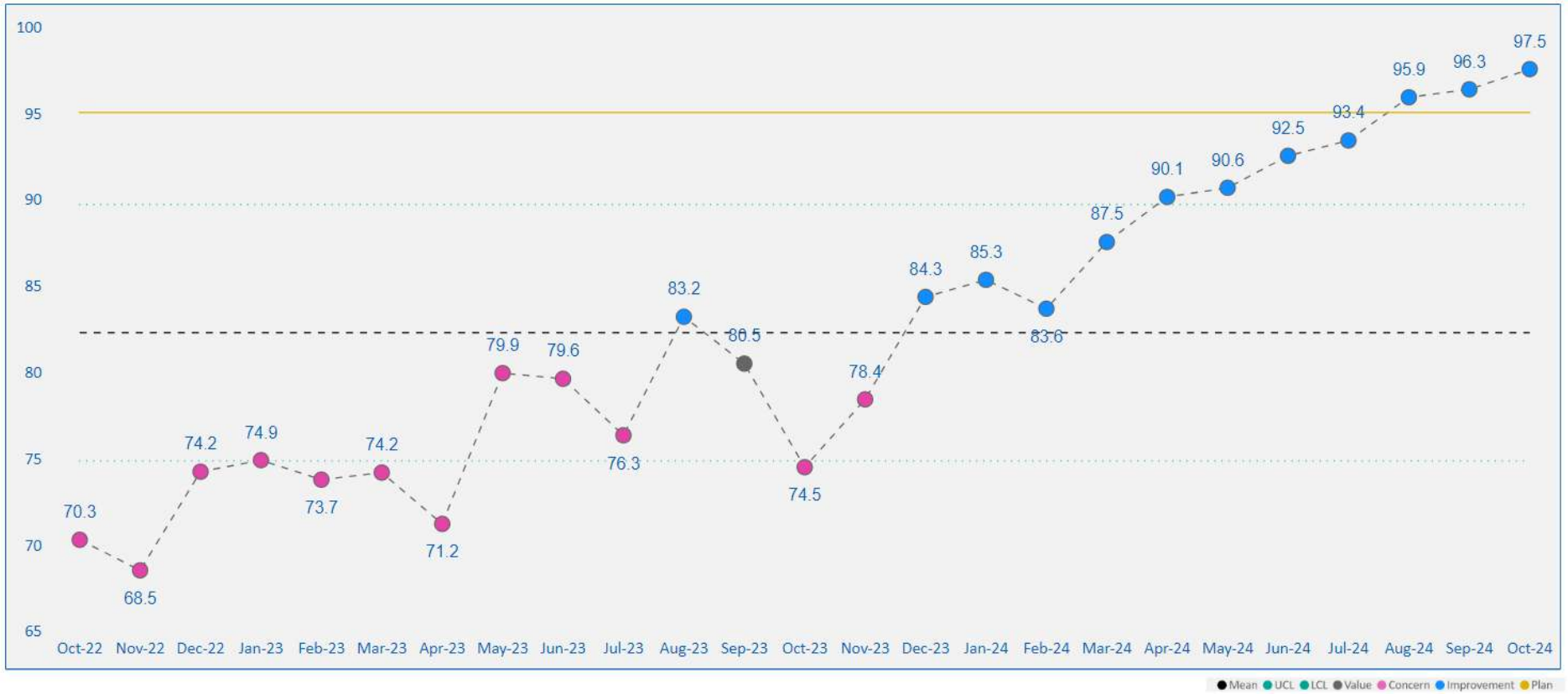

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 11 months and is now above the 95% target and trajectory at 97.51% .
B: Why has it happened?	The service plan was to reach the 95% target by June 2024. However, despite continued improvments the 95% target was not acheieved, and a revised trajectory has been put in place to meet the 95% target by December 2024. October 2024 performance is at 97.51%, 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 October 2024 shows a 11% 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 as progress was slower than anticipated due to staffing challenges a revised trajectory was 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 have started 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 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 October 2024 seeing a 11% 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. Work is also being undertaken to reduce the number of single session contacts and these have been on a declining trend.
E: What do we expect to happen?	The service expects to see a continuing improvement reaching and maintaining 95% target by end December 2024 as the contacts undertaken by the new staff begin to come through. August - October performance has shown the that they have met the target and will continue 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 (%)

October 2024

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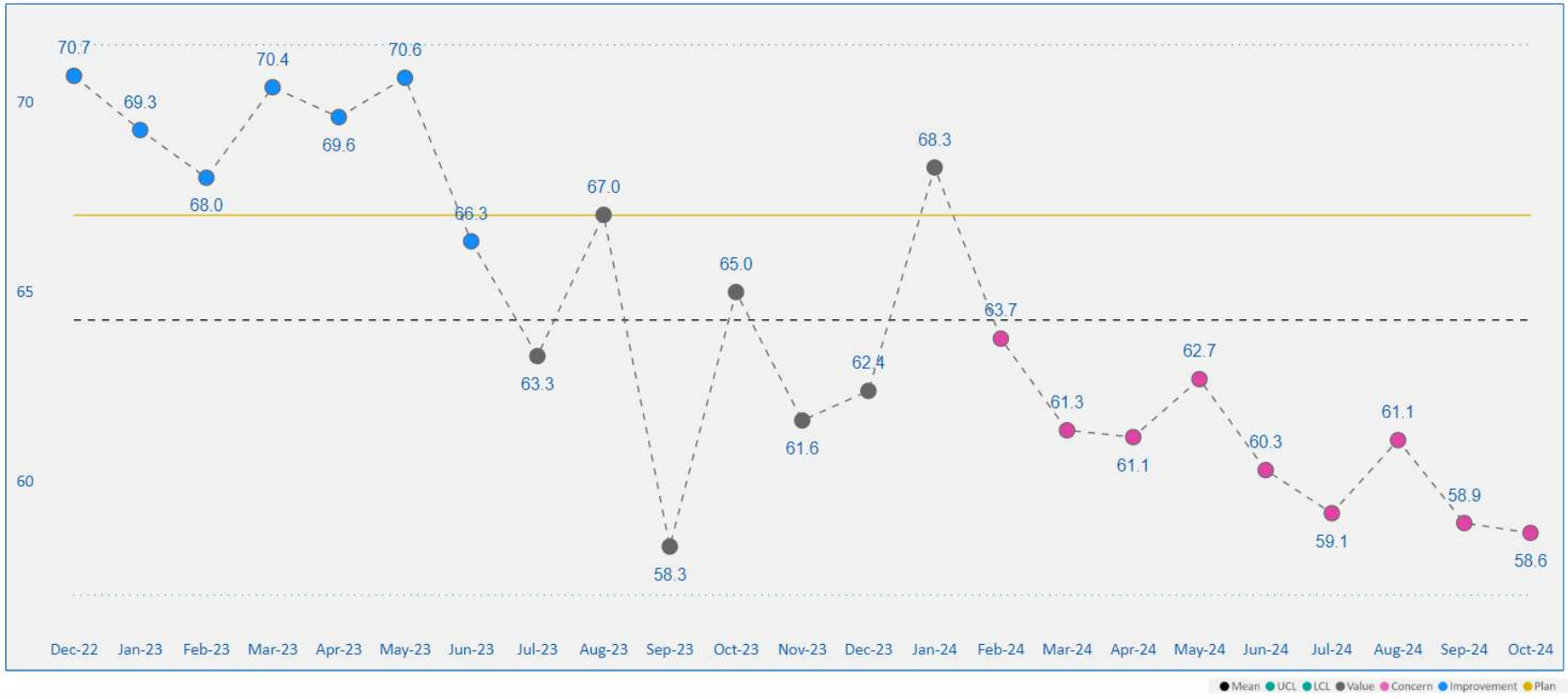

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. October 2024 at 58.61% below the lower control limit for the 9th month. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety 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.

Talking Therapies: Reliable Recovery Rate (%)

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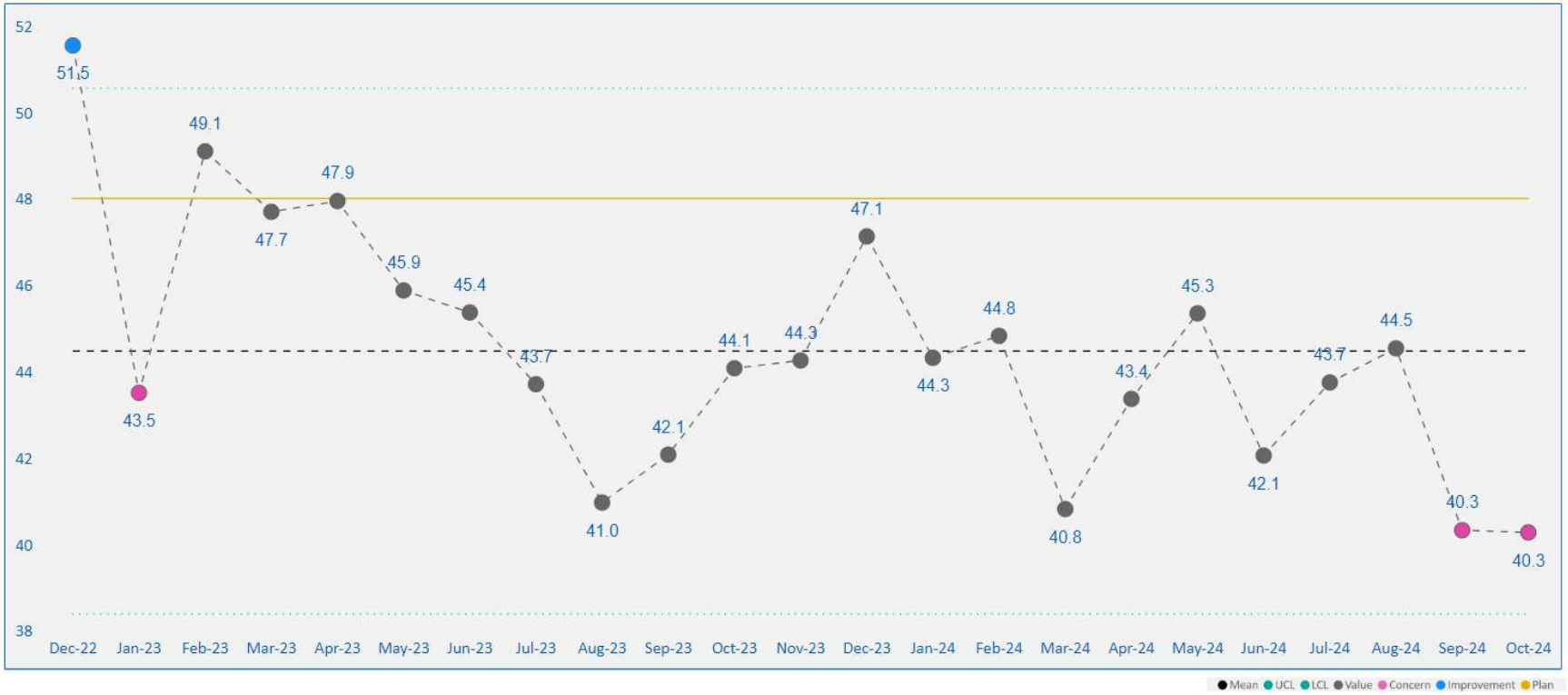

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. October 2024 position has reduced and remains below the 48% target at 40.27% and below the lower control limit. 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.

Staff Sickness (%)

October 2024

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Question	Answers
A: What has happened?	Trust wide sicknes absence rate for October 2024 was 6.2%, this is still high and above the Trust target of 3.9%. However, at Team or division level the rates differ and encouraging. For example, Corporate teams showed a sickness rate of 3.4% as of October, with 1.2% short-term and 2.2% long-term sickness, indicating corporate teams are experiencing fewer absences than the broader Trust average with particularly high sickness remain notable, with the Pharmacy Team at 7.7% and Customer Relations Team at 4.5% . In other Teams , Acute& Urgent Care, overall sickness absence remains high at 7% for October slight reduction on 0.5% on last month. Long term sickness 4.2% which is the same as previous month and short term sickness reducing by 0.4% to 2.8%. Absence rates in Home Treatment Team remain high at 8.8% (6.2% long term sickness and 6.2% short term sickness). The Return to Work meetings (RTW) completion rate has risen slightly to 50% in Corporate, although still below the targeted 70%. RTW contact is low at 54.5% across acute and 0% reported for October, indicating ongoing challenges with managers completing these meetings.
B: Why has it happened?	Chronic Long-Term Sickness in some areas with high sickness absence rates are accoutable for these hot spots. Persistent long-term sickness in high-stress teams, are be due to underlying health conditions and job-specific pressures. Limited RTW contact completion may indicate resource limitations in HR or delays in coordinating return-to-work plans, particularly for teams managing higher sickness rates. Long term sickness in some teams are due to a number of reasons such as pregnancy related and related to employee relations case management. Stress, anxiety and depression continue to be the top reasons for sickness absence. Injury at work is also increasing and one of the five reasons for sickness absence.
C: What are the implications and consequences?	Operational Inefficiencies: • High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. Increased Risk of Burnout: • Ongoing vacancies and low RTW contact rates mean that some employees may experience greater strain, increasing burnout risk and potentially leading to a cycle of recurring sickness.
D: What are we doing about it?	Enhanced HR Sickness Clinics: • Establish structured HR-led sickness clinics, focusing areas with high-sickness absence rates to offer early interventions and personalised support plans. These clinics aim to reduce long-term sickness by providing targeted resources. Improved RTW Processes: • Efforts to increase RTW contact completion include dedicating HR resources to ensure that returning employees have a structured plan to re-enter their roles, with a goal to improve contact rates beyond 70%. Focused Recruitment for Key Gaps: • The Trust continues to work on reducing vacancy rates through targeted recruitment strategies, aiming to relieve pressure on overburdened teams and improve overall workforce stability. The People Team will continue to focus on HR clinics to ensure we are challenging where RTW are not being completed or understand the reasons for this. Continue to seek support from ADs , Heads of Nursing and other senior managers to support the management of sickness absence.
E: What do we expect to happen?	Reduction in Sickness Rates: • With the introduction of HR clinics and improved RTW processes, sickness rates are expected to decrease gradually over the next 3-6 months, especially for long-term absences. Enhanced Operational Stability: • As appraisal completion improves and vacancies are addressed, operational efficiency should stabilise, reducing pressure on existing staff and minimising burnout risks. Timeline: • The timeline for these interventions is set over the next 3-6 months, with HR sickness clinics expected to impact sickness rates positively within the first three months of implementation.
F: How will we know when we have addressed issues?	Sickness Rate Reduction: • A target reduction in long-term sickness rates, aiming for a 1-2% improvement in high-sickness teams by the next quarter. RTW Contact Improvement: • RTW contact completion consistently above 70% will signal that sickness management processes are improving. HR Sickness Clinic Effectiveness: • Success of HR clinics will be measured by reduced sickness rates and positive feedback from high-sickness teams.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals (%)

October 2024

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Question	Answers
A: What has happened?	The trust's Appraisal compliance is 79.8% which is an increase from September which was 79.7%. 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 67.3%, Exec-Nursing 67.9%, Exec - Resources - 64.1%, New Care Models 52.2%, and Strategy, People and Partnerships 75%
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 update- the appraisal staff survey has been sent Trust wide/connect/completion of appraisal, over 100 responses received and we are currently reviewing the qualitative data. Further respondents have joined the working together groups and further workshops to support the implementation of the change ideas. In addition to the BAU activities, L&D have confirmed the flowchart process with key stakeholders and commencing communication of the flowchart to support staff experience and clear signposting to 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 (%)

October 2024

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Click here to follow link

Trust

Divisions

Services

Commentary

*All means and SPC control limit calculations are based on data for the last 25 months

Question	Answers
A: What has happened?	The overall Fundamental Training compliance increased from 93.1% in September to 93.6% in October. 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 - 83.1%, Exec Dir - Medical - 92.9%, Exec Dir Nursing - 94.3%, Exec Ops - 93.7%, New Care Models - 87.4%, Strategy, People and Partnerships - 89.4% . Temporary Staffing Compliance has decreased from 90.8% in September to 90% in October however it remains above the Trust Target of 75%
B: Why has it happened?	The grace periods for SRS's Fundamental Training and Oliver McGowan's e-learning have ended. Since SRS compliance is classroom-based, it is not possible to achieve 95% compliance in a short period of time given the availability of trainers, in addition to this the DNA rate remains higher than average due to the course being required but only a few select wards. However we have seen a 15.7% increase in compliance this month for SRS Conveyance. We expect overall compliance to stay above 90% however because of the addition of new training to the traffic lights in August, including Mask-Fit-Testing, Oliver-McGowan Tier1 webinar, and Tier2 face-to-face, we are taking steps to approach 95%.By the end of the year, Dual Diagnosis will only be completed once every year instead of every three years, and Patient Safety will also be added to traffic light.
C: What are the implications and consequences?	• Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • The Trust is adding more FT training on traffic light, and the majority of these trainings are face-to-face, which depends on the trainer's availability. Additionally, DNA rate is an issue for face-to-face training, as we have experienced so the L&D team won't be able to increase the Trust's overall compliance to 95% at the end of this year. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
D: What are we doing about it?	• For Fundamental Subjects with less than 95% compliance, a recovery plan with monthly trajectories is in place. • External ELS and ILS training is purchased in order to meet compliance requirements including an additional 200 ILS spaces between October and December. • Regular business operations, with L&D persistently chasing staff to fill spaces in order to maintain compliance at the necessary percentages. • Extra notifications about upcoming training are being sent out by the Fundamental Training staff. • Each staff member assigned to complete the new training receives an email from the FT team at least one month before it goes live on the traffic light. Staff will have more time to complete the training because new courses added to traffic light will have a six-month grace period as well. • ILS courses have been organised out in the hot spot areas to target compliance
E: What do we expect to happen?	Based on the recovery plans and trajectories we expect compliance to reach 90% with all subjects by January 2025. The increase in ILS spaces that have been purchased from RSUK will support the trajectories as those staff who have expired will now have spaces to book onto training. The expectation is that the DNA emails, reminder emails to staff and reports for AD and CDs will decrease DNA rates. Increasing the grace period for the new Fundamental Training subjects will not affect the overall Trust compliance in that give period as it will enable staff to become compliant before the grace period expires.
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight Reporting System

Incidents Resulting in Harm: 1 - Patients (%)

October 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust

Divisions

Services

Commentary

*All means and SPC control limit calculations are based on data for the last 25 months

Question	Answers
A: What has happened?	26% of our incidents reported during the month resulted in harm. In cases where the threshold for duty of candour has been met, the appropriate actions and disclosures required by legal standards are enacted. These actions include open and honest communication with affected relevant parties and providing the necessary support and information to the individuals involved.
B: Why has it happened?	Reporting has consistenly been above the mean of 21, since November 2023, when the Trust began reporting pshycholoigcal harm in addtion to phsysical harm
C: What are the implications and consequences?	High numbers of incidents alongside a low rate of harm indicate a learning culture.
D: What are we doing about it?	We continue to work hard to reduce harm caused to patients through incidents, this is through risk formulation and personal behavioural plans
E: What do we expect to happen?	A range of physical, relational and procedural changes are underway, with a particular focus on inpatient settings is designed to reduce harm levels.
F: How will we know when we have addressed issues?	Levels of harm will further reduce.

Incidents of Self Harm

October 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Click here to follow link

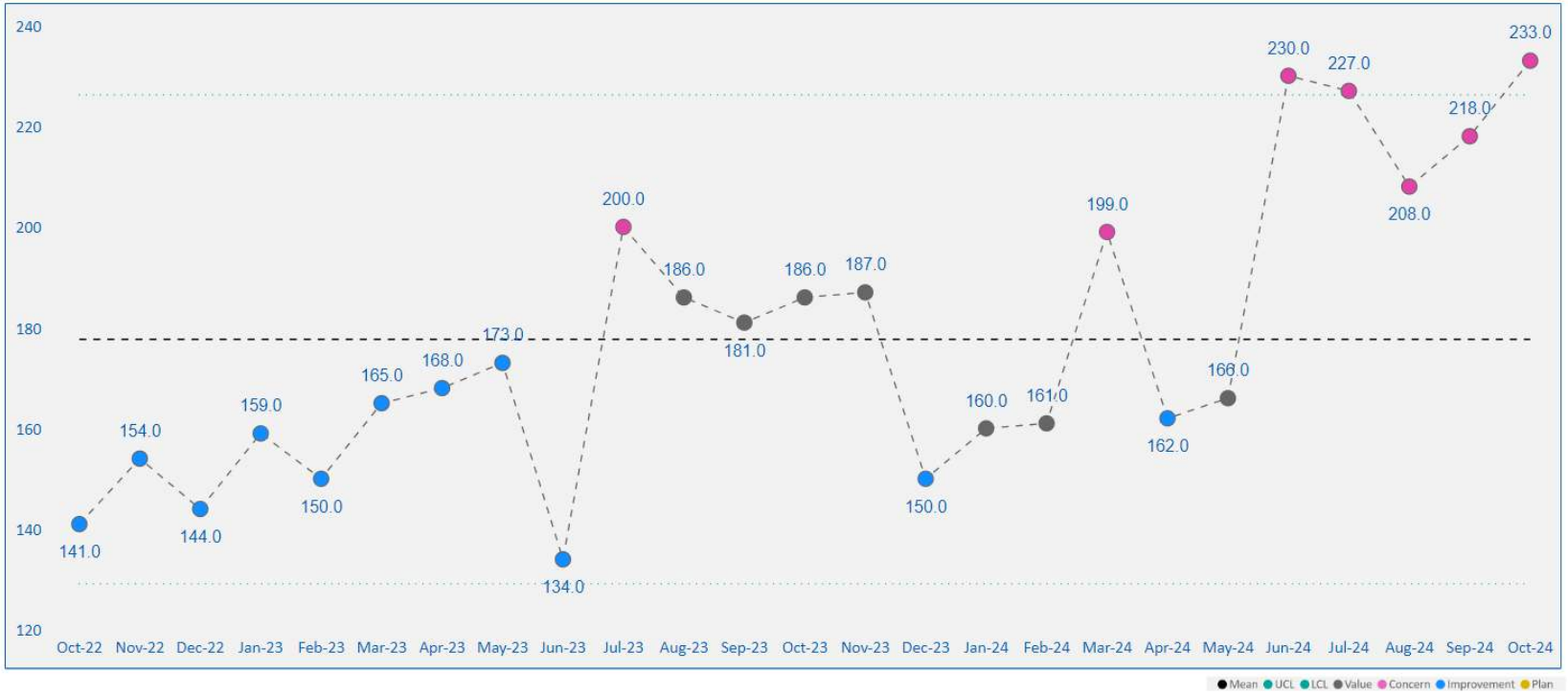
Trust

Divisions

Services

Commentary

*All means and SPC control limit calculations are based on data for the last 25 months



Question	Answers
A: What has happened?	During October there were 233 incidents reported which is fifth consecutieve month above the mean of 177. Most incidents occurred within acute care and secure care settings.
B: Why has it happened?	Some service users use self harm as a coping mechanism
C: What are the implications and consequences?	Patients came come to significant harm and there is a risk that our staff will become psycholigically harmed
D: What are we doing about it?	We have introduced a number of improvement programmes which include the introduction of safety huddles and the use of personalised behavioural plans
E: What do we expect to happen?	Reduction in the use of self harm through the use of personalised support plans
F: How will we know when we have addressed issues?	Reduction in such incidents

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 21st November 2024

2024/25 Performance metric Improvement Trajectory update

2024/25 Performance Improvement metrics

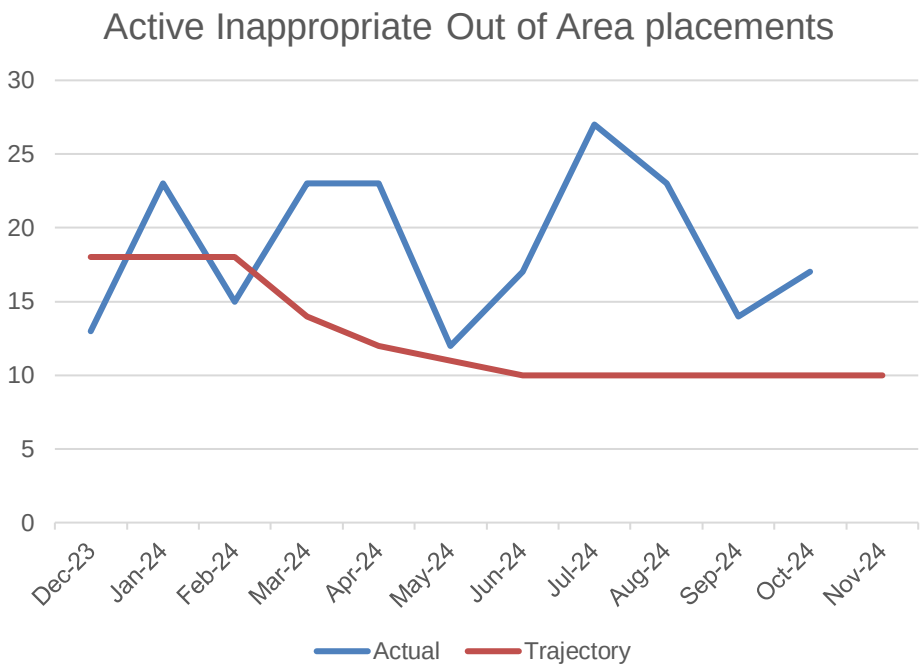
- During 2023/24 the following metrics were identified by FPPC for improvement. Action plans and trajectory updates have been provided. The table below also outlines changes to national metrics arising from the 2024/25 planning guidance.

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

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.

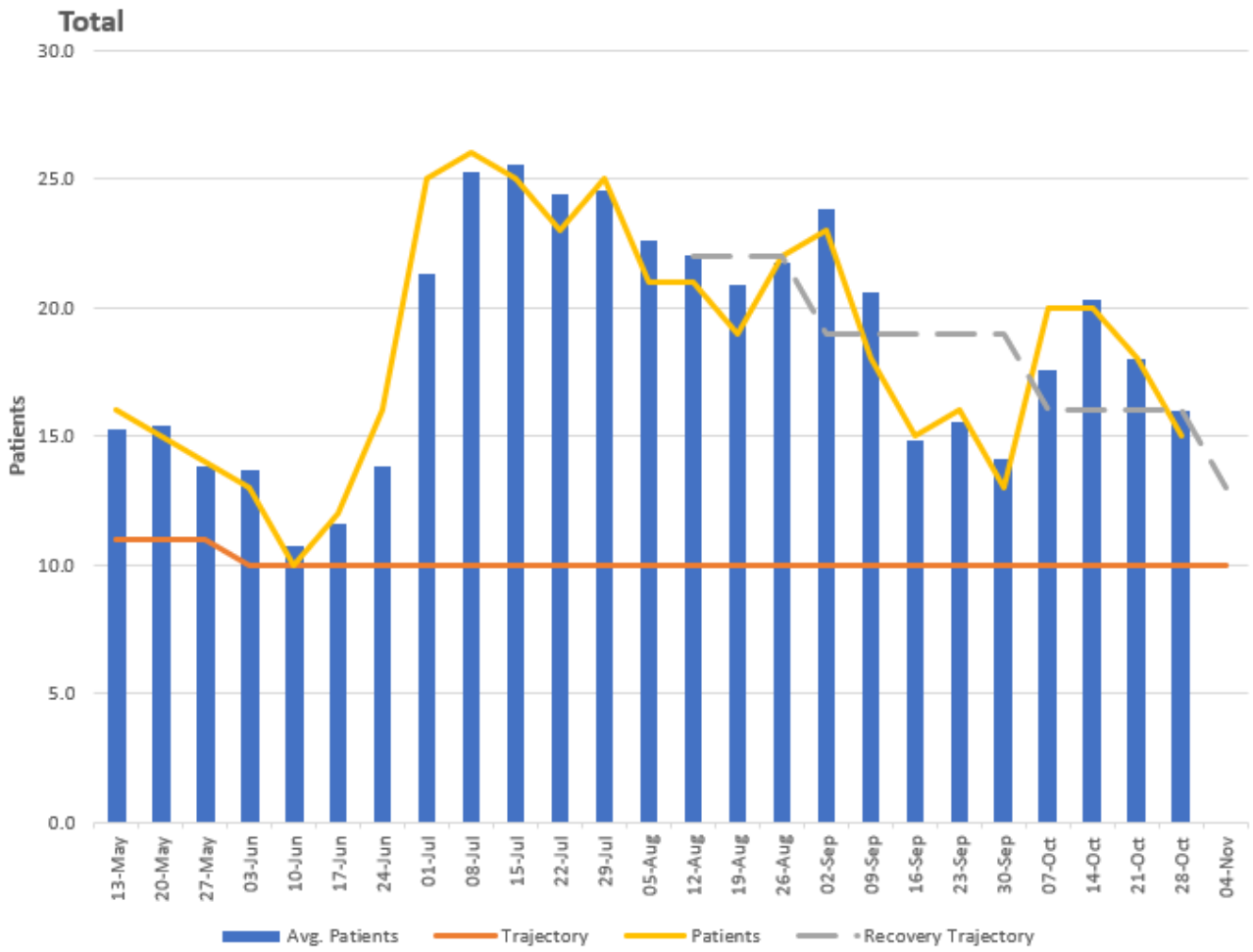
A Trust trajectory has been agreed as part of the 2024/25 national planning requirements to reduce and not exceed 10 PICU placements from June 2024 onwards. The target for inappropriate acute placements is zero from April 2024.

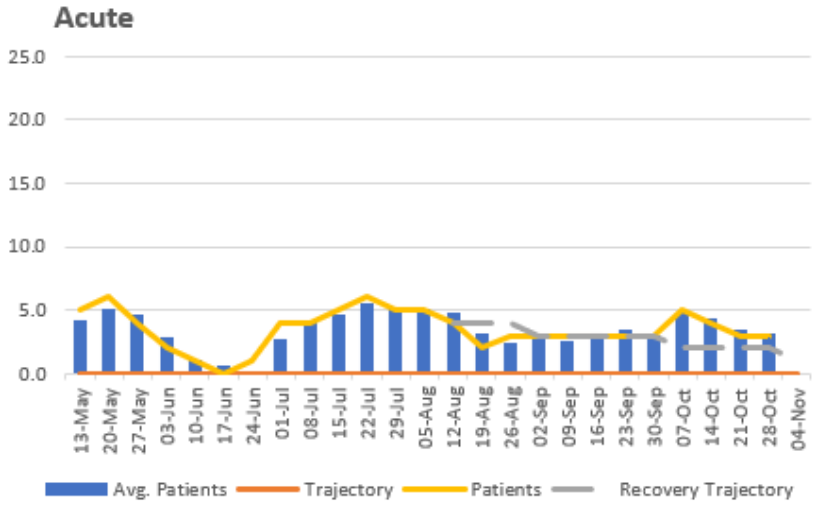
Deteriorating performance at the end of October – Total of 17 (target 10) inappropriate placements, 3 acute (target 0) and 14 PICU (target 10).

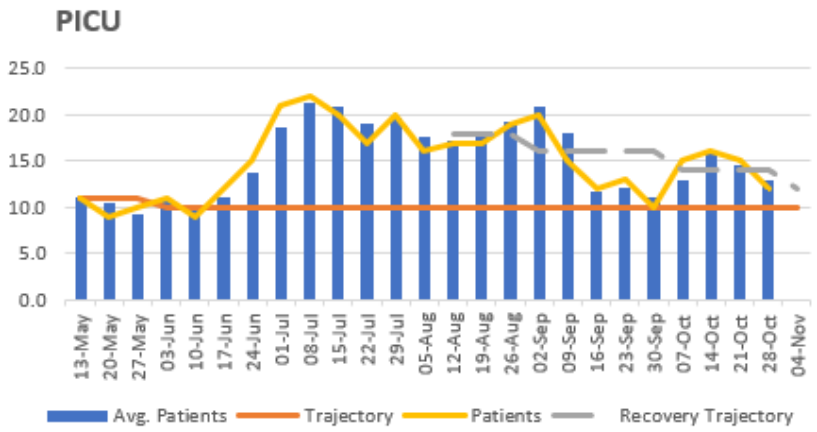
The Trust's productivity action plan continues to focus on workstreams to better manage demand, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available.

Slide 4 below highlights the weekly progress being achieved, monitored via the Patient Flow Steering Group. Demand during October has risen and a key pressure point remains the impact of those Clinically Ready for Discharge (CRFD) that are not within Trust control, particularly social care and housing impacting on reducing the available Trust capacity to support repatriation.

2. Inappropriate Out of Area Bed Usage - BSMHFT







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

Action Plan - update

Completed

- **Locality Model** – 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

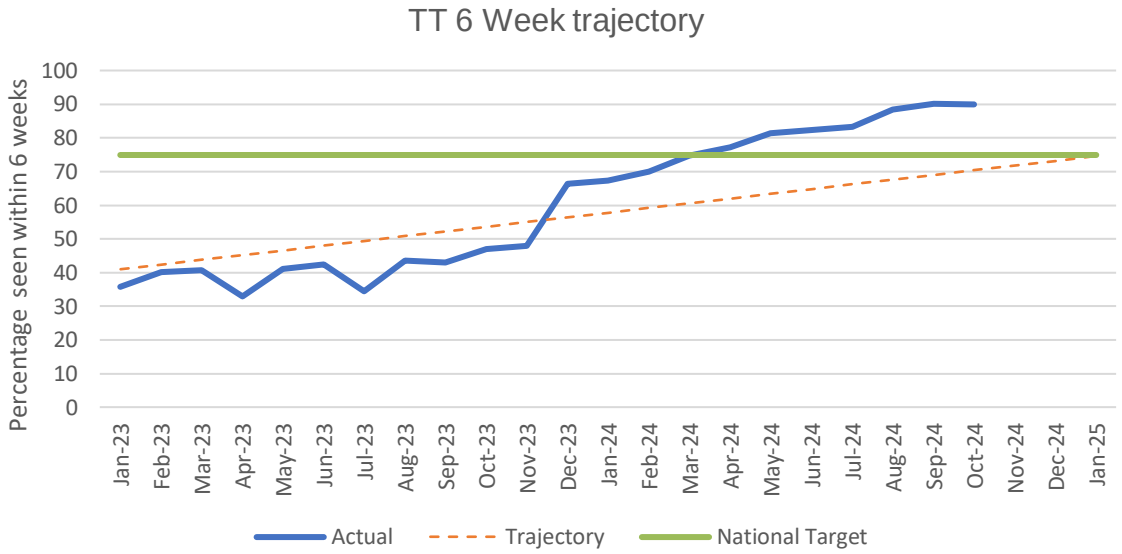
- **Demand Management/Gatekeeping -** Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' 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.

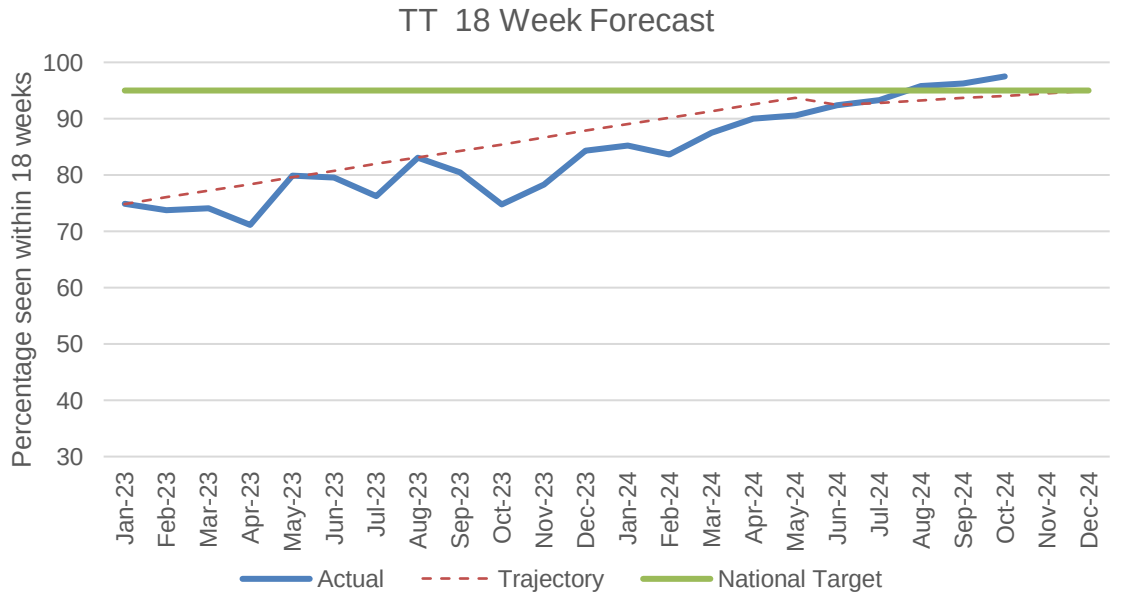
Longer term or requires additional support from ICS

- **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

Birmingham and Solihull Mental Health NHS Foundation Trust





Trajectory provided by Associate Director for Specialties

Service users seen within 6 weeks - The service plan was to reach the 75% national target by January 2025. However, successful drive of the action plan focusing on new referrals has led to a continued improved position exceeding trajectory.
October 2024 performance is at 89.88%, above trajectory and exceeding the national 75% standard for the seventh month in a row which is the highest performance in the last 3 years.

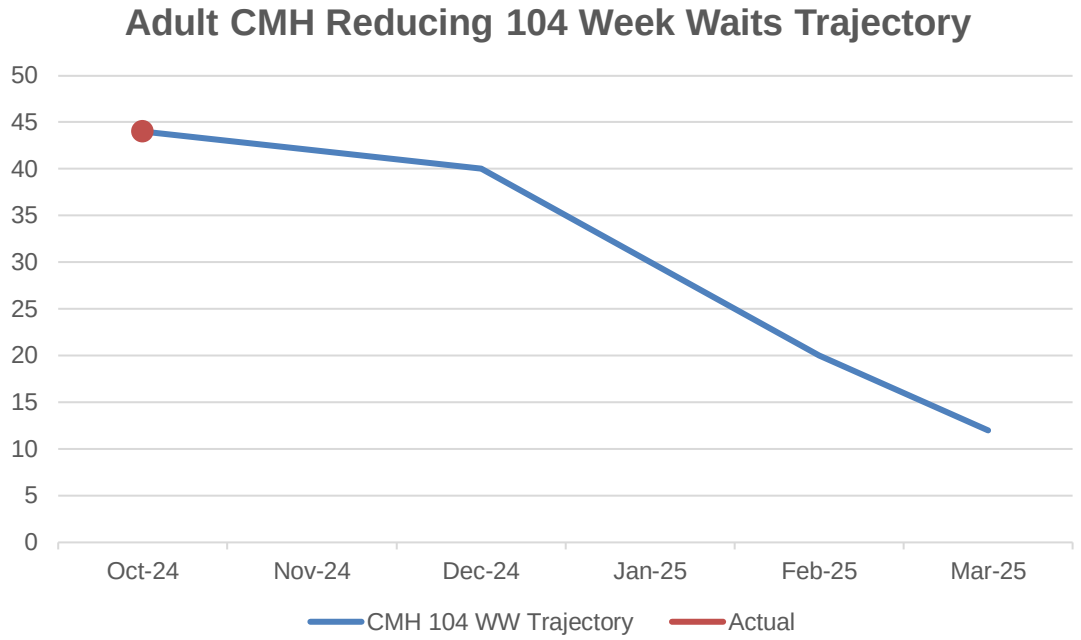
Service users seen within 18 weeks – A revised trajectory was put in place by the service to meet the 95% target by December 2024 based on staffing plans being in place to support. Good progress has been made over the last 11 months due to increased capacity and October has met the 95% target for the third time in 3 years at 97.51%.

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

Talking Therapies – update on Service's action plan

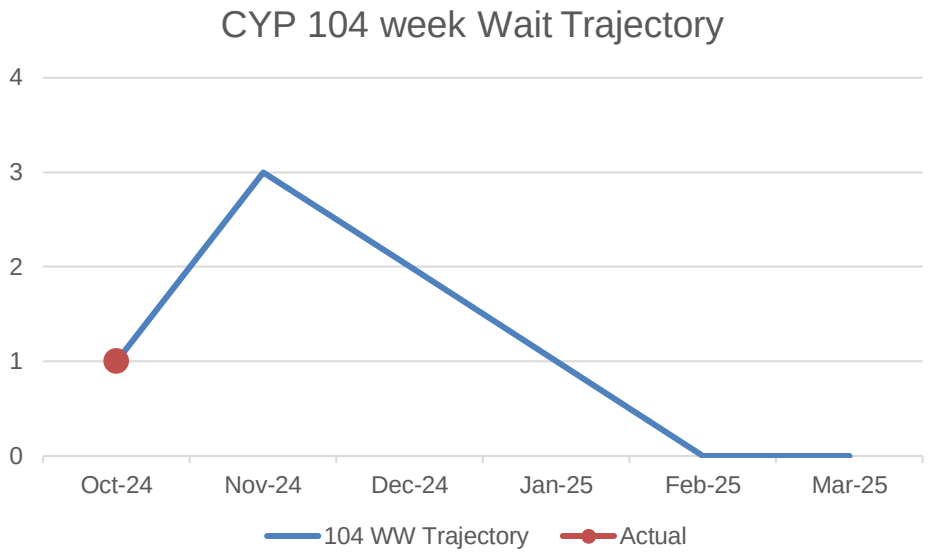
- 6 week waiting time standard – ahead of planned trajectory, good progress and meeting the 75% national target for the first time in three years.
- 18 week waiting time standard – Progress made, with increased performance at 97.51% and now above the 95% national standard. Improved capacity is assisting in the progress being achieved.
- New staff continue recruited with 9.8 higher intensity workers at step 3 and 8 Psychological Wellbeing Practitioners (PWP) step 2 have 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 continued to fall in July (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.

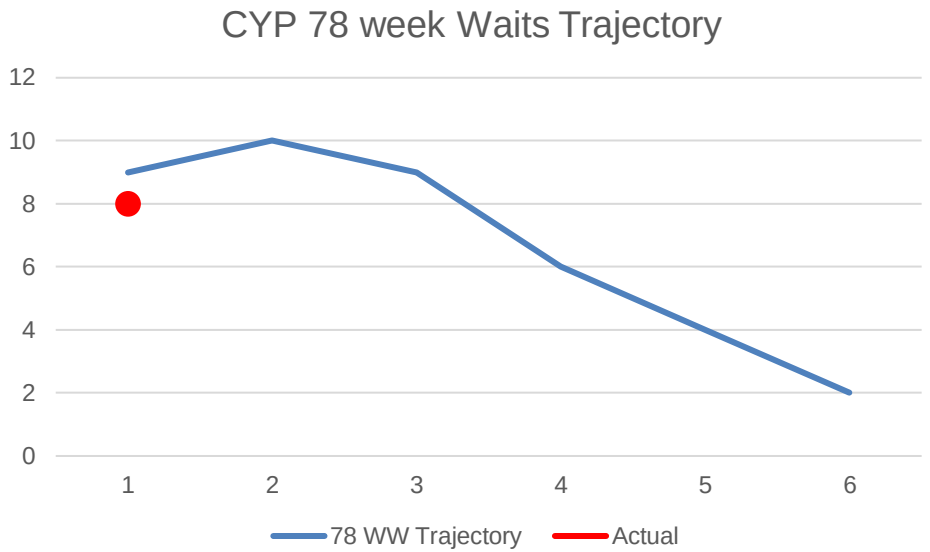
Adult - National Waiting times reduction trajectories



- Following the national planning guidance for 2024/25, NHSE requested Trust submissions by 8th November to reduce long waits in community mental health services for adults and CYP by March 2025.
- For Adult services, the Trust's focus is on reducing long waits over 104 weeks by March 2025.
- The improvement trajectory agreed with service leads submitted is to reduce long waits from 45 service users to 12 by end March 2025.
- Progress will be provided to FPPC each month based on these trajectories

CYP national Waiting times reduction trajectories





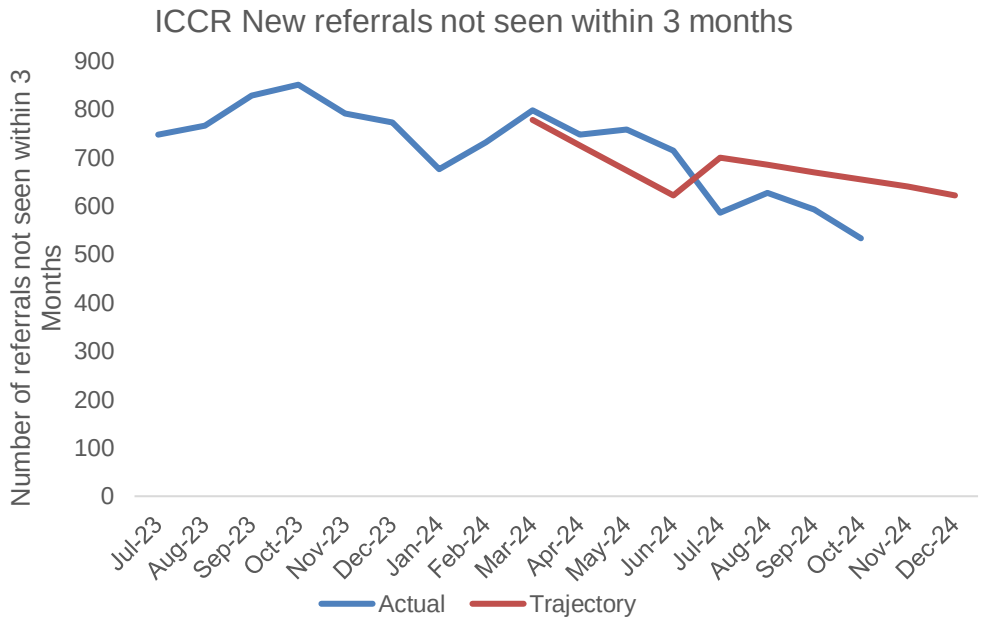
- For CYP services (Solar and ADHD), as the number of service users waiting for first contact over 104 weeks is small in volume, further improvement is required to reduce long waits over 78 weeks. As a result improvement trajectories have been submitted for both areas.
- The improvement trajectory agreed with service leads and submitted to NHSE is to reduce long waits over 104 weeks to 0 and to reduce waits over 78 weeks from 10 to 2 service users by end March 2025.

Adult CMHTs - New Referrals not seen within 3 months

ICCR Due to the high number of patients waiting to be seen for a first appointment by CMHTs, the service continues to focus on reducing these long waits. Although progress has been made, the original improvement trajectory to achieve a 20% reduction by end June 2024 was not achieved.

Service leads reviewed the action plan and submitted revised improvement trajectories to achieve the 20% reduction by end December 2024. This has already been achieved and exceeded.

A new related area of work aligns to the national 2024/25 operational planning guidance that focuses on reducing long waits for adult and CYP services. (Reference Slides 8 and 9)



Note - ICCR Trajectory provided by Associate Director for ICCR.

Adult CMHTs - New Referrals not seen within 3 months

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 is being 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 88% since November 2023 from 94 to 11 in October 24. Clinical service managers are ensuring that all patients have a future appointment for those waiting over 52 weeks
- Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in. Those waiting for 26-52 weeks has reduced by 9 patients in the last month.
- Trajectory in place to reduce those waiting over three months for a first appointment by December and then reviewing those awaiting a follow up appointment.
- National trajectory has been submitted to ICB and NHSE to reduce those waiting over 104 weeks for second contact

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.

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:

- Establishing a Multidisciplinary triage HUB to include Birmingham Healthy MINDS and NMHTs to direct referrals to the appropriate service on referral.
- CMHT caseload validation to identify service users whose needs can be addressed in primary care via the Neighbourhood Mental Health Teams (NMHTs).
- 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. Currently undertaking a review of the cohort to see how many would be suitable. Clinic due to commence next year.
- Projects are in place in Solihull, Longbridge and East to look at different ways to increase flow.

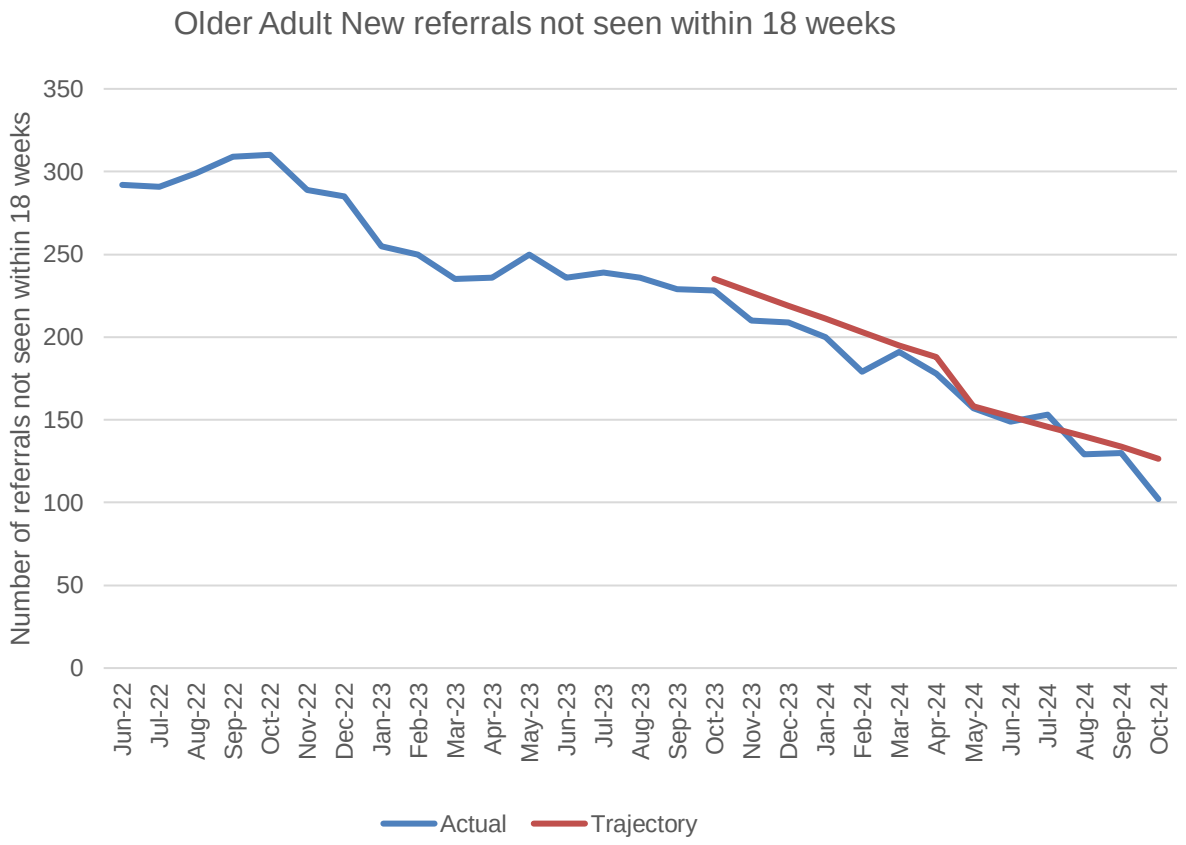
New Referrals not seen within 3 months- Older Adults

Birmingham and Solihull Mental Health NHS Foundation Trust

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, and a further trajectory was set to provide an additional 20% reduction by October. Good progress continues to be made, and October's trajectory of 126 achieved.

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

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



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

compassionate inclusive committed

New Referrals not seen within 3 months

Older adults CMHTs Action Plan:
Regular meetings in place to review service user data with managers and at FPPC.

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. The service are working to ensure that those waiting have a future appointment booked.

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 are in care homes and have had phone reviews with care home staff only 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.

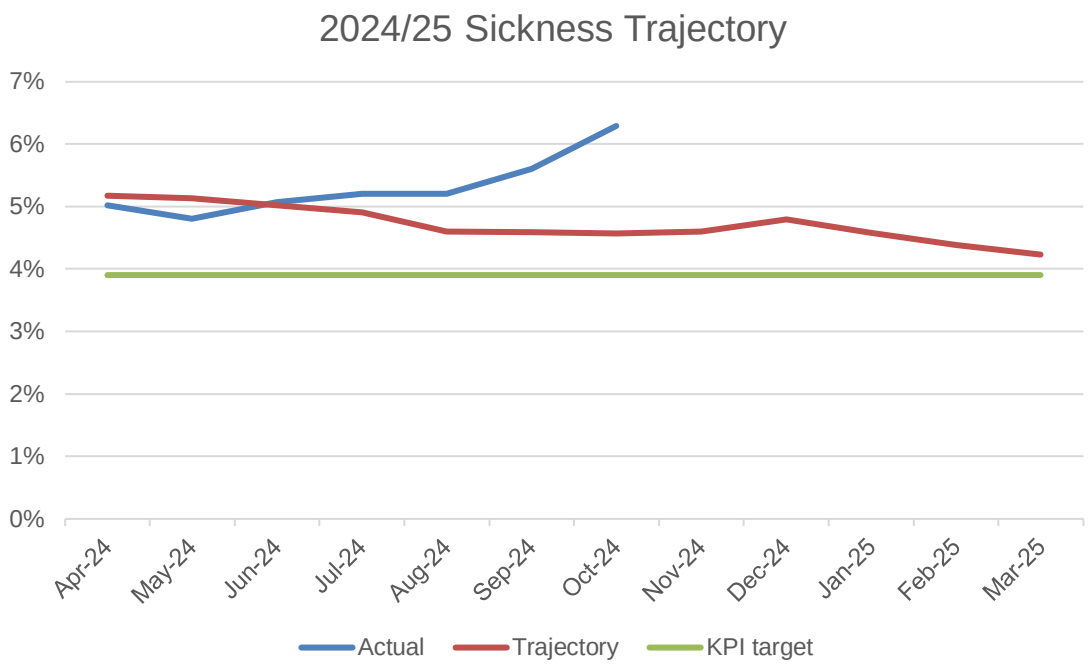
- The service is focusing on reducing the service users waiting for more than 20 weeks

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2024/25 update

Sickness Absence

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



Sickness levels on increasing trend and at 6.29% in October 2024 above the improvement trajectory of 4.57%. Long-term sickness has remained at 4% and short-term sickness has increased to 2.27%.

Action Plan:

To reach the target, there is continued focus in these areas:

Enhanced HR Sickness Clinics:

- Establish structured HR-led sickness clinics, focusing areas with high-sickness absence rates to offer early interventions and personalised support plans.
- These clinics aim to reduce long-term sickness by providing targeted resources.

Improved RTW Processes:

- Efforts to increase RTW contact completion include dedicating HR resources to ensure that returning employees have a structured plan to re-enter their roles, with a goal to improve contact rates beyond 70%.

Note - Trajectory and commentary provided by People team

Sickness Absence

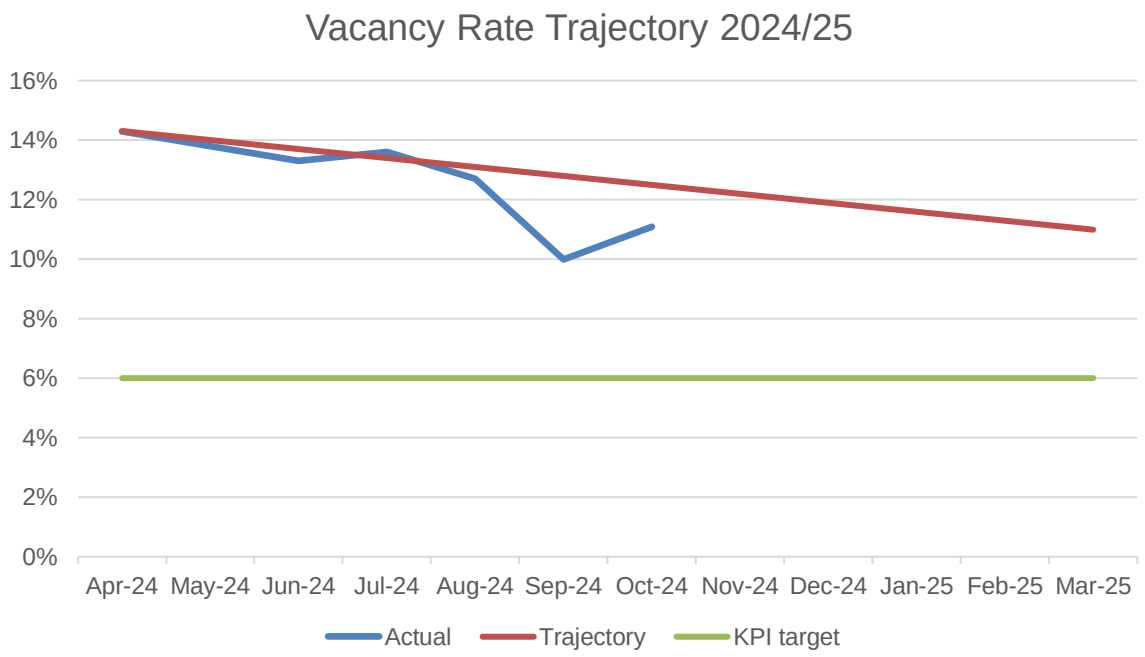
People Team Action Plan cont:

Focused Recruitment for Key Gaps:

- The Trust continues to work on reducing vacancy rates through targeted recruitment strategies, aiming to relieve pressure on overburdened teams and improve overall workforce stability.
- The People Team will continue to focus on HR clinics to ensure we are challenging where RTW are not being completed or understand the reasons for this. Continue to seek support from ADs , Heads of Nursing and other senior managers to support the management of sickness absence.

Vacancies

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



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%. Improving trend observed. October vacancy rate at 11.1% and below trajectory of 12.5% for October 2024.

- 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, the 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 successfully.
- The trust hosted a stand at the University of Nottingham's Nursing event in October with a view to attracting further nurses into the trust.
- Following a considerable centralised recruitment event for band 5 nurses across the year, multiple offers have been made, again with them being slotted into our vacancies successfully.

Note - Trajectory and commentary provided by People team

Vacancies

Action Plan update:

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.

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 13th 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.

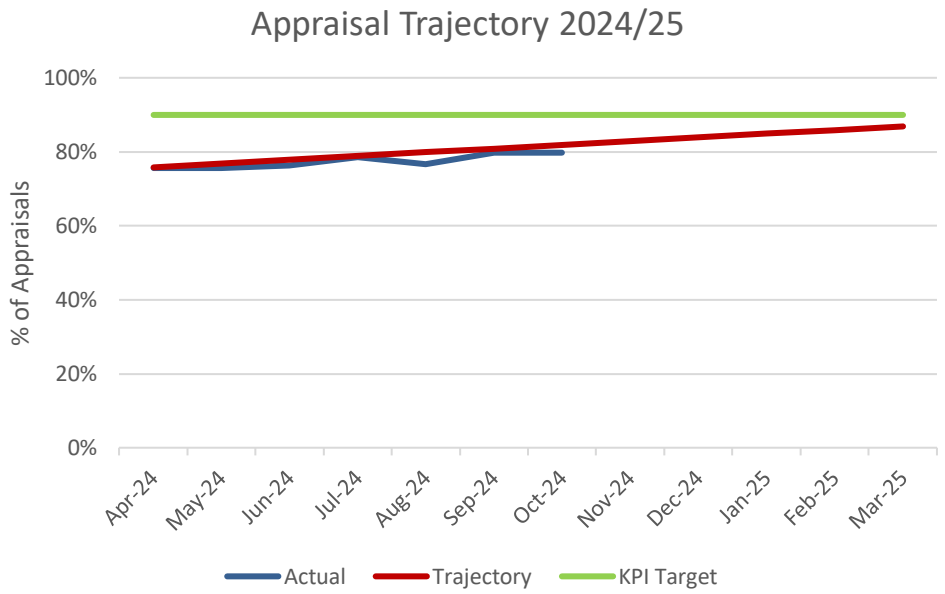
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 October 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.

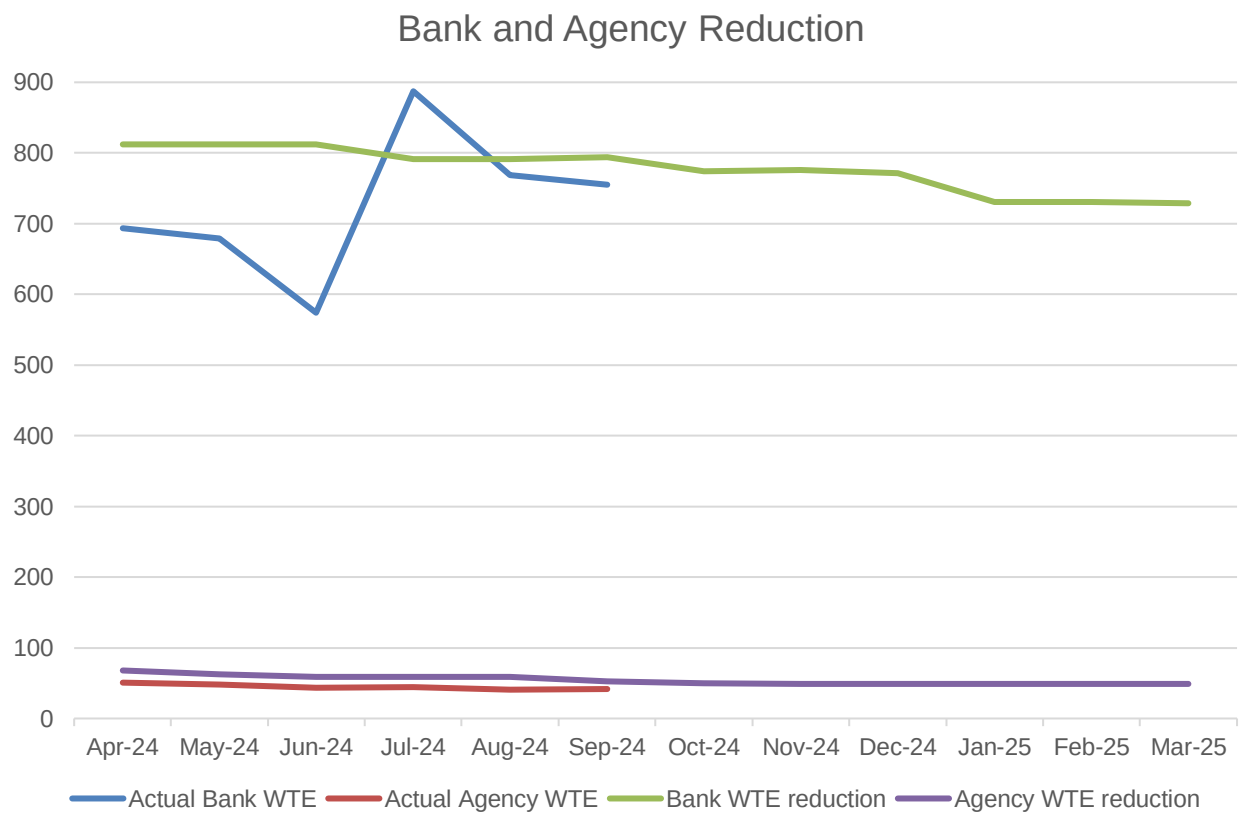
October 2024 appraisal performance has remained at 79.8% just below trajectory.

Actions:

- The appraisal staff survey has been sent Trust wide with over 100 responses received - currently reviewing the qualitative data.
- Further respondents have joined the working together groups and further workshops to support the implementation of the change ideas.
- In addition to the BAU activities, L&D have confirmed the flowchart process with key stakeholders and will be commencing communication of the flowchart to support staff experience and clear signposting to support.

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.

September has shown a small decrease in bank use from 768 to 755 WTE, below trajectory and agency has moved from 41 to 42 WTE, remaining below trajectory.
October figures are not yet available.

Note - Trajectory and commentary provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- A detailed agency reduction programme is in progress working in conjunction with ICB / NHSE 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 NHSE Midlands above cap improvement requirements will ensure that all above cap nursing bookings margins will decrease by 50% by the end of December 2024 and will be fully compliant with cap rates by the end of January 2025.
- As mentioned above, 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. 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.

FPPC is asked to note that from March 2024, a revised framework is being implemented with service level deep dive meetings being held. 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.

Performance Delivery Group (PDG) – 7th November 2024
The meeting focused on the following areas:

i) Deep Dives and Divisional Leadership reviews – The Director of Resources provided an update on the following areas:
   - Development of the Service Line Deep Dive review process which to date has been well received by all stakeholders, shared the planned feature to provide a summarized outline of all service line RAG ratings per divisional portfolio which will then begin to indicate potential themes and dependencies that can inform future reviews as part of service line improvement plans. This summarised view was also shared at the last FPPC meeting and the first report of this is attached as Appendix 3.

     In addition, to support the recommended actions from an internal audit report, waiting times data/discussion and inclusion of relevant benchmarking where available would be included in review meetings where appropriate.

   - Commencement of Divisional leadership reviews – these will complement service line review meetings. The Executive Team plans to meet the divisional senior leadership team on a quarterly basis to allow a focus on team working and management and delivery of the Trust's finance, people, quality and performance priorities and understanding dependencies across the team to do so.

ii) The Associate Director of Performance and Information presented a summary of the latest 2023/24 NHS Benchmarking data covering Adult and Older Adult Community and Inpatient services. It was agreed that relevant service areas review the data and provide an update at future service line deep dives on learning/actions being taken forward.

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

- Secure and Offender Health Deep Dive – 25th October focusing on Ardenleigh, HJVS and Offender Health.
- Specialties Deep Dive – 7th November 2024 focusing on Art Psychotherapy and the Veterans service (Op Courage).
- Integrated Community Care and Recovery Deep dive – 12th November 2024 focusing on Steps 2 Recovery services.

2. Secure and Offender Health – 25th October 2024

The focus for the service area deep dive this month was on Ardenleigh, HJVS (Health and Justice Vulnerability Service) and HMP Birmingham. The related presentations are included as Appendix IIb, IIc, and IId. A summary of the agreed service line RAG rating are outlined in the table below:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Ardenleigh services: RAG ratings revised to reflect discussion at the deep dive meeting						
Women's Blended Service ok	Amber	Amber	Green	Amber	Green	Amber
CAMHS	Amber	LSU	Green	Amber	Green	LSU
Youth First	Amber	Amber	Amber	Amber	Green	Amber
Offender Health	Amber	Red	Green	Amber	Green	Amber
HJVS (RAG ratings revised in line with discussion at the meeting)	Green	Green	Green	Amber	Green	Green

Ardenleigh services: Discussion summary

Overall - Staff survey completion – support needed.

Women's Secure Blended service

- Overall improved standards noted across the service due to impact and embedding of new staff.
- Lower acuity levels observed across the three wards.
- Improved operational performance and in workforce KPIs.
- Issues regarding availability of appropriate equipment to meet physical needs of bariatric patients, raised with estates team to help address.
- Workforce culture issues on one of the wards highlighted for action.
- Recruitment continuing to reduce vacancies. Will impact positively in reducing TSS expenditure and sickness absence over time.

Secure CAMHS

- Low secure unit (LSU) - Service remains highly acute with complex risks being managed, ward is closed to new admissions.
- LSU – new commissioning agenda, site would not be able to support the blended model for CAMHS.
- Restricting admissions to Adriatic ward, managing high levels of complexity/acuity/risk, ward layout and bedroom space also does not meet the needs of complex patients.
  ACTION: Escalation agreed for team to raise with Nursing and Quality Leads for support to look at options for utilising Parkview to help with de-escalation.
  Also agreed that Business case proposals to support a revised model of care should be expedited for Executive Team review.

- Medium secure unit (MSU) has low number of patients which is cause for concern from commissioners.
- MSU - OD/ EDI work has commenced.
- MSU – vacancy rates, recruitment being undertaken, with long term sickness impacting on use of bank staff.
- MSU – Nationally is held in high regard with 2 members of the team holding lead positions and supporting with the service specification going forward.

Youth First

- Workforce generally cohesive and skilled at working together. Increased sickness levels have impacted on caseload management and increased workload.
- Consultant due to join the team soon.
- Adherence to training fluctuates. Some of this is due to sickness and the complexity of increased caseloads. Team manager is working to address this with the team.

Offender Health: Discussion Summary:

iii) Quality and Safety - Environment continues to be a concern, healthcare wings in poor state of repair and medication hatches not fit for purpose.
Improvements in hepatitis C screening and ACCT training.

iv) Workforce - High vacancy rate in Birmingham Community Health Care and Birmingham Recovery Team was impacting but new staff have commenced and organisational development work across teams planned to start in November.
Staff survey action plan in place.

v) External/Strategy - Issues requiring BCHC leadership/input remain an issue.
ACTION: Executive Director of Operations to raise with BCHC Executive counterpart.
Relationships with HMP have improved and further joint work continuing.

Health Justice Vulnerability service: Discussion Summary:

- High level vacancy rates impacting quality, performance, people and finance. However, recent success in recruitment to fill vacancies will result in positive changes once staff are in place. Service RAG rating above reflects this position.
- Implementation of quality measures and review led to improved clinical practice particularly around safeguarding, information sharing and risk formulation.
- Notable shift in culture over the past 12 months, staff survey actions around developing the current workforce, increasing inclusion, co-production, and civility within the team.
- Limited space for community outreach staff in the community base. Rooms not disability friendly and this will need to be addressed to meet staff needs.

3. Specialties – 7th November 2024

The focus for the service area deep dive was on and the Veterans service (Op Courage) and Art Psychotherapy service. The presentations shared by the service leads are included as Appendix IIe and IIf.

Veterans (Op Courage)

Domain Level RAG rating review:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Veterans (Op Courage)		Green	Green	Green	Green	Green

Discussion Summary:

Positive examples of good practise shared at the meeting, service value has been recognised regionally and nationally and positive feedback received following a ministerial visit including hearing experiences from service users. Small team but effective team work in place, work well together to overcome barriers, no waiting list for treatment pathway, using a trauma informed care model which has a positive impact on staff retention, wellbeing and quality,

Actions and support required by service leads:

- Receiving timely support from the People team and Occupational Health due to capacity challenges in those teams.
- Revised patient level reporting needs to be established – support required from the informatics team.
- Ongoing system level work required.
- Regional geography impact on recruitment and retention, creates challenges due to the mileage cap and lone working
- Issues with recording RMS and Clinical Supervision as figures do not reflect high levels being achieved. Service leads to review recording challenges.
- Estate capacity raised, Director of Finance agreed to follow up.

Art Psychotherapy

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Art Psychotherapy		Green	Green	Green	Green	Green

Discussion Summary

- The service is available across community services and currently has 145 people waiting for therapy. There are a number of mitigations in place to try and reduce waits including the introduction of appointments within 3 weeks of referral, increased group interventions, development of MBT (Mentalisation Behavioural therapy), improved data collation relating to non-attendance and introduction of an Experts by Experience Art Psychotherapy Group commencing in January 2025.
- There are no waits between assessment and therapy
- Positive feedback from the 2023/24 staff survey

- Funding for 2 away days annually is a challenge and as service grows this will be a cost pressure that will need to be considered.

4. Integrated Community Care and Recovery – 12th November 2024

The focus for the service area deep dive this month was Steps 2 Recovery. The presentation shared by the service lead is included as Appendix IIg.

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Steps 2 Recovery	Amber	Green	Green	Green	Amber	Green

Discussion Summary

Positive examples of good practise shared included:

- Successful service developments leading to successful recruitment and retention. Previous high levels of vacancies now reduced and current 6 vacancies are out for recruitment.
- Positive staff experience within the service noted.
- Converting David Bromley House (DBH) to a female only unit has resulted in no females being placed outside Birmingham.
- The development of an Intensive Community Rehabilitation Team (ICRT) has enabled to divert people who may have needed a bed and have reduced the use of Out of Area placements which has achieved savings.
- Highlighted that the number of individuals with a stay of 5 years + was higher in those placed out of area then those within BSMHFT beds and work is underway to review support needs for these service users where appropriate.
- Reviewing needs of service users in acute adult inpatient beds to see if the ICRT can support individuals to assist in capacity management within adult acute services.
- Development of a patient council and a service user experience survey to seek feedback for ongoing learning to inform action planning.
- Planning to rollout a peer review of the quality standards across the service.
- Forward House undertaking the Trust's Culture of Care programme.

Actions & Support requests

- Feedback awaited on the completion and outcomes of the Trust's staffing review highlighting need for additional staffing.
- Budget to align to staffing establishment requested as this continues to add cost pressures to the service.
- Success of the ICRT which has led to the development of a business case for a second team.
- Development of an independent placement team to case manage all independent rehab placements.
- Invest to save approaches and potential for ringfencing of savings accrued to be reinvested back into the service raised.
- Service Lead working with commissioners to review section 117 care packages and alternative provision.

Performance Delivery Group – 7th November 2024

NHS Mental Health Benchmarking 2023/24

Adult & Older Adult Inpatient service & Community Mental Health Teams

Resident based Population Report

What do they tell us about BSMHFT?.....And the 'So What?'

Tasnim Kiddy & Julie Keith

November 2024

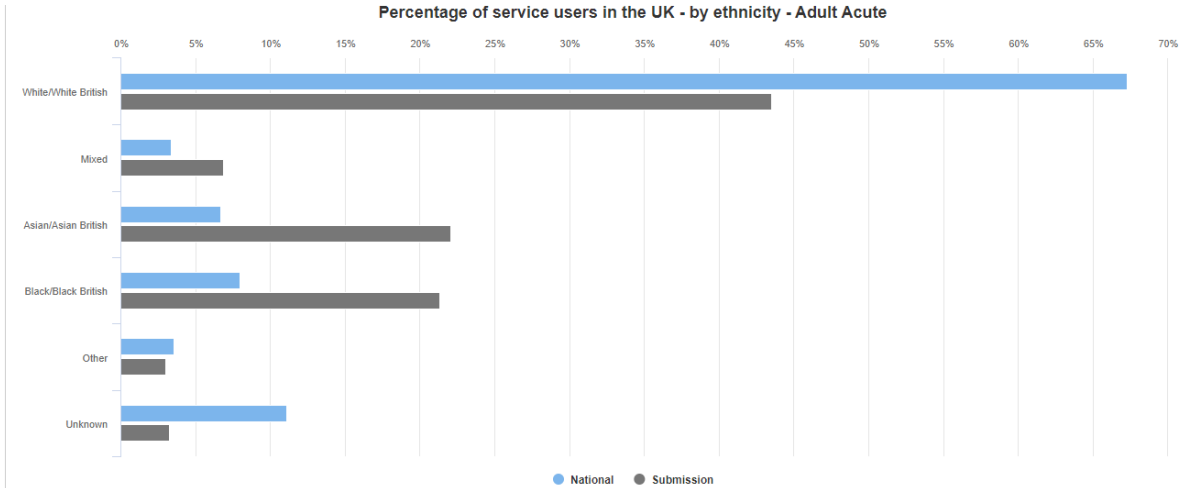
Background

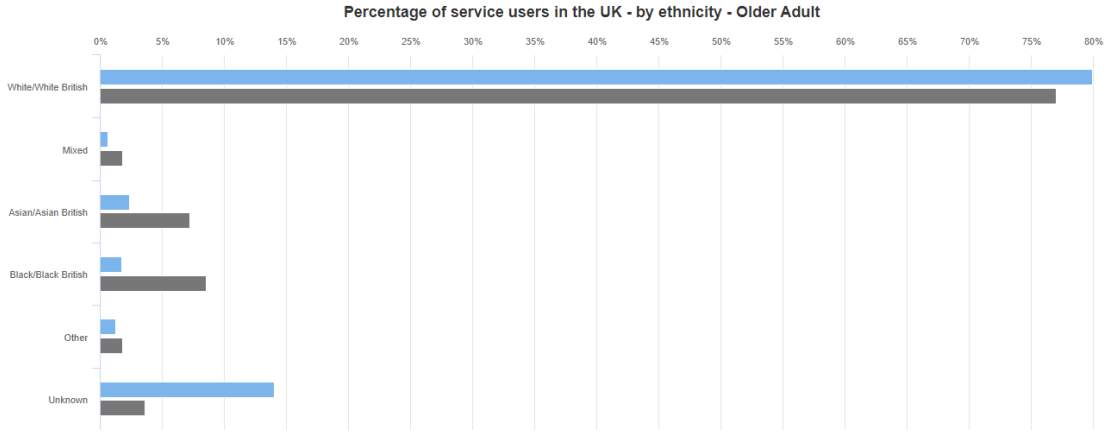
- Annual National benchmarking Resident Population Report – adult & older adult MH services
- Based on 2023/24 financial year.
- Covers activity , finance, workforce and quality
- High participation - 50 English Providers, 13 Scottish health Boards, 7 Wales health Boards, 2 trusts from northern Ireland, State of Jersey and 1 Independent providers.
- Note – The national mean for all metrics will be affected by number of Trusts responding to that metric – therefore variable or low participation can skew the position
- Routine key metrics covered – provides good base for year on year comparisons/changes
- Care Cluster related metrics have been removed this year
- **New** - Benchmarking on outcomes and waiting times in development
- Note that Weighted population report and Other Metrics available via online toolkit only

Ethnicity – Admissions and community caseload

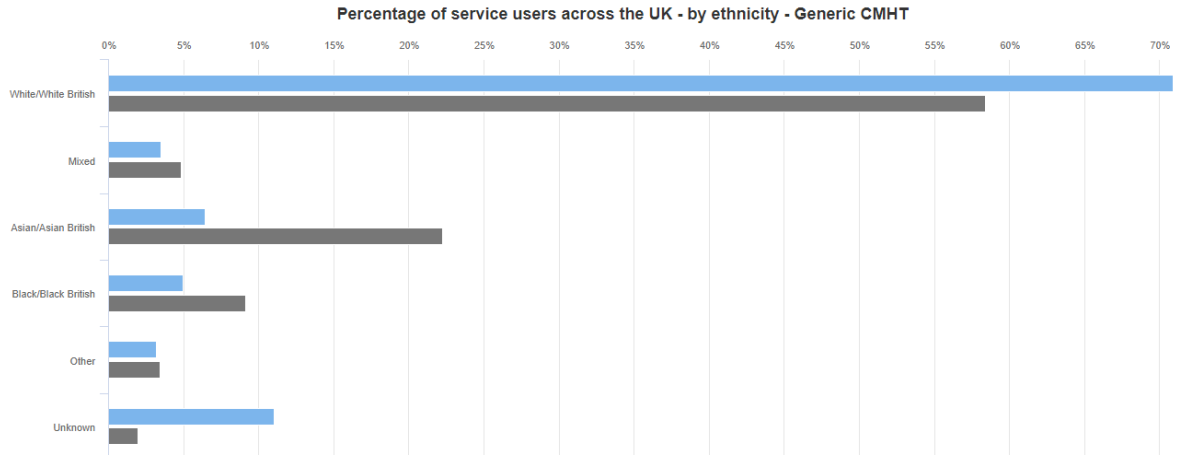
(*Grey bar is BSMHFT*)

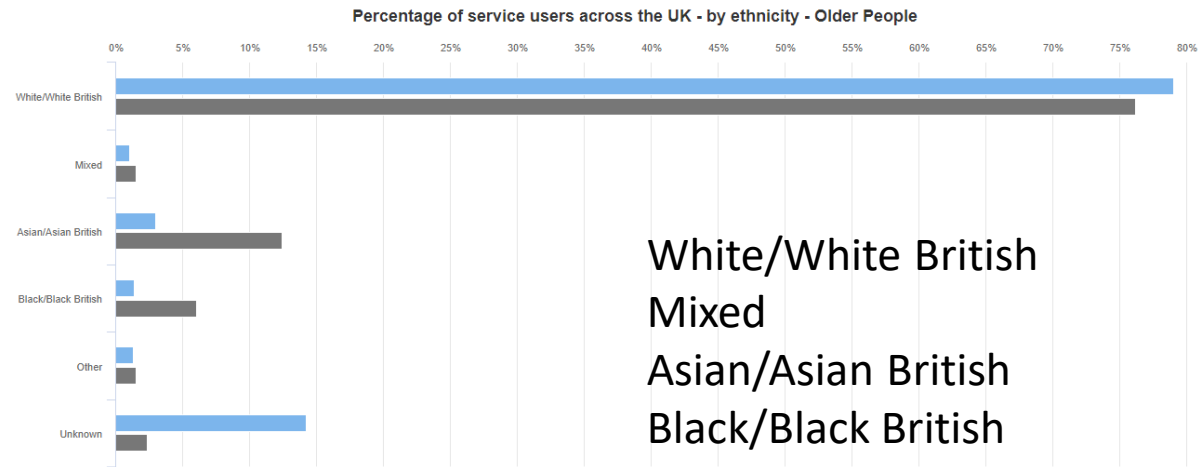
Inpatients





Community





White/White British
Mixed
Asian/Asian British
Black/Black British
Other
Unknown

Adult Acute inpatients

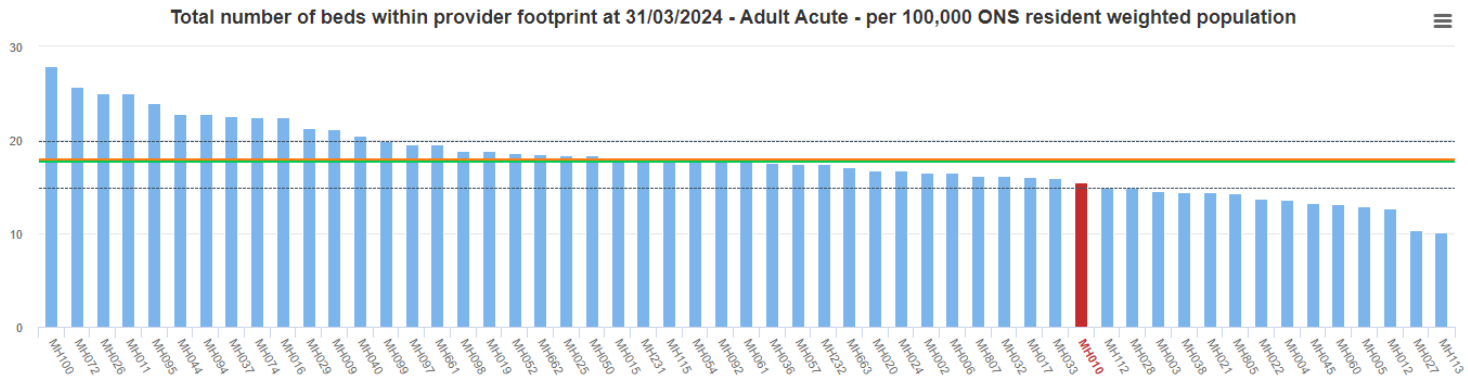
Adult Acute Inpatients themes – consistent to previous years

Metric	Low – High	MH010	Mean	Median
Beds per 100,000 resident population at 31st March 2024		24	23	22
Bed occupancy rates (excluding leave)		96%	93%	96%
Admissions per 100,000 resident population		171	204	195
Admissions - patients not previously known to services (as a % of all patients admitted)		7%	12%	7%
Admissions - patients of no fixed abode (as a % of all patients admitted)		2%	3%	2%
Length of stay (excluding leave) (days)		51	41	41
Admissions under the Mental Health Act as a proportion of all admissions		65%	49%	49%
Admissions under the Mental Health Act per 100,000 resident population		112	93	83
Length of stay for Mental Health Act detentions (days)		56	47	45
Bed days lost for patients clinically ready for discharge as a proportion of occupied bed days		10%	10%	10%
Readmission rate within 30 days		3%	9%	8%
WTE vacancies as % of staff in post		10%	14%	13%
Cost per 10 beds		£2,333,389	£2,292,178	£2,199,998
Restraint per 10,000 occupied bed days		147	173	133
Prone restraint per 10,000 occupied bed days		54	12	7

Consistent themes:

- **Lower number of beds**
- **High levels of occupancy**
- **Lower number of admissions**
- **Longer length of stay** and LOS higher for admissions under the MHA
- **Higher levels of admissions under the MHA** 65% compared to national average of 49%.
- **15% of patients whose stay is longer than 90 days occupied 51% of all bed days** on adult acute wards
- **Prone Restraint** higher than national average
- **Readmission rate** lower than national average
- **Clinically Ready for discharge** – bed days lost in line with national average

Adult Acute: Number of beds and Occupied Bed Days



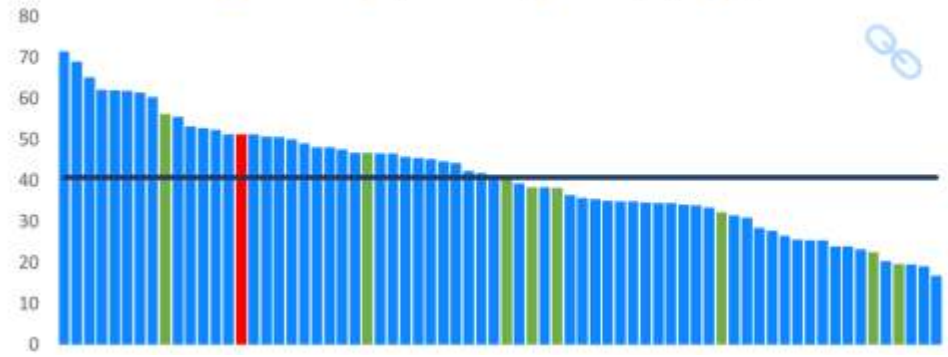
The number of beds based on resident population is 22.6 above the national average of 21.5. (based on 74 responses) however this drops to only **15.49** based on weighted population compared to the national average of 17.89. **The trust is 15th lowest based on 55 responses.** Combined with the **long length of stay** leads to a low number of admissions – **9th lowest.**

Bed occupancy rate is 95.5% compared to a national average of 93%.

Readmissions are in the bottom quartile at 1.8% compared to a national average of 5%

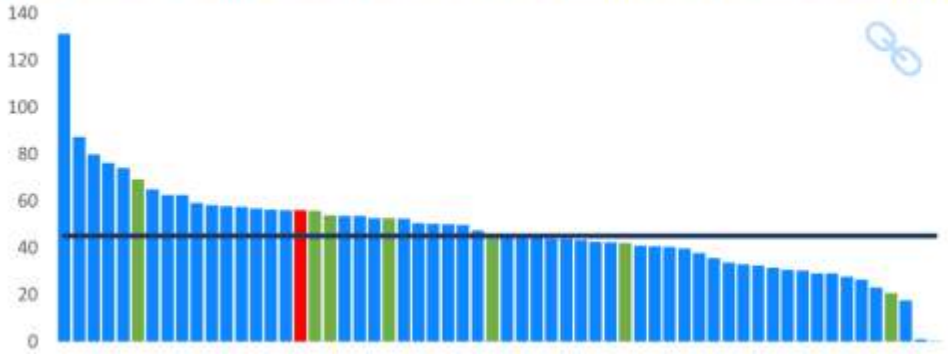
Adult Acute: Length of Stay/ CRFD

Adult Acute - length of stay (excluding leave) (days)



MH010	51
Mean	41
Median	41
Upper quartile	50
Lower quartile	33
N	70

Adult Acute - length of stay for Mental Health Act detentions (days)



MH010	56
Mean	47
Median	45
Upper quartile	56
Lower quartile	35
N	60

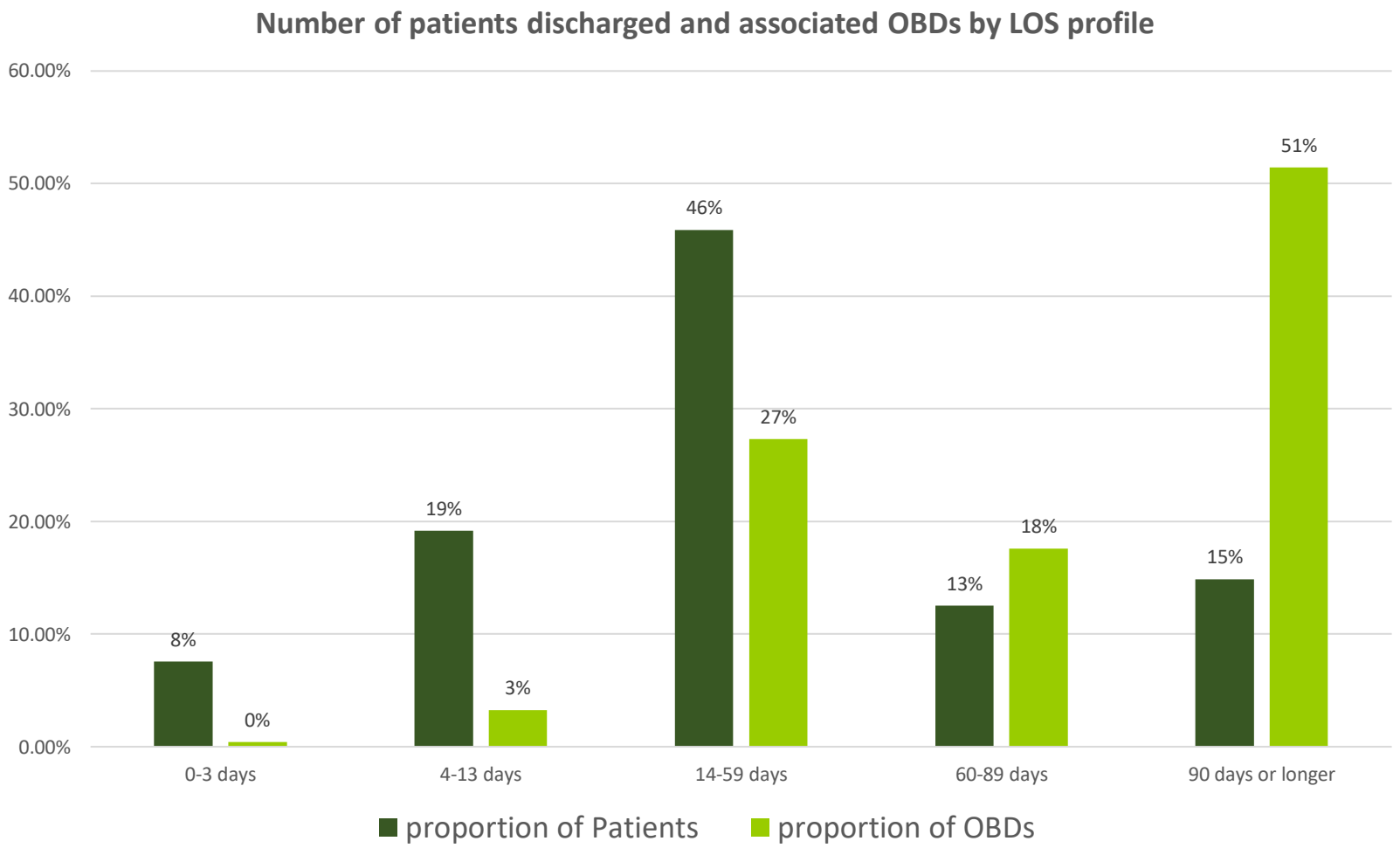
The average length of stay was **51 days** compared to a national average of 41 days This is in the top quartile and the 15th highest (was previously 5th highest).

Admissions under the MHA increase the LOS experienced and increase our figures to 56 days remaining above the national average of 47 days

The number of admissions under the MHA is 11th highest and in the top quartile.

The number of bed days lost to CRFD is 9.9% and in line with the national average of 10%.

Adult Acute: Occupied bed days and LOS within provider footprint



46% of patients discharged within 14-59 days, occupy 27% of bed days.

15% of patients whose stay is longer than 90 days occupied 51% of all bed days on adult acute wards

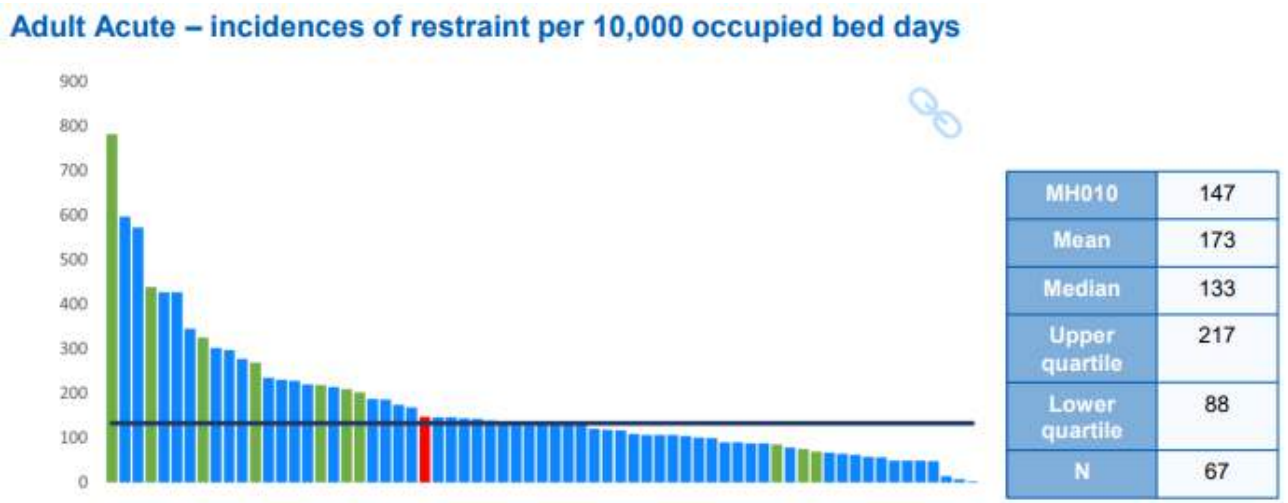
Adult Acute: Restraint

Incidents of restraint per 10,000 occupied bed days are below the national average.

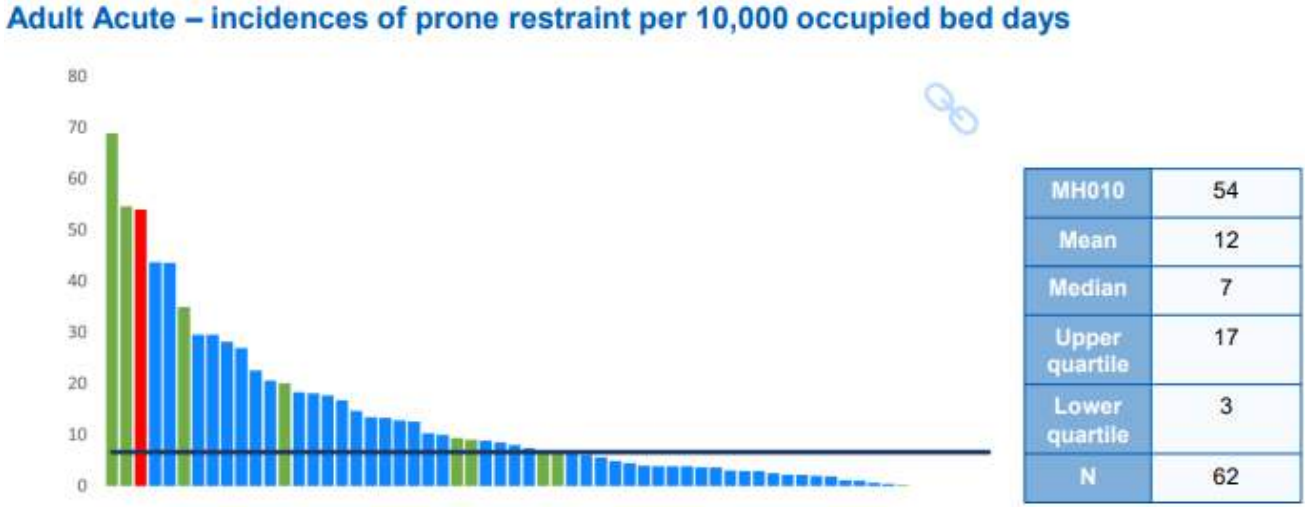
Prone restraint is the 3rd highest at 54 in the top quartile against the national average of 15.8. This is an increase from 2022/23 which was 35.8.

Use of seclusion is 14.23, below thw national average of

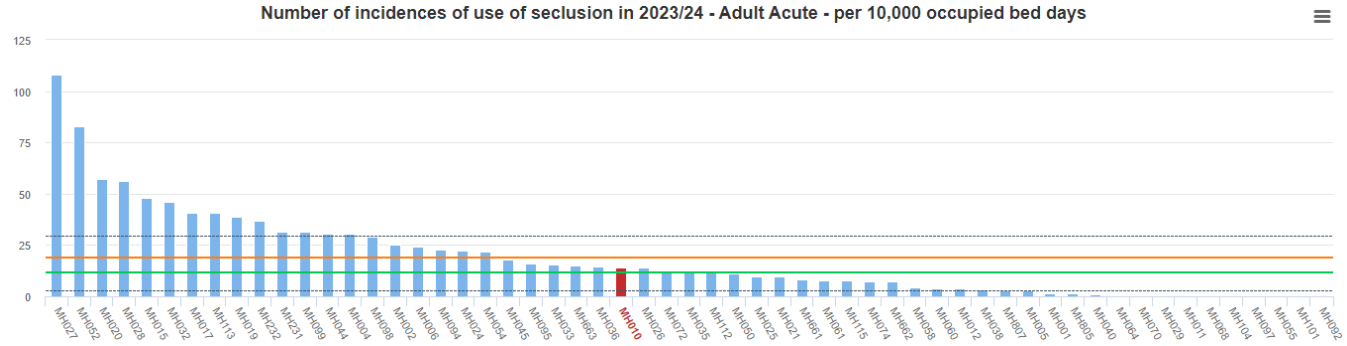
Deaths of services users per 10,000 occupied bed days at 0.14 compared to a national average of 0.48



MH010	147
Mean	173
Median	133
Upper quartile	217
Lower quartile	88
N	67



MH010	54
Mean	12
Median	7
Upper quartile	17
Lower quartile	3
N	62



Adult acute IP workforce

- Staff Vacancy below national average
- Staff sickness below the national average and below the lower quartile
- The total of qualified nurses per 10 beds is just in the lower quartile and when weighted population is applied moves to the 10th lowest at 9.7 compared to the national mean of 14.

10.48

Below mean & median

Mean 14.24%

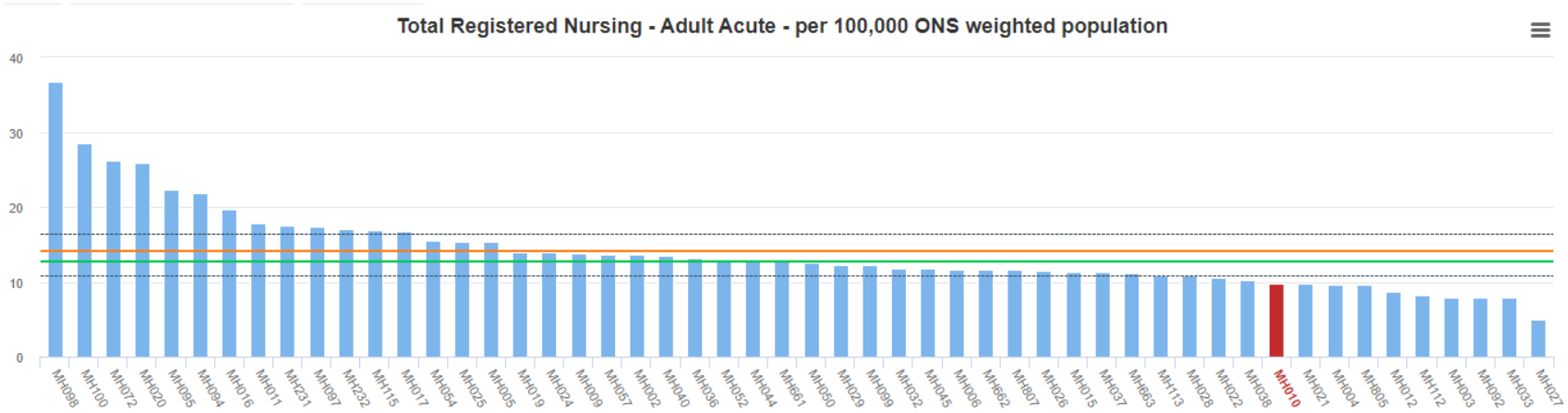
Vacancy rate (all staff)

1.26%

In lower quartile

Mean 6.88%

Sickness absence



Older Adult Inpatients

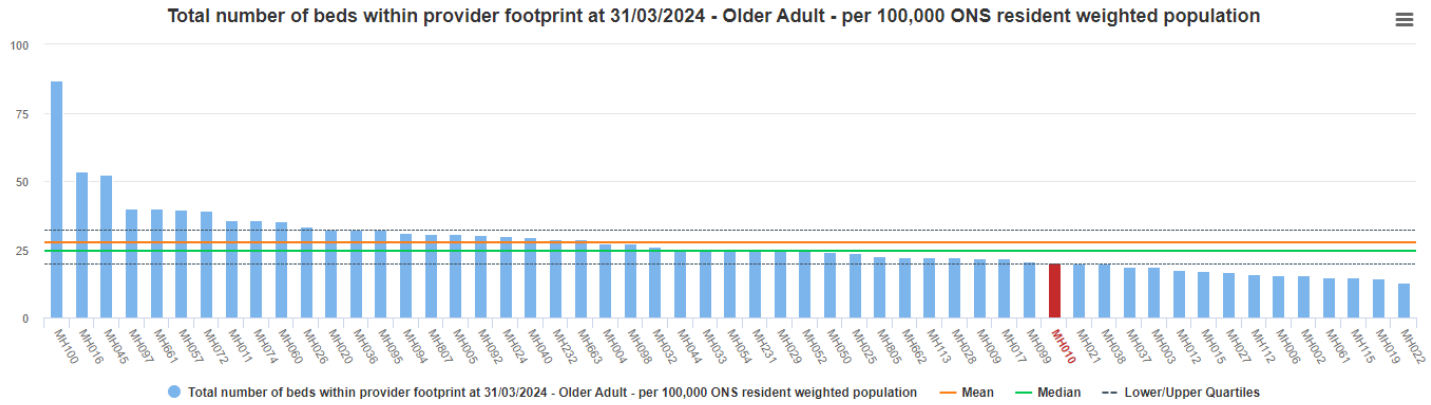
Older Adult IP Acute: themes

Metric	Low – High	MH010	Mean	Median
Beds per 100,000 resident population at 31st March 2024		31	44	35
Bed occupancy rates (excluding leave)		95%	88%	90%
Admissions per 100,000 resident population		98	152	128
Admissions - patients not previously known to services (as a % of all patients admitted)		4%	15%	7%
Admissions - patients of no fixed abode (as a % of all patients admitted)		0%	1%	1%
Length of stay (excluding leave) (days)		110	91	90
Admissions under the Mental Health Act as a proportion of all admissions		68%	56%	60%
Admissions under the Mental Health Act per 100,000 resident population		67	80	80
Length of stay for Mental Health Act detentions (days)		119	97	93
Bed days lost for patients clinically ready for discharge as a proportion of occupied bed days		15%	16%	15%
Readmission rate within 30 days		2%	5%	4%
WTE vacancies as % of staff in post		0%	13%	12%
Cost per 10 beds		£2,490,339	£2,173,416	£2,128,901
Restraint per 10,000 occupied bed days		178	124	80
Prone restraint per 10,000 occupied bed days		8.9	1.8	0.6

Consistent Themes:

- **Low number of beds**
- **High levels of occupancy**
- **Low number of admissions**
- **Long length of stay** – in top quartile and LOS increases slightly when service users admitted under the MHA
- **LOS** higher than the national average for those with stays between 60-89 days
- 55% of patients who **stay is longer than 90 days occupied 80% of all bed days on** older adult acute wards
- **Restraint and Prone restraint** are higher than the national average
- Low **readmission rate**
- **CRFD days** just below the national average

Older Adult: Number of beds



MH010	95%
Mean	88%
Median	90%
Upper quartile	94%
Lower quartile	85%
N	72

The number of beds is lower than the national average using the weighted population – 15th lowest in the bottom quartile
This increases for registered population to 31 beds with a national average of 44

Lower number of admissions based on weighted population , 37% less than the national average.

Bed occupancy rate is 95% and above national average.

Readmissions within 30 days of discharge are below the lower quartile at 1.8%.

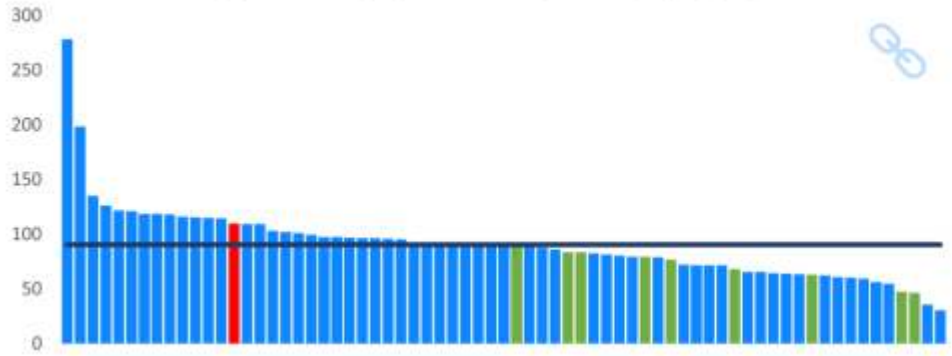
Older Adult: IP Length of Stay and CRFD

The average length of stay was 110 days compared to a national average of 91 days - In the top quartile.

Admissions under the MHA increase the LOS experienced to 119 days remaining above the national average of 97 days.

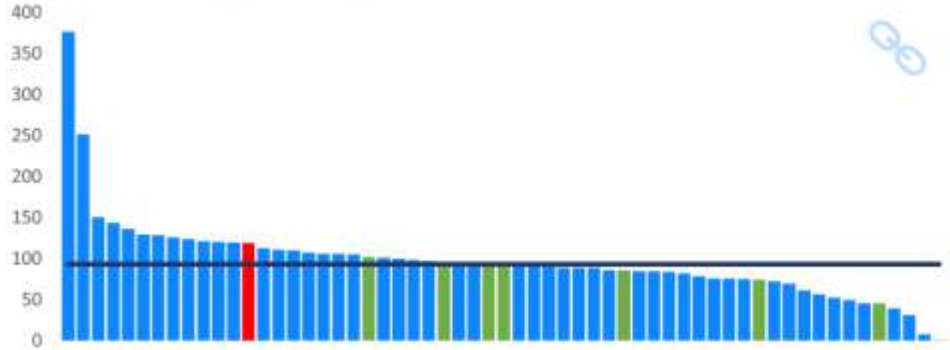
The number of bed days lost to Clinically Ready for Discharge has increased by 4% to 15% and is just below the national average at 16%

Older Adult - length of stay (excluding leave) (days)



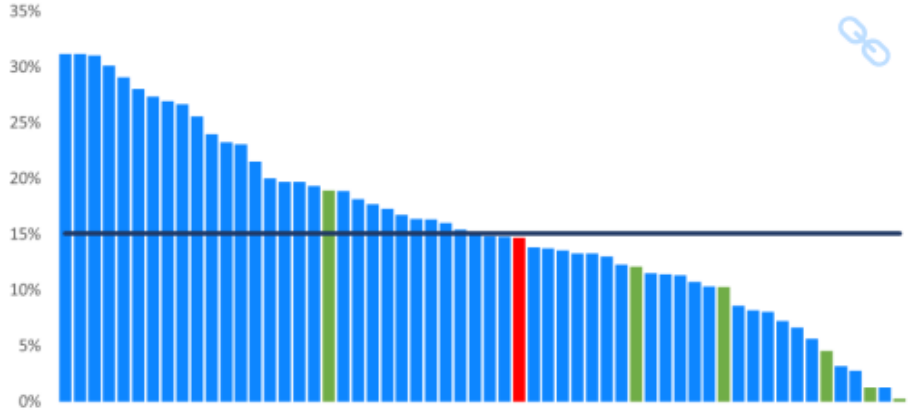
MH010	110
Mean	91
Median	90
Upper quartile	102
Lower quartile	72
N	69

Older Adult - length of stay for Mental Health Act detentions



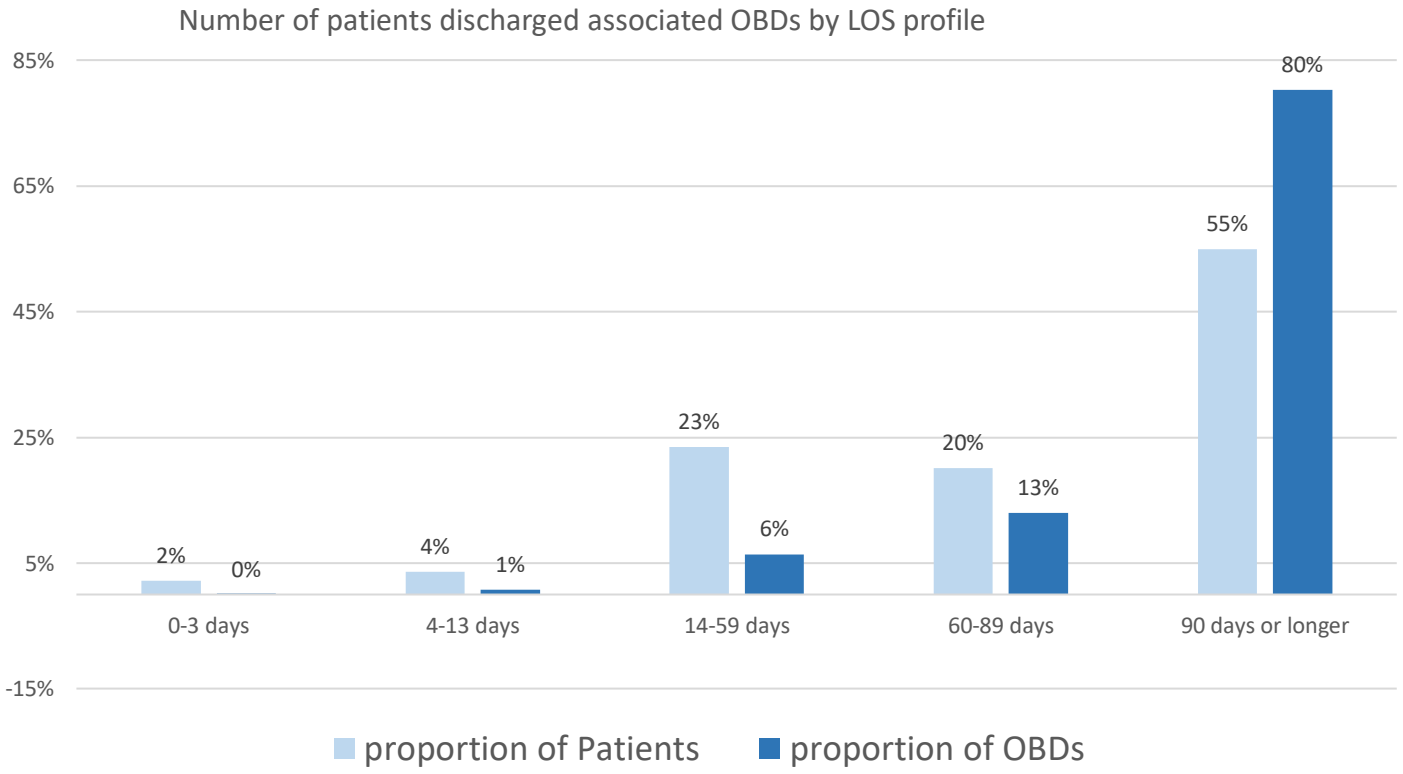
MH010	119
Mean	97
Median	93
Upper quartile	110
Lower quartile	76
N	59

Older Adult – bed days lost for patients clinically ready for discharge as a proportion of occupied bed days (%)



MH010	15%
Mean	16%
Median	15%
Upper quartile	20%
Lower quartile	11%
N	58

Older adult Occupied bed days / LOS



23% of patients discharged between 14-59 days, occupy 6% of bed days.

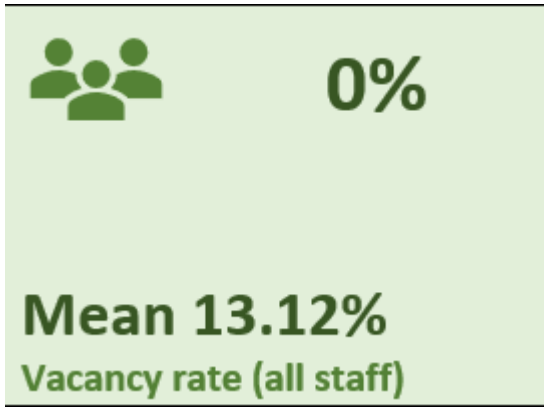
55% of patients whose stay is longer than 90 days occupied 80% of all bed days on older adult acute wards

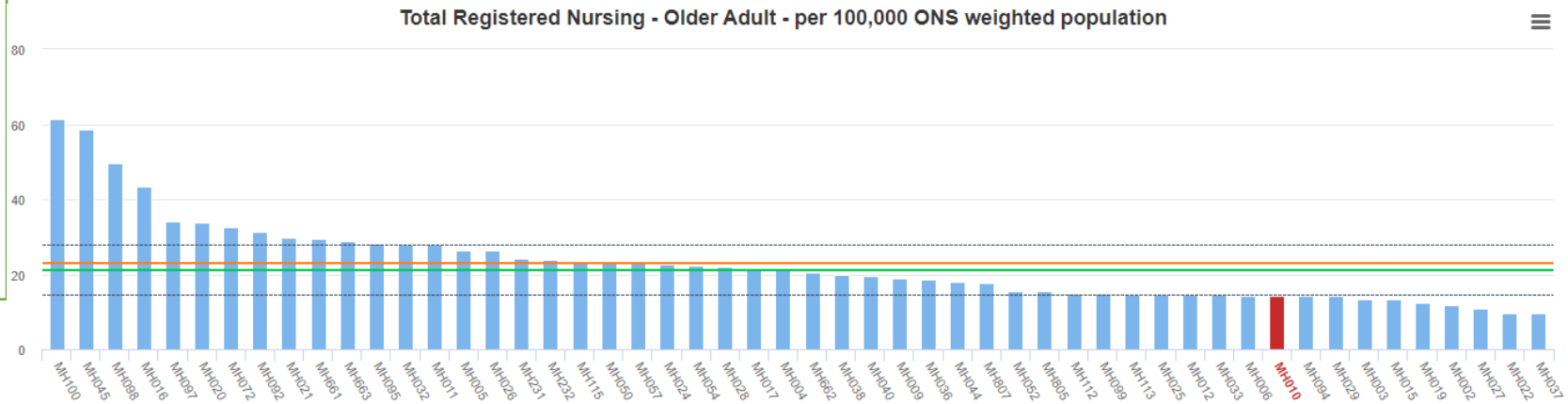
Older adult: IP workforce

Staff **Vacancy** below the mean and below the lower quartile. This is 0% due to the over recruitment of HCA's

Staff **sickness** below the mean and below the lower quartile

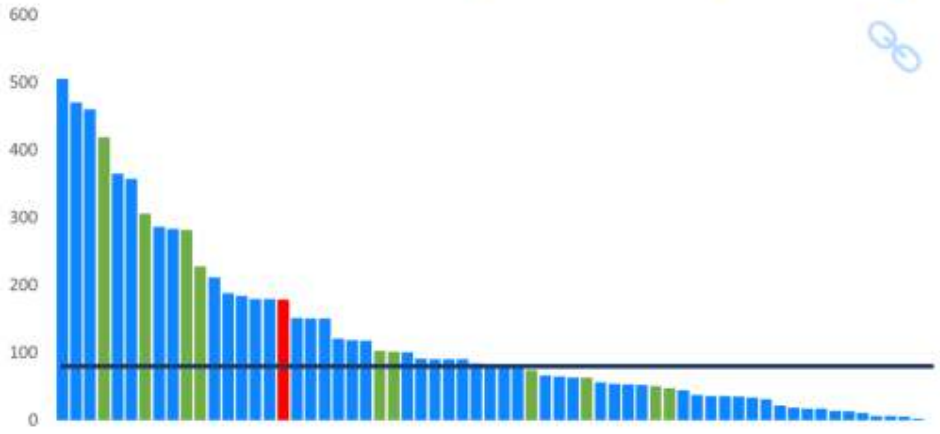
The **total registered nursing** per 10 beds is lower than the national average and drops into the lower quartile when weighted population is applied.





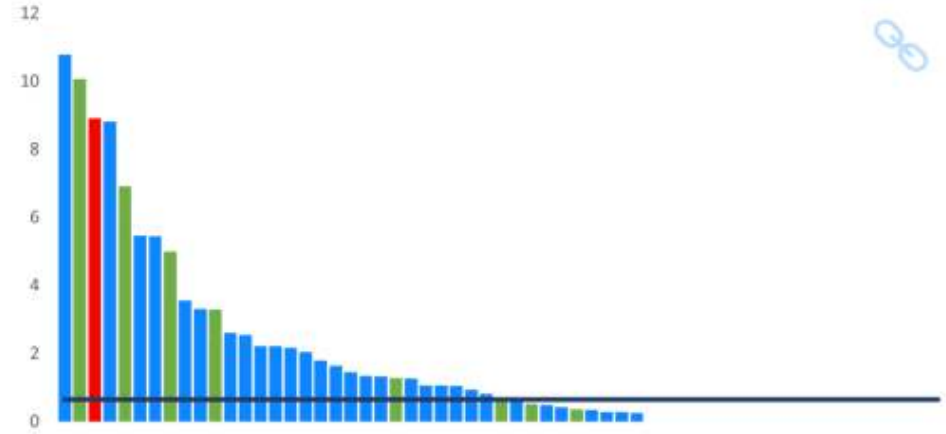
Older Adult IP : Restraint

Older Adult – incidences of restraint per 10,000 occupied bed days



MH010	178
Mean	124
Median	80
Upper quartile	179
Lower quartile	36
N	64

Older Adult – incidences of prone restraint per 10,000 occupied bed days



MH010	8.9
Mean	1.8
Median	0.6
Upper quartile	2.2
Lower quartile	0.0
N	59

Incidents of restraint per 10,000 occupied bed days are above the mean and in line with the upper quartile at 178 compared to the national average of 124.

Prone restraint is the 3rd highest at 8.9 above the national average of 1.8. This is an increase from 2022/23 which was 5.3.

We are in the top quartile for both restraint and prone restraint.

Deaths per 10,000 occupied bed days below the national average and in bottom quartile.

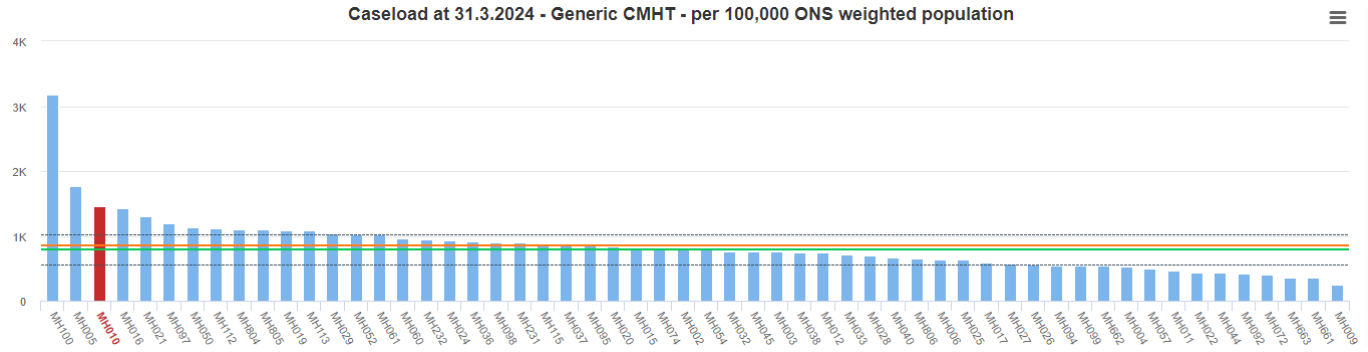
Adult Community

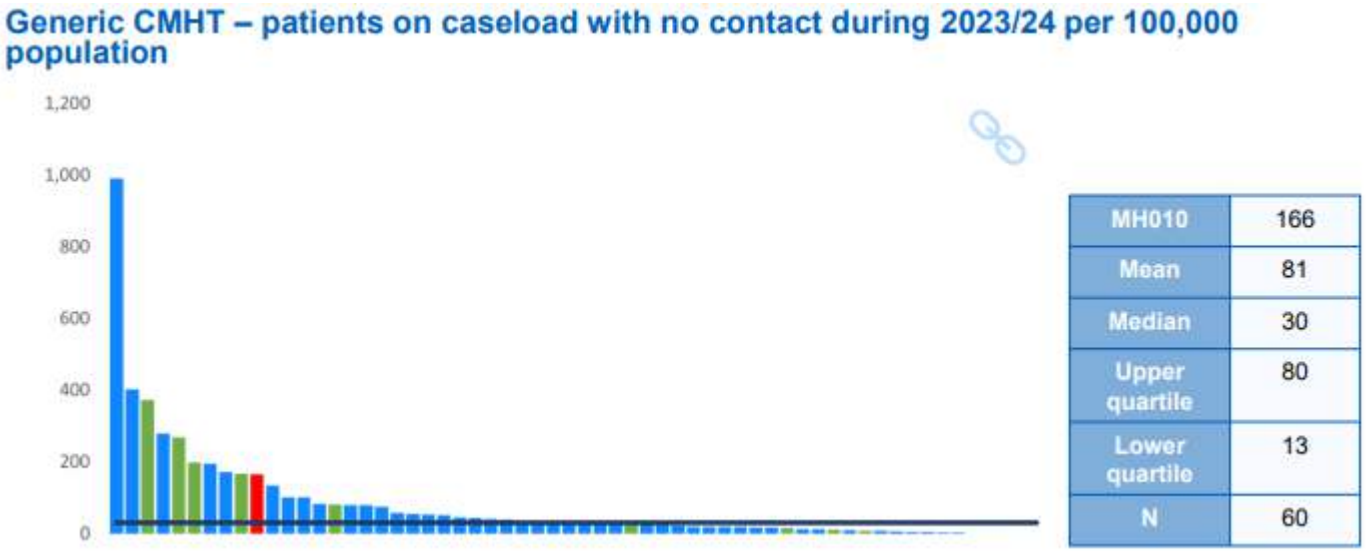
Adult community: Referrals/ Contacts/staffing

Metric	Low – High	MH010	Mean	Median
Referrals received per 100,000 population		1,668	1,706	1,569
Referral acceptance rate		47%	82%	86%
Median waiting time referral to 1st appointment (weeks)		...	5.0	4.0
Median waiting time referral to 2nd appointment (weeks)		...	10.0	8.0
Community caseload per 100,000 resident population at 31st March 2024		2,131	1,055	906
Patients on caseload with no contact in 2023/24 per 100,000 population		166	81	30
Contacts delivered per 100,000 population		19,198	15,608	15,133
Proportion of contacts delivered face-to-face		70%	65%	66%
Proportion of contacts delivered non-face-to-face		30%	35%	34%
Proportion of contacts delivered digitally		1%	4%	3%
Community WTE per 100,000 population		39.2	49.5	44.8
Cost per contact		£218	£261	£264
Cost per patient on caseload (caseload at 31st March 2024)		£1,963	£4,545	£4,272

- The **number of referrals** we receive is just below the national average
- Acceptance rate is amongst the lowest, 47% against a national average of 81% ***we are checking the data***
- However, caseload levels amongst the highest
- Number of contacts at 13,159 is just below the national average of 13,777 & face to face contacts above the national average.
- However, patients on caseload with no contact amongst the highest.
- Adult CMHT had low total number of staff as at 31.03.2024 compared to the national average

Adult community: Caseload/ Contacts

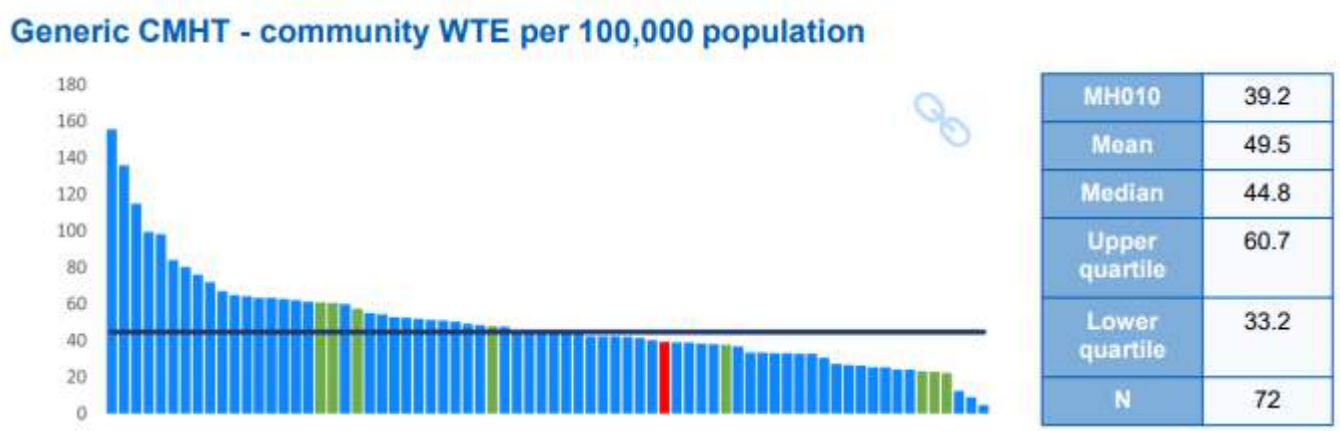




MH010	166
Mean	81
Median	30
Upper quartile	80
Lower quartile	13
N	60

- 6th highest **Caseload** above the mean and in the top quartile for weighted population at 1,461 compared to the national average of 849.
- **Patient on the caseload** with no contact in 2023/24 at 166 compared to a national average of 81- 10th highest. This moves to 7th highest on weighted population
- **70%** of patients were seen face to face compared to the national average of 65% (above the national average) This is an improvement from last year at 61%

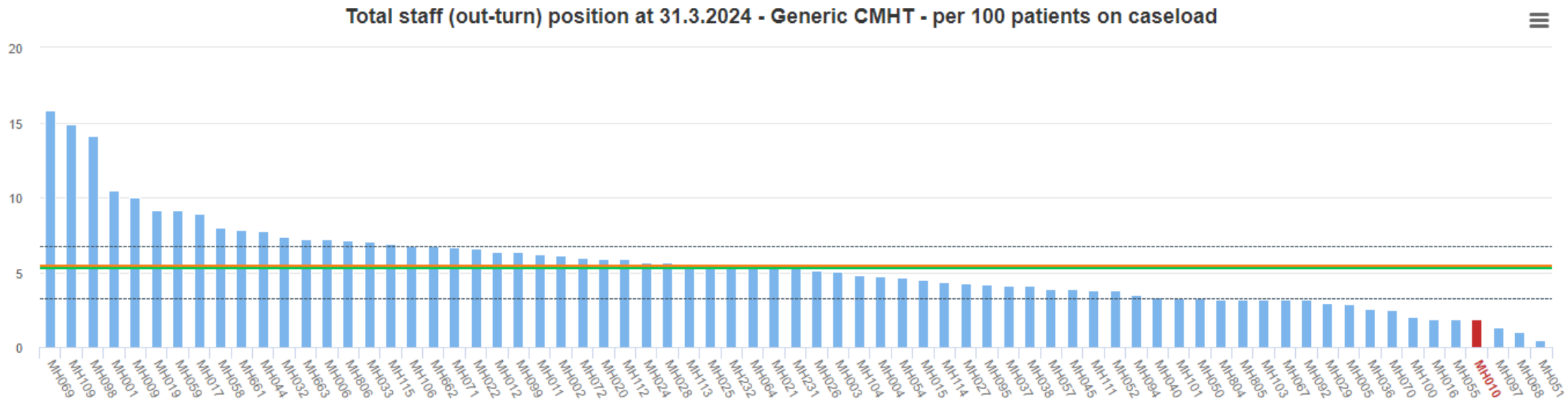
Adult CMHT: staffing



MH010	39.2
Mean	49.5
Median	44.8
Upper quartile	60.7
Lower quartile	33.2
N	72

Total staff per 100,000 registered population at 39.2 below the national average of 49.5.

Per 100 people on the caseload staffing is the 4th lowest (the same as 2022/23)



Older Adult Community

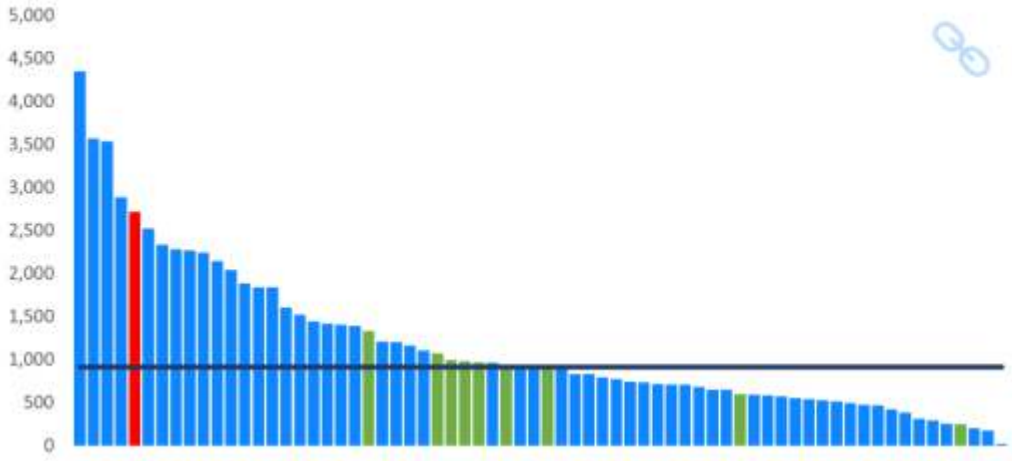
Older Adult Community

Metric	Low – High	MH010	Mean	Median
Referrals received per 100,000 population		2,594	2,620	2,499
Referral acceptance rate		73%	86%	90%
Median waiting time referral to 1st appointment (weeks)		...	3.3	2.2
Median waiting time referral to 2nd appointment (weeks)		...	8.5	6.0
Community caseload per 100,000 resident population at 31st March 2024		2,717	1,174	916
Patients on caseload with no contact in 2023/24 per 100,000 population		318	111	46
Contacts delivered per 100,000 population		19,855	20,377	18,064
Proportion of contacts delivered face-to-face		71%	66%	64%
Proportion of contacts delivered non-face-to-face		29%	35%	36%
Proportion of contacts delivered digitally		2.0%	1.0%	0.6%
Community WTE per 100,000 population		57.4	71.4	66.4
Cost per contact		£359	£325	£270
Cost per patient on caseload (caseload at 31st March 2024)		£2,624	£6,263	£5,183

- Comparatively very high **Caseload** levels, in upper quartile for weighted population – **3rd highest**
- **Unique service users** on the caseload for 2023/24 was 2,334 compared to 1,699 and above the average.
- The **number of referrals** marginally below the national average and acceptance rate lower than the national average of 86%
- **Number of contacts** below the national average
- **Higher proportion of patients seen face to face** above national average and is an 8% increase from last year.
- Older Adult CMHT had low levels of staff at 31.03.2024 compared to national average.

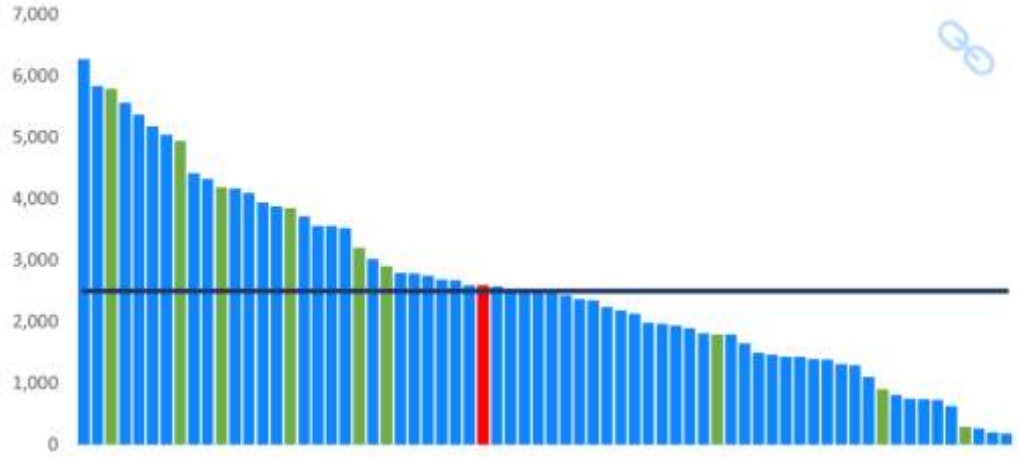
Older Adult community: Caseload/Referrals/ Contacts

Older people - community caseload per 100,000 resident population at 31st March 2024



MH010	2,717
Mean	1,174
Median	916
Upper quartile	1,461
Lower quartile	579
N	68

Older people - referrals received per 100,000 population

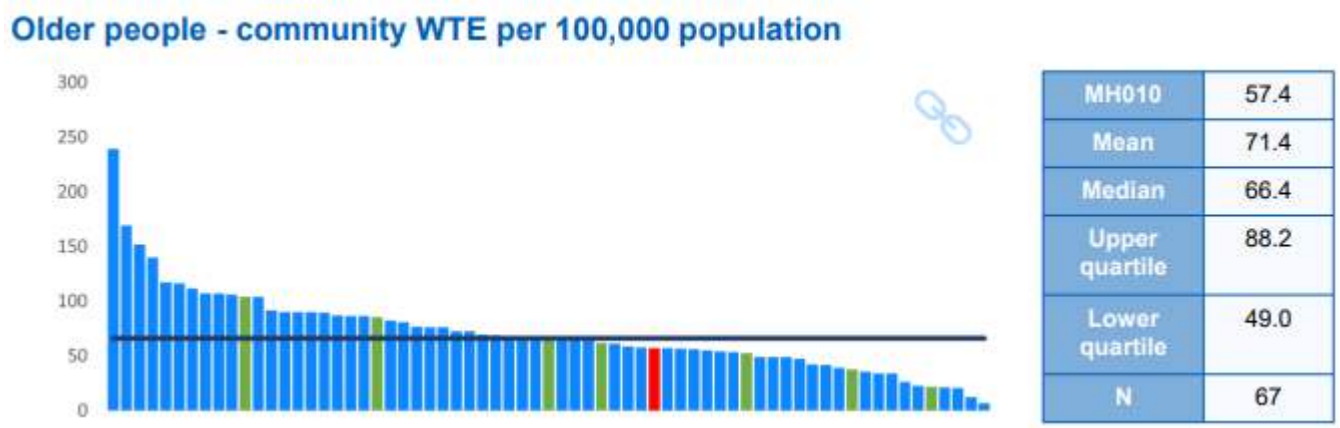


MH010	2,594
Mean	2,620
Median	2,499
Upper quartile	3,600
Lower quartile	1,453
N	68

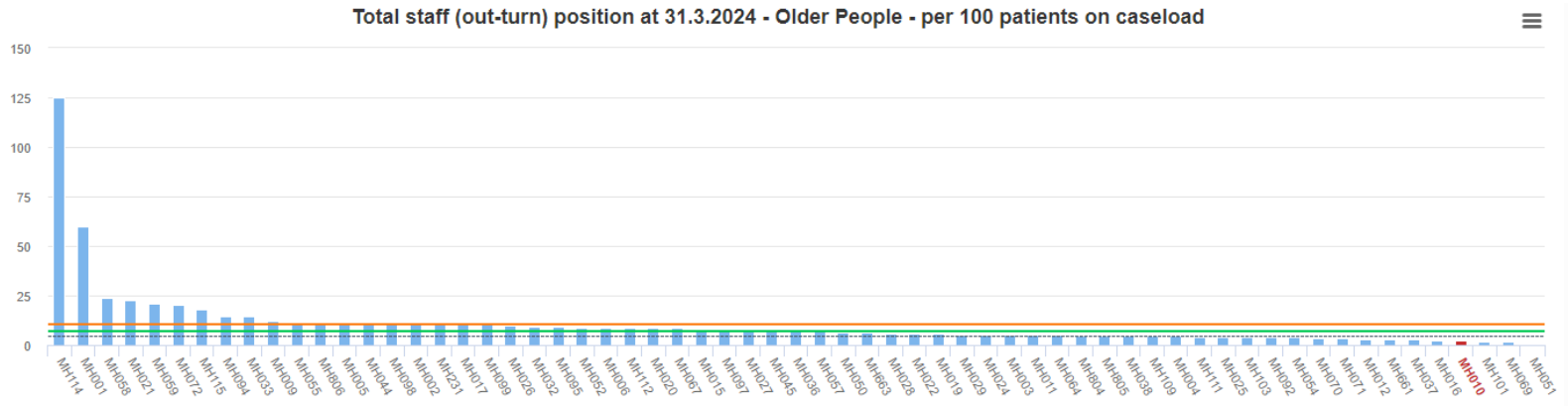
- **Caseload** above the mean and the upper quartile for resident population at 2717 compared to the national average of 1174 – 5th highest.

- The number of **referrals** received is below the national average and acceptance rate is in lower quartile at 73% and below the national average of 86%.

Older Adult CMHT: Staffing



MH010	57.4
Mean	71.4
Median	66.4
Upper quartile	88.2
Lower quartile	49.0
N	67



- Total staff per 100,000 population at 57.4 and below the national average of 71.4
- Per 100 people on the caseload staffing is the 4th lowest.
- The number of Consultants per 100 patients on the caseload is the 6th lowest at 0.14 compared to the national average of 0.60
- The number of registered nurses per 100 people on the caseload is 0.83 compared to the national average of 3.6

Appendix

Summary of key metrics:

- PICU
- Home Treatment
- Secure
- AOT

Summary of key metrics: PICU

Metric	Low	High	MH010	Mean	Median
Admissions per 10 beds			97	72	63
Bed occupancy rates (excluding leave)			97%	89%	93%
Length of stay (excluding leave) (days)			49	72	53
Admissions under the Mental Health Act as a proportion of all admissions			57%	83%	88%
Bed days lost for patients clinically ready for discharge as a proportion of occupied bed days			6%	7%	6%
WTE vacancies as % of staff in post			30%	18%	18%
Cost per 10 beds			£4,441,032	£4,175,367	£4,053,754
Restraint per 10,000 occupied bed days			406	468	397
Prone restraint per 10,000 occupied bed days			122	47	30

Summary of Key metrics: Home Treatment (*based on registered population*)

Metric	Low	High	MH010	Mean	Median
Referrals received per 100,000 population			900	1,623	1,067
Referral acceptance rate			75%	91%	97%
Median waiting time referral to 1st appointment (weeks)			...	0.1	0.0
Median waiting time referral to 2nd appointment (weeks)			...	0.3	0.1
Community caseload per 100,000 resident population at 31st March 2024			29	33	25
Patients on caseload with no contact in 2023/24 per 100,000 population			0	3	0
Contacts delivered per 100,000 population			7,177	5,648	5,163
Proportion of contacts delivered face-to-face			86%	64%	64%
Proportion of contacts delivered non-face-to-face			14%	38%	37%
Proportion of contacts delivered digitally			0.5%	1.2%	0.2%
Community WTE per 100,000 population			12.9	22.3	20.3
Cost per contact			£210	£486	£355
Cost per patient on caseload (caseload at 31st March 2024)			£52,232	£85,375	£72,887

Summary of key metrics: Medium Secure

Metric	Low	High	MH010	Mean	Median
Admissions per 10 beds			6	4	4
Bed occupancy rates (excluding leave)			92%	85%	86%
Length of stay (excluding leave) (days)			646	693	662
Admissions under the Mental Health Act as a proportion of all admissions			88%	90%	100%
Bed days lost for patients clinically ready for discharge as a proportion of occupied bed days			5%	6%	3%
WTE vacancies as % of staff in post			6%	13%	13%
Cost per 10 beds			£3,004,640	£2,652,682	£2,722,271
Restraint per 10,000 occupied bed days			81	68	47
Prone restraint per 10,000 occupied bed days			23	8	4

Summary of key metrics: Low Secure

Metric	Low	High	MH010	Mean	Median
Admissions per 10 beds			1	4	4
Bed occupancy rates (excluding leave)			98%	88%	91%
Length of stay (excluding leave) (days)			935	823	800
Admissions under the Mental Health Act as a proportion of all admissions			100%	90%	100%
Bed days lost for patients clinically ready for discharge as a proportion of occupied bed days			6%	7%	6%
WTE vacancies as % of staff in post			3%	14%	13%
Cost per 10 beds			£1,710,146	£2,081,303	£2,040,634
Restraint per 10,000 occupied bed days			0	62	16
Prone restraint per 10,000 occupied bed days			0	5	1

Summary of key metrics: AOT (based on registered population)

Metric	Low – High	MH010	Mean	Median
Referrals received per 100,000 population		4	11	10
Referral acceptance rate		21%	77%	89%
Median waiting time referral to 1st appointment (weeks)		...	4.2	2.0
Median waiting time referral to 2nd appointment (weeks)		...	7.2	5.0
Community caseload per 100,000 resident population at 31st March 2024		61	31	30
Patients on caseload with no contact in 2023/24 per 100,000 population		1	1	0
Contacts delivered per 100,000 population		3,557	1,527	1,165
Proportion of contacts delivered face-to-face		86%	77%	83%
Proportion of contacts delivered non-face-to-face		14%	23%	17%
Proportion of contacts delivered digitally		2.5%	1.2%	0.9%
Community WTE per 100,000 population		9.3	5.3	5.0
Cost per contact		£376	£342	£313
Cost per patient on caseload (caseload at 31st March 2024)		£21,809	£16,903	£13,937

Secure and Offender Health Accountability Framework domains self assessment

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
HMP Birmingham		Environment continues to be a concern. Not fit for purpose medication hatches and Healthcare wings are in a poor state	Q+P meetings indicate good contractual compliance with data sets and standards, in some areas we are overperforming over benchmarks	High vacancy rate in BCHC and BRT (30%) However, new staff are and have started, vacancy rate was 50% in June. In BRT some very complex staff have been managed out of the organisation, joint OD work planned for November now we have a a workforce in place	Currently underspent , however, late returns from HMP for bed watch and escorts and swing the position	Lack of oversight from BCHC AD on performance and recruitment.
		Late receptions (operation safeguard) introduce significant risks, we have mitigation, however, pressure from		Staff survey action plan in place and being carried out	Clinical constant watch data has reduced from circa 100k a year to less than 15k for last 2 years	Working relationship has improved dramatically with HMP, however, with constant changes to their SLT, and issues around enablement this

		custodial staff remain				remains a system issue.
		3 recent DIC which have all taken place within 36 hours of arriving at HMP Birmingham, HMP custodial issues are at the centre of these DICs, however, some learning identified for healthcare which has already been implemented.		Operational and HR KPIs have steadily increased over the last 12 months, and are now being sustained		Culture if integration is improving. However, still work to do
		Huge improvements noted in Hep C screening		Some joint OD work about to take place across BSMHFT and BCHC		
		Huge improvement in ACCT training, moved from 41% to 75%				
Directorate						

Please indicate whether each domain for the service is Red/Amber or Green and provide an overall RAG rating for the service

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	Strategy, transformation and external
Health & Justice Vulnerability Service		Vacancy levels are having impact on consistent service delivery – pathway closures occurring at least once weekly.	Challenges around operationalising several elements of tender 12 months on due to high vacancy levels.	Significant B6 qualified vacancies > 50% currently on risk register.	Significant underspend due to number of vacancies. (£445K due to vacancies)	Clearly outlined strategic priorities shared across the service and aligned with staff appraisals ensuring inclusion and input from all within the team around the ongoing development of the service.
		Delays in initial contact with service users referred from OOA, target is 3 days but often contact is 7 days post-referral.	Data capture has improved over the past 12 months, now capturing all elements of work being completed within the team however is still being collated manually which is resource intensive and leaves us open to risk of human error re: data input/outcomes.	Impact of staff wellbeing with an increase in sickness short and long-term. Risk of burn out and pulling pathway leads into clinical activity.	Pressure to fund additional resource to meet service need out of underspend	Model of integration and collaborative working with our VCSE partners is improving but still room for improvement.
		Implementation of quality measures and quality lead has improved efficiency and clinical practice particularly around safeguarding, information sharing and risk formulation.	KPI indicators are above performance targets.	Notable shift in culture over the past 12 months, still work to do around developing the current workforce, increasing inclusion, co-production, and civility within the team and across disciplines – as indicated in staff survey action plan.		Risk of relationship damage with WMP if unable to deliver service in Stechford custody in line with current model at Perry Barr Custody.

		Environment not suitable in Stechford Custody – no identified room/base, staff unable to assess in cells due to lack of space and posed risk from service users to others. Limited space for community outreach staff in our community base. Staff requiring to use FIRST hot-desking as overspill area, line managers do not have space for confidential conversations, booking rooms takes away from clinical space for service users.		Organisational Development input for the SLT to improve team cohesion		Good engagement and well-established relationships with partner agencies, stakeholders and VCSEs.

Secure and Offender Health Accountability Framework domains self assessment

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Women's secure Blended service		Standards of quality have remained stable. Wards are working more effectively with the Matron. Over capacity for admissions. Ongoing challenges to meet Physical health and Bariatric needs for service users. Lack of appropriate Fire exit routes.	General progress within KPI's across all areas. Increased adherence to ADR's and clinical supervision.	Culture on Citrine remains a concern. Recruitment continues to progress with reducing vacancies across the service. Upcoming challenge with leadership stability expected on Citrine due to a change in ward management.	We continue to have increased TSS expenditure, largely due to sickness and staffing pressures. We will continue to see a reduction in this over the next month given increase in recruitment and reduction in clinical acuity.	Continued progression within the acute pathway with increased attendance and engagement across both wards. Development of the outreach provision within the service remains positive with good connections now established. Progress with the Dawn House proposal.
Secure CAMHS		**LSU** – Due to increase in acuity and staff competency to manage risk. Ward Manager and Matron supporting the ward to support with safety	**LSU and MSU -** Improvement across both services. KPI's have increased and are in target range for both wards.	**LSU –** Ongoing challenges due to relational security. Multiple staff sickness episodes ongoing.	**LSU/ MSU** Significant expenditure for bank/ agency staffing due to ongoing vacancy rates in addition to enhanced observations and	**LSU** – new commissioning agenda does not have a place for LSU. Site would not be able to support the blended model for CAMHS.

		and in turn maintaining quality. Service remains highly acute, with complex risks. Currently closed to admissions.	Significant shift in attitude towards clinical supervision.	Improved recruitment.	increased clinical acuity. EPC's are again in place for LSU.	Escalation of the concerns around the current LSU.
		MSU – Stability within the service, very low service user numbers. Reduction in LTS this month.		**MSU** – OD/ EDI work has now commenced. However engagement has been low. Several Long term sickness remain in place. Ongoing B5 vacancy rates- plan to support IEN's into the ward to reduce this shortfall. A further 2 RMN's have now been recruited.		**MSU** – Nationally is held in high regard with 2 members of the team holding lead positions and supporting with the service spec going forward.
Youth First		Despite sickness challenges, working well as a team to meet deadlines for referrals. High risk within their caseload.	Adherence to training fluctuates. Some of this is due to sickness and the complexity of increased caseloads. Team manager is working to address this with her team.	Workforce are generally cohesive and skilled at working together. Increased sickness levels have impacted on caseload	No current concerns within this area.	QI project to review access to feedback.

				management and increased workload. Consultant due to join the team soon.		
Service 4						
Service 5						
Directorate						

Please indicate whether each domain for the service is Red/Amber or Green and provide an overall RAG rating for the service

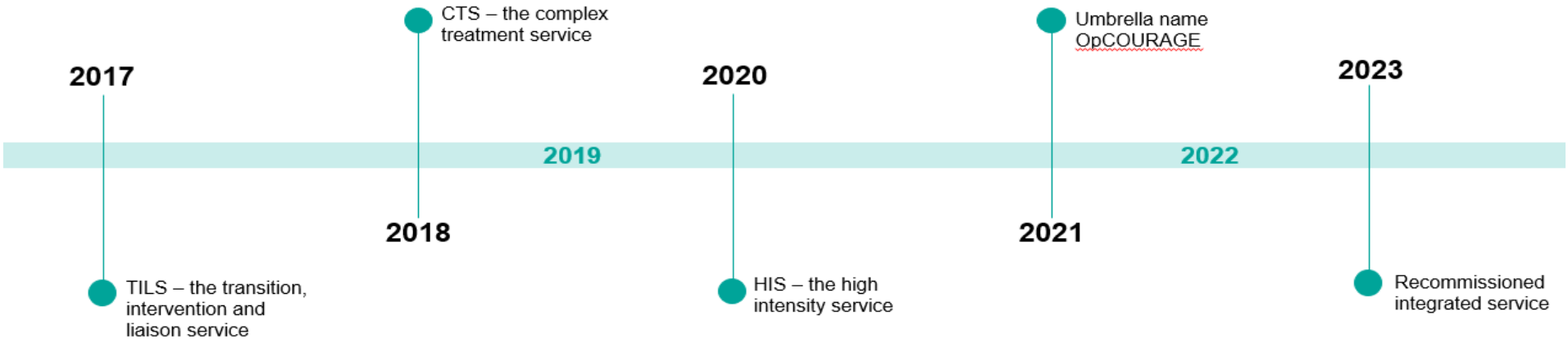
Birmingham and Solihull Mental Health NHS Foundation Trust

Midlands Op COURAGE Partnership: Deep Dive Overview

November 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

The background:



The here and now:

- Integrated service went live on 1 April 2023
- Seven regions across England
- Integrated pathway model
- Additional to, not replacement for, other mainstream mental health teams

OpCOURAGE

NHS
The Veterans Mental Health and Wellbeing Service

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T: 03003 733 332

East
E: mevs.mhm@nhs.net
T: 0300 034 9991

Midlands
E: mevs.mhm@nhs.net
T: 0300 323 0137

South West
E: mevs.mhm@nhs.net
T: 0300 034 9986

London
E: veteransservice@candi.nhs.uk
T: 0203 317 6818

South East
E: gateway@berkshire.nhs.uk
T: 0300 365 2000 (Option 4)

Make sure you register with a GP

If you've left the military, it's important to register with an NHS GP and tell them that you've served in the Armed Forces. You can then get help from services dedicated to caring for veterans. To find your nearest GP go to www.nhs.uk

For more information on Op COURAGE go to www.nhs.uk/opcourage

Urgent and emergency support from other NHS services

If you're having a mental health crisis, you can get help by:

- **Calling 111 or 999**
- **Booking a GP appointment**
- **Going to your nearest A&E**

If you're still serving, you can also call the Military Mental Health Helpline on 0800 323 4444.

Midlands Op COURAGE

Proudly delivered in partnership by:

NHS Lincolnshire Partnership NHS Foundation Trust

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

NHS Coventry and Warwickshire Partnership NHS Trust

St Andrew's HEALTHCARE Registered Charity No. 1104951

mhm mentalhealthmatters

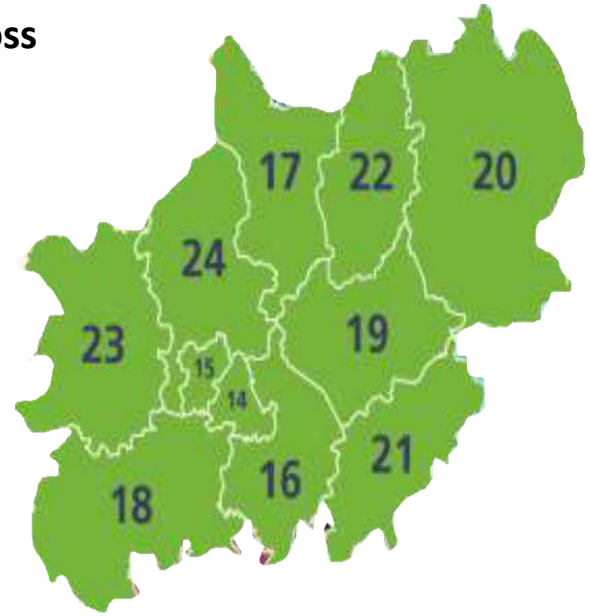
WALKING WITH THE WOUNDED Supporting Those Who Served

Tom Harrison House "Honour, Hope, Healing"

THE RIPPLE POND YOUR FORCES FAMILY NETWORK

The area we cover:

- **The Midlands Partnership provides the service across the following Integrated Care Boards (ICBs):**
- 14. NHS Birmingham and Solihull
  15. NHS Black Country
  16. NHS Coventry and Warwickshire
  17. NHS Derby and Derbyshire
  18. NHS Herefordshire and Worcestershire
  19. NHS Leicester, Leicestershire and Rutland
  20. NHS Lincolnshire
  21. NHS Northamptonshire
  22. NHS Nottingham and Nottinghamshire
  23. NHS Shropshire, Telford and Wrekin
  24. NHS Staffordshire and Stoke-on-Trent



The picture in the Midlands:

- Referrals to service overall increased by 19% in 2023/24 compared to previous year.
- Increase in urgent team referrals compared to previous year (HIS) was 12.5%
- Increase in non-urgent team referrals compared to previous (TILS) was 21%
- **1905** referrals between April 2023 until end of September 2024
- Current waits at the front end of the pathway due to demand vs capacity
- Increased acuity in referrals

Service highlights

- Team share risk management
- No waiting list for treatment pathway
- Trauma-informed care model: positive impact on staff retention, wellbeing and clinical quality
- High levels of supervision, CPD and RPG
- Co-production
- Working together across region to support demand
- Established MDT to support clinical decision-making
- Strong relationship with NHSE and ministerial office
- Recognition internally, regionally and nationally

Areas for development

- Support from other services internally (e.g. HR, recruitment, OH) can be limited
- Data systems do not accurately reflect activity
- Ongoing 'system' level work required
- Regional geography can impact recruitment, and creates challenges around mileage cap, lone working etc

Birmingham and Solihull Mental Health NHS Foundation Trust

Arts Psychotherapies Service – Community Art Psychotherapy Team

Francesca Norouzi

Consultant Art Psychotherapist,

Head of Arts Psychotherapies

Birmingham and Solihull Mental Health NHS Foundation Trust

What are Arts Psychotherapies

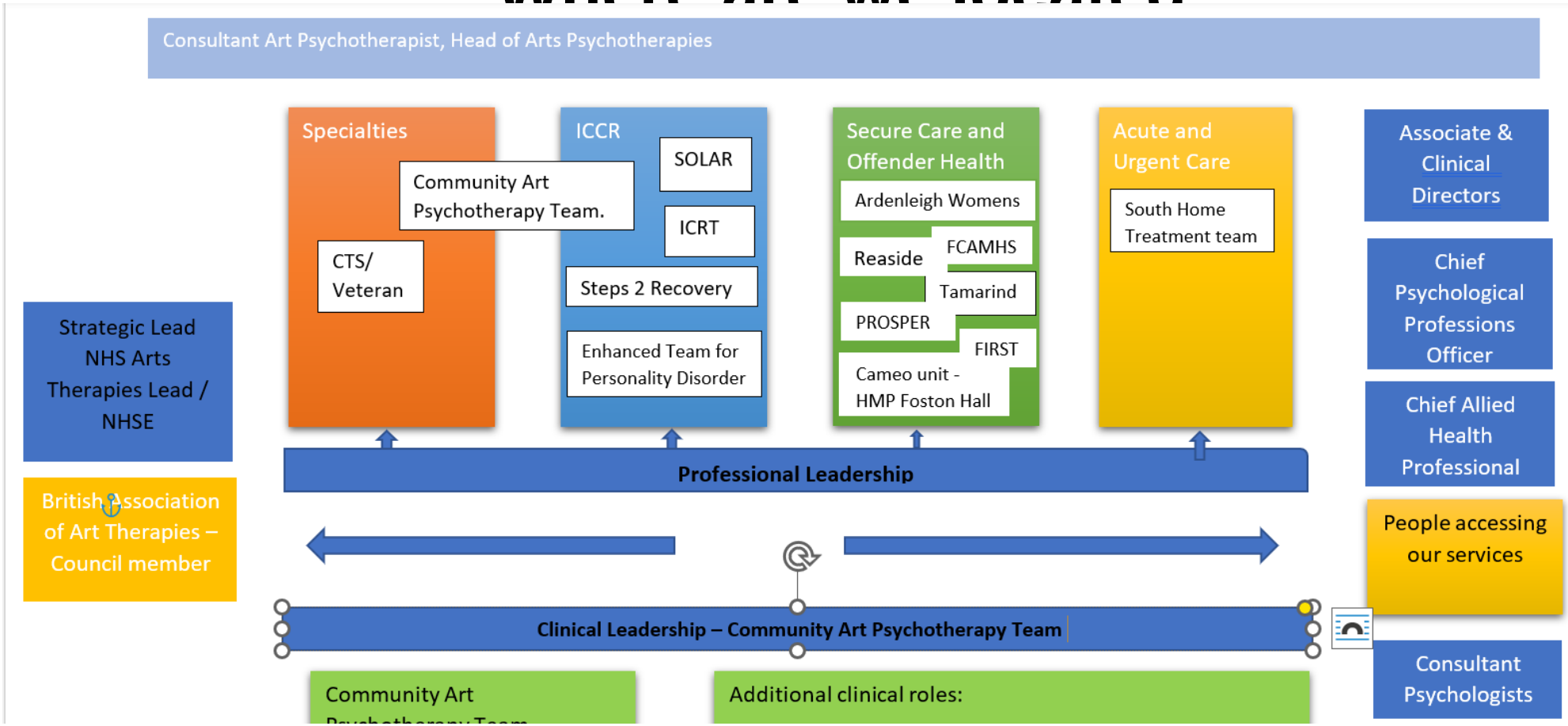
- A form of psychodynamic psychotherapy
- Utilises art making, music, story telling, creativity to support exploration,of psychological difficulties experienced by people

Who can benefit?

- People who find talking therapy difficult, or struggle to talk about their experience
- People who haven’t been taught a language to describe their emotional experience
- People who over verbalise as a way of avoiding emotional connection

Birmingham and Solihull Mental Health NHS Foundation Trust

Where are we located

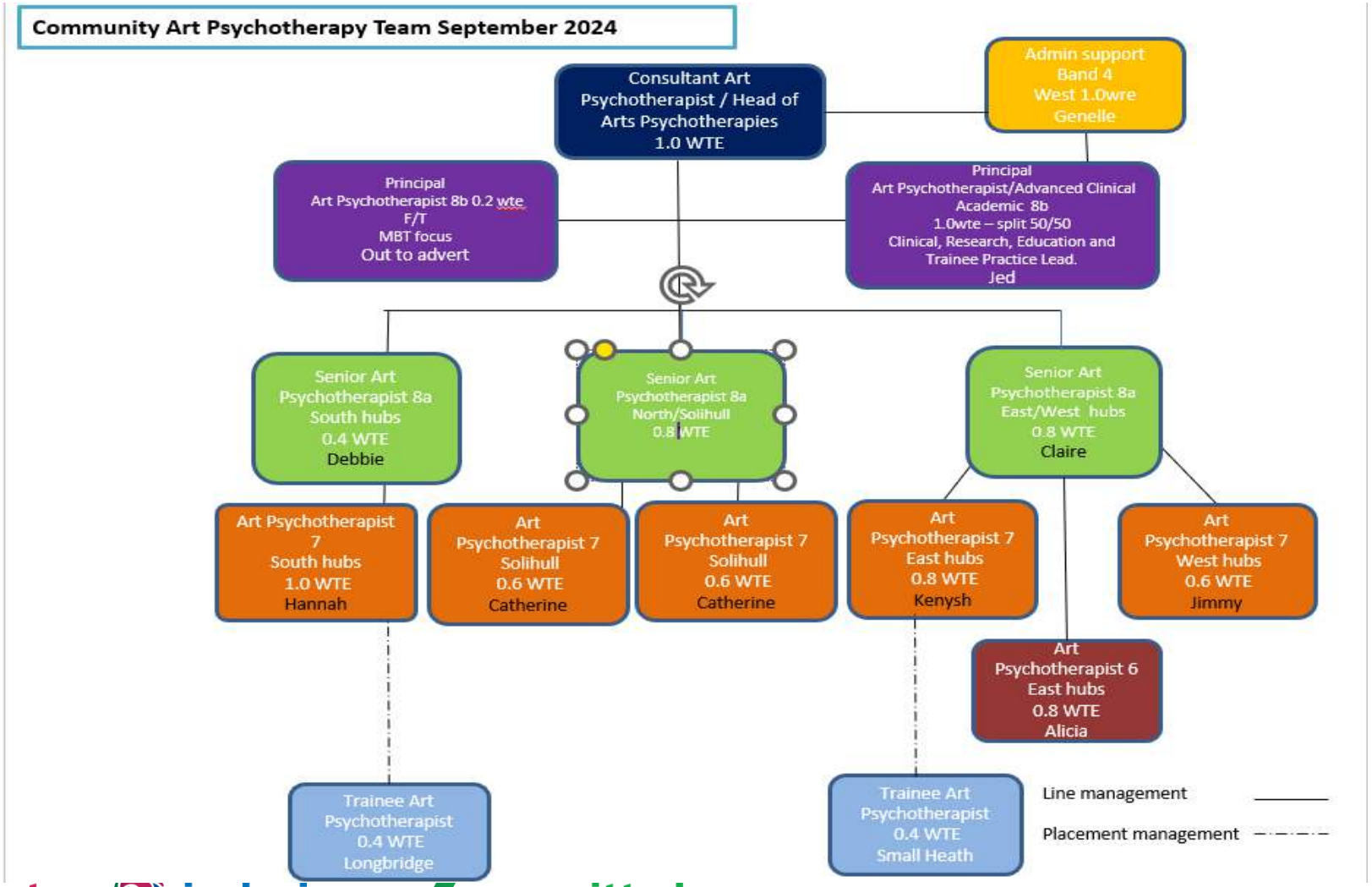


compassionate inclusive committed

Arts Psychotherapies Service

Birmingham and Solihull Mental Health NHS Foundation Trust

Community Art Psychotherapy Team



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Arts Psychotherapies Service

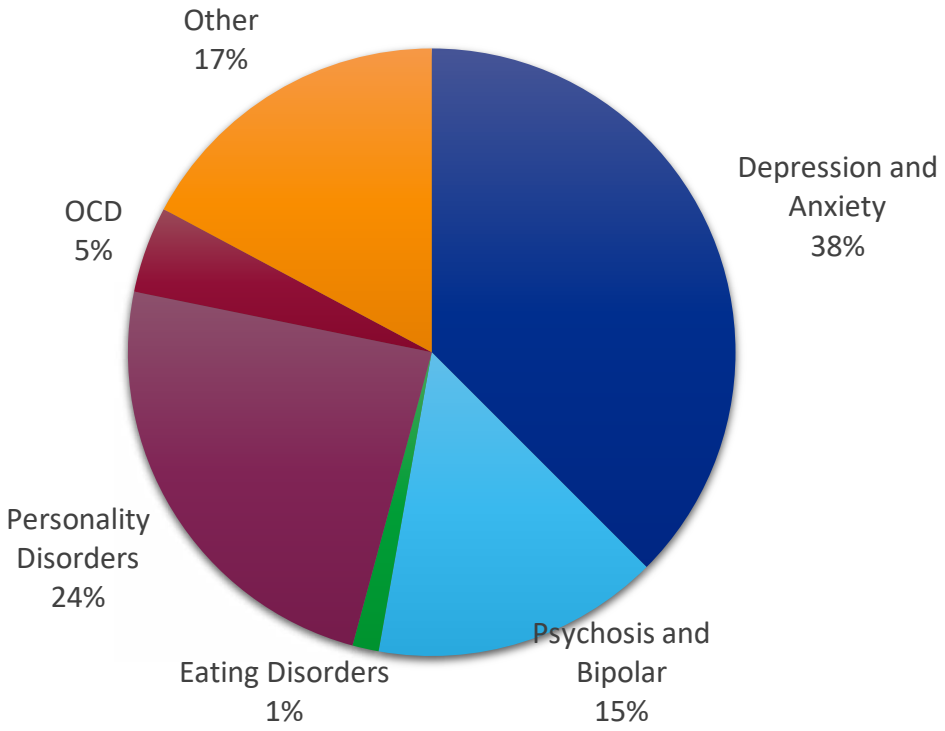
Birmingham and Solihull Mental Health NHS Foundation Trust

Quality & Safety

Referrals to the service: 1st April 2023 – 31st March 2024

	2022 - 2023	2023 - 2024
Solihull	31	38
North	24	37
South	45	49
East	40	55
West	28	26
Total	**168**	**216**

SMI categories of referrals



Birmingham and Solihull Mental Health NHS Foundation Trust

Quality & Safety

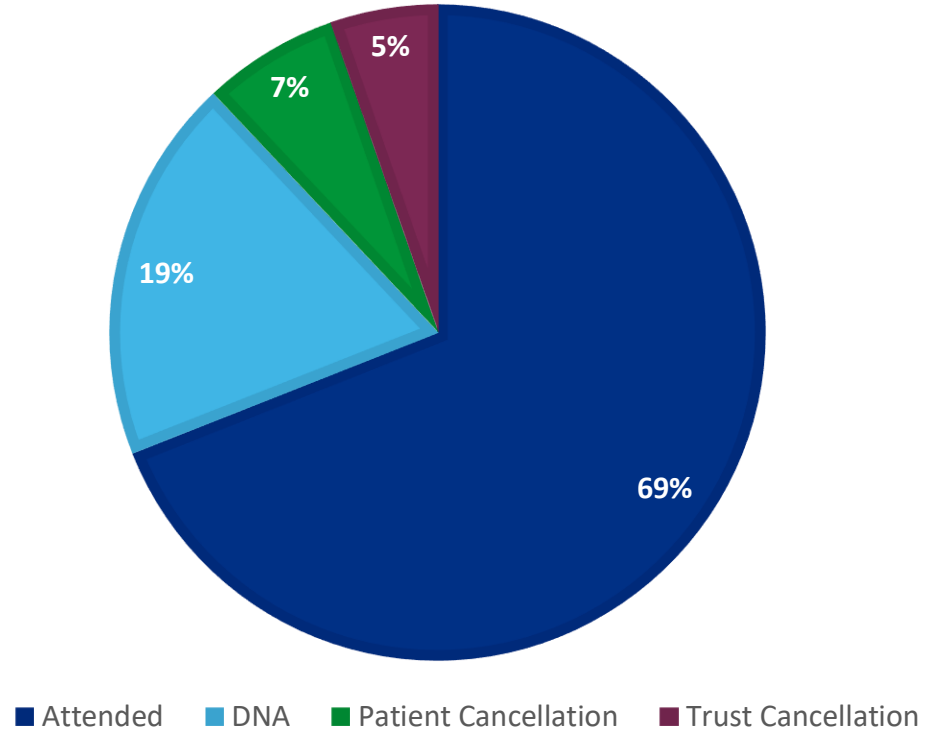
November 2024:

147 SU's waiting for therapy across 5 hubs.

Mitigation Plan:

- Intro Appointments within 3 weeks of referrals
- Increased group interventions
- Development of MBT
- EBE Art Psychotherapy group Jan 2025
- Improve data collation relating to non attendance

Attendance Rates April 1st 2023 – March 31st 2024



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Operational performance

- Quality Assurance Structure and Process Document &

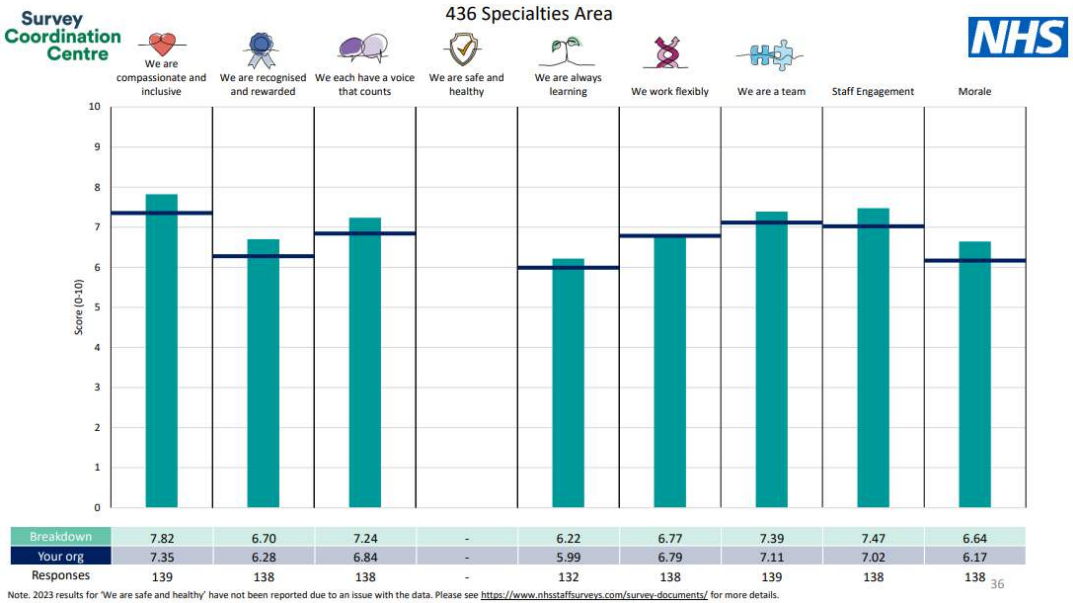
SOP for Community Art Psychotherapy Team

- Consultation to all CGC's and PPAC, closes 17th November 2024 – will support the development of Community Art Psychotherapy KPI's

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce and Culture

- Positive feedback 23/24 from Staff Survey



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.82	6.70	7.24	-	6.22	6.77	7.39	7.47	6.64
Your org	7.35	6.28	6.84	-	5.99	6.79	7.11	7.02	6.17
Responses	139	138	138	-	132	138	139	138	138

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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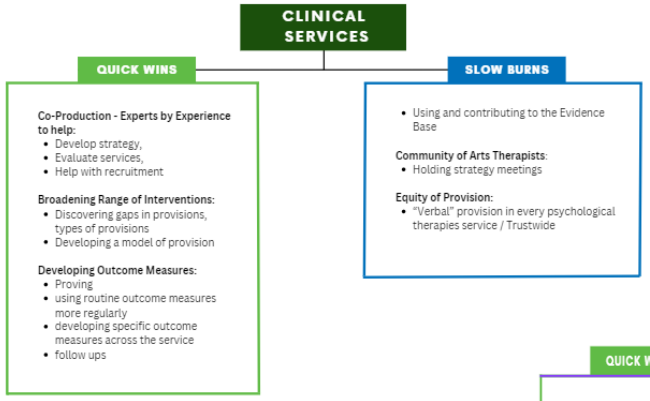
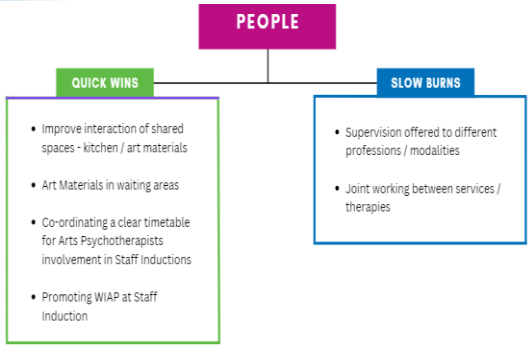
Arts Psychotherapies Service

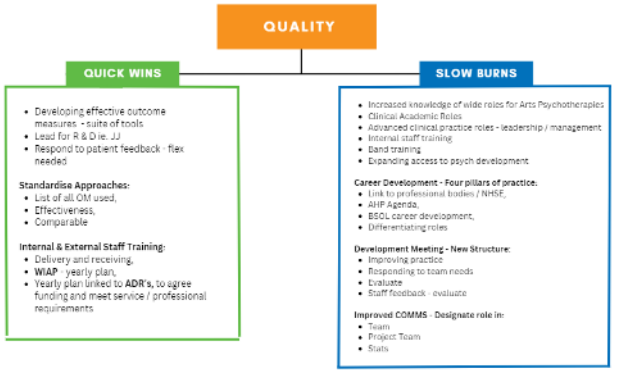
Birmingham and Solihull Mental Health NHS Foundation Trust

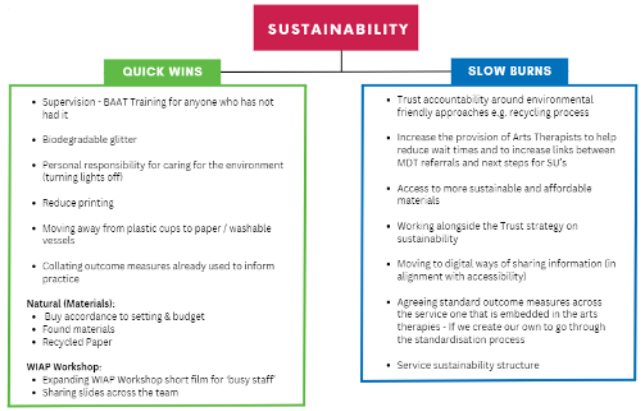
Workforce and Culture

- Service Away Day – How we are supporting the Trust strategy & Health Inequalities Plan









Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce and Culture

Staff Retention

- In the last 5 years we lost 4 substantive staff members, 2 have moved to different parts of the country, 1 was successful in recruiting to FTB and the other travelled around the world!

- We've developed from 5 staff members to 22 art, drama and music therapists.

Birmingham and Solihull Mental Health NHS Foundation Trust

Awards

Local

- Monika Muthi AHP Award for Innovation and Development
- Deborah Tomlin-Taylor Caring Minds Champion Award
- Community Art Psychotherapy Team AHP Team of the Year
- Community Art Psychotherapy Team October Trust Team of the Month

National

- Francesca Norouzi APNA Impactful Equality, Diversity and Inclusion Champion
- Dr.Jed Jerwood Inaugural CAHPO Gold Award for Excellence
- Dr. Jed Jerwood NIHR Senior Clinical and Practioner Research Award

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance

- Recognised as a financially well lead service – Chris Brown
- Fully recruited to establishment
- NIHR funding has brought a new dimension to budget management – I am learning!

Challenges:

- As Professional Lead for Art, Drama and Music Psychotherapists I deliver 2 away days a year, but funding is resourced from the Community Art Psychotherapy Team budget/as service grows this will need to be considered.

Strategy, Transformation and External

- Staff Development
- Succession planning
- Recruiting externally but also internally as a result of promotion
- Developing new roles
- Research active COPICS/SCHEMA
- Supporting NHSE Project – NHSE Film

S2R Deep Dive

- November 2024

- Richard Salkeld
- Tom Bell
- Vanessa Katri
- Catherine Amphlett

Current Services

- High Dependency HDU
  - – Endeavour Court, Erdington (Male, 14 beds)
- Complex Care CCU
  - - Dan Mooney House, Knowle (Male, 15 beds)
  - - David Bromley House Knowle (Female, 15 beds)
- Community Rehabilitation CRU
  - - Grove Avenue, Moseley (Mixed Gender, 10 beds)
  - - Hertford house, Olton (Male, 10 beds)
  - - Forward house, Erdington (Mixed Gender, 12 Flats)
  - - Rookery Gardens, Erdington (Mixed Gender, 23 Flats)
- Intensive Community Rehabilitation ICRT
  - - Community Tenancy Based Service, BSOL wide (Mixed Gender, 50 Caseload)

Quality and Safety

- High compliance rates with fundamental training, with specific service focus on ILS, ELS, Averts, Safeguarding with local training arranged onsite to maximise attendance
- Drive on Reducing Restrictive Practice, including service user surveys, Positive Behaviour Support plans, Individual QI projects and monitoring through Forum and CGC
- Bronze BSMHFT Values Award for 'Quality Improvement, Research and Innovation' for QI project work
- Grove Avenue nominated for Royal College of Psychiatrist national award, for Team of the year for Quality Improvement, recognising their project on Improving patient experience of mealtimes.
- Focus on Staff Huddles, Reflective Practice, Observations Management, Staff Meetings, Reducing Aggression through Safe Wards and Soft Words approaches / QI programmes
- Roll out of wide scale Peer Review on Quality Standards across the service.
- Wholesale review of Service Operational Framework putting ICRT at the front door of the service, along with development of Recovery Clinical Pathway to embed a team-based multidisciplinary approach to care grounded in shared assessment, team formulation, and collaborative working and Step off points to community pathway at every opportunity

Quality and Safety

- Regular monitoring of clinical progress and outcome measurement via the Rehab assessment suite.
- Staff training programme development and ongoing provision of in-house training e.g. relapse prevention/early signs work.
- Monthly Clinical Forum attended by MDT reps, which enables trust wide updates, feedback from committees and quality standards, sharing best practice, complex case discussion, project planning and collaboration.
- Matron's oversight of Compliance and Quality issues through Audit Cycles. This is monitored through feedback and assurance to each team. S2R food standards and safety audit planned, with service user involvement.
- Workstream on In house, Post incident support, including regular reflective practice space, and escalation of strategic approach needed trust wide.
- Rigorous assessment to ensure safe admission to Non-Ligature units and oversight of Anti Ligature interventions / plans for HDU (On risk Register)
- Management of Site Security Incidents at Forward House has action plan following escalation through Trust CGC (On Risk Register)

Service User Experience

- Development of Patient's Council supported by the Participation team to seek views on experience, positives and improvements. Current theme: access to transport to support Activities
- Roll out of Activity Worker roles to support Active Rehabilitation
- Annual Service User Experience Survey to seek views – leading to You Said, We Did Action Statements
- Continuous push on FFT feedback – typically with high praise for staff
- Frequent service user unit-based Mutual Help meetings to seek feedback, co-produce activity programmes
- Expert by experience involvement in development and planned implementation of staff training on S2R philosophy and key principles.
- New Exit Interview to seek reflections on stay, and to seek EBE involvement post discharge for the service – supported by the Participation team.
- Project to uplift CAC activity Hub in coproduction with service users for service wide use.
- Production of Quarterly Newsletter to celebrate good news stories, service user activities and experience.

S2R Performance Data – Bed State

Bed Numbers and Out of Area				
Area	Unit	Nov-23	Apr-24	Oct-24
BSMHFT	CCU	30	29	29
	CRU (LEGIONELLA AT FH)	46	44	49
	HDU	13	14	14
BSMHFT Total		89	87	92
Independent Provider	Independent Provider CCU	38	35	32
	Independent Provider HDU	62	53	47
Independent Provider Total		100	88	79
Grand Total		189	175	171

Bed Occupancy and Referrals to S2R

Bed occupancy							
Area		May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
BSMHFT Total		88%	92%	95%	91%	94%	93%
ICRT Caseload							**32**
Referrals (Inpatients)		May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
		12	10	12	14	16	13

LoS – S2R vs. Independent Provider

BSMHFT LOS				Independent Providers		
Unit	LOS	Oct-24		Unit	LOS	Oct-24
CCU	0-2 Years	43%		CCU	0-2 Years	21%
	2-4 Years	43%			2-4 Years	27%
	4-5 Years	3%			4-5 Years	12%
	5 Years +	10%			5 Years +	39%
CCU Total		100%		CCU Total		100%
CRU	0-6 Months	31%				
	6-12 Months	24%				
	12-18 Months	22%				
	18 Months +	24%				
CRU Total		100%				
HDU	0-1 Year	50%		HDU	0-1 Year	22%
	1-2 Years	43%			1-2 Years	45%
	2 Years +	7%			2 Years +	33%
HDU Total		100%		HDU Total		100%

S2R Waiting Lists

Waiting Lists				
Area	Unit	**May-23**	**Oct-24**	
BSMHFT	CCU	3	3	
	CRU	11	4	
	HDU	6	2	
BSMHFT Total		20	9	
Independent Provider	Independent Provider CCU	1	0	
	Independent Provider HDU	8	3	
Independent Provider Total		9	3	
Grand Total		**29**	**12**	

S2R Financial Position

		£'000s					
		Other Non Pay			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
Steps to Recovery	Income	0	3	(3)	0	(19)	19
	Pay	855	865	(11)	5,127	5,211	(84)
	Drugs	11	14	(3)	63	81	(17)
	Clinical Supplies	2	1	1	11	11	0
	Other Non Pay	27	38	(11)	159	171	(12)
Steps to Recovery Sub-Total		893	922	(28)	5,361	5,455	(95)

S2R Performance Data - Finance

Finance Actions

- Maintain close scrutiny of budgets with Finance Team
- Push for permanent uplift of staffing establishment at DBH
- Completion of MHOST staffing review highlights need for Higher staffing establishment
- MDT opportunities from this, Health Instructors, OT assistants, Activity Workers, PSW's to improve quality of Rehab
- Consider non recurrent opportunities as they arise – In reach worker, Integrated Social Workers to support flow
- Liaison with Community Sector for co-production input (Anawim / Claire Rigby)

S2R Financial Position

Regarding Pay, the bottom-line position does not accurately reflect the actual position for the service. This is affected by:

Mid-Point Pay setting – some £100K additional YTD

Cost Pressure additional posts – 5 additional HCA posts to elevate the establishment mainly at David Bromley – some £100K additional YTD

Need for increased observations and sickness cover – No data on costs

This all likely to bring us within budget. **How do we benchmark against other inpatient services?**

Workforce and Culture

- Our CQC report in 2022 graded us as Requires Improvement, citing staffing gaps, Attention to audit, workforce dynamics in one team
- Focus over the last two years, including recruitment drive, investment in psychological services provision, oversight of Audit by Matrons and CGC / Investment in QI approaches, investment in staff cultures. Forward House engaged with Culture of Care programme
- Staff Culture focus includes Action Learning Sets, EDI team involvement, staff training, supervision, Reflective Practice Groups. Emphasis on post Staff Survey focus groups to develop action plans and acknowledge staff concerns. Team Away Days focused on team cohesion and morale.
- Has led to positive recruitment, retention, improved staff morale – low sickness rates, staff survey results
- Excellence Eclipses to recognise individual clinical excellence and teamwork
- OD support and spiritual care leads input into teams for aways and post incident support.

S2R Staffing Gaps - Comparison

Service Staffing Gaps			
		Oct-22	Oct-24
RMN's		20	1
HCA's		9	3
Other		11	2
	Total	**40**	**6**

S2R Staffing

Recruitment supported by Centralised Recruitment, IEN enrolment, Active Service Promotion

Focus on Staff Wellbeing and Team Development supporting retention

Service becoming recognised from Student Placements / Recognition as a Good ‘employer’

Strategy, Transformation and External

- Continued development of ICRT service. Low current caseload and referral rates so drive on In-reach to Acute services and S2R units to source referrals required
- Expansion of ICRT remit to include assessment of all potential S.117 packages from Acute and S2R to divert to ICRT, review of all high-cost current S. 117 packages to divert to ICRT, Outreach to S2R community discharges to ensure safe community transition
- Development of Independent Placement team (based on national renowned methodologies) to case manage all independent Rehab placements with ambition for significant reduction of quantum numbers, reduction in LoS, repatriation of all placements within BSOL footprint
- Partnership arrangement with Local provider based on governance assured block contract for 15 Male HDU beds in Highgate

Strategy, Transformation and External

- Increase in partnership arrangements with VCFSE partners to develop Peer Support, Housing experts, Community Navigators and Community step down facilities
- Accommodation Strategy with MHPC – to improve quality and assurance of discharge accommodation through integrated system care with Health, Housing and the LA
- Active Informatics reporting to track system flow and associated costs – Broadcare alignment with Insight
- Involvement in workstream programmes – Review of S. 117 care package Delivery (with MHPC), Collaborative project on Secure Care / Secondary Care interface (with Reach Out)

S2R Accountability Framework domains self-assessment

Service	Overall	Quality and Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
S2R	Amber	Amber	Green	Amber	Green	Green

Service Area Deep Dive Self Assessment

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
31-May-24	Acute & Urgent care	Eden Acute		Red	Amber	Red	Red	
31-May-24		Eden PICU		Amber	Amber	Amber	Red	
31-May-24		Endeavour House		Green	Amber	Green	Red	
31-May-24		George ward		Red	Green	Red	Red	
31-May-24		Larimar		TBC	Green	Amber	Red	
19-Jul-24		All HTT	Amber	Amber	Amber	Red	Amber	Red
19-Jul-24		HTT West	Green	Amber	Green	Green	Green	Red
19-Jul-24		HTT North	Green	Green	Green	Amber	Green	Red
19-Jul-24		HTT South	Amber	Amber	Amber	Amber	Amber	Red
19-Jul-24		HTT Zinnia	Red	Amber	Red	Red	Amber	Red
19-Jul-24		HTT Solihull	Amber	Amber	Amber	Green	Red	Amber
20-Sep-24		Central & East Inpatients	Amber	Amber	Amber	Amber	Red	Green
15-Nov-24		South In-patients						
17-Jan-25		Urgent Care: Psychiatric Liaison/Bed Management						
		ECT						
		Inpatient Psychological services						
12-Mar-24	ICCR	SOLAR						
4-Jun-24		Homeless CMHT	Green	Green	Amber	Amber	Green	Green
4-Jun-24		Rough Sleeper MH Team	Green	Green	Green	Amber	Green	Amber
4-Jun-24		Health Exchange	Amber	Green	Amber	Amber	Green	Amber
20-Aug-24		Neighbourhood MH Teams	Amber	Amber	Amber	Amber	Amber	Green
20-Aug-24		Adult CMHTs	Amber	Amber	Amber	Amber	Amber	Amber
10-Sep-24		SIAS	Green	Green	Amber	Amber	Green	Amber
10-Sep-24		Recovery Near You	Green	Green	Amber	Amber	Green	Green
10-Sep-24		COMPASS	Green	Green	Green	Green	Amber	Green
1-Nov-24		S2R Wards	Amber	Green	Green	Green	Amber	Green
1-Jan-25		AOT						
1-Mar-25		ICRT						
1-May-25		SPS						
1-Jul-25		Cascade						
1-Sep-25		ADHD						
1-Nov-25		Enhanced Team for Personality Disorder						
		Solihull Day Hospital						
		Oaks Group Therapies/ Psychological Therapies						
11-Apr-24		FIRST			Green	Green	Green	

21-Jun-24	Secure	Secure CAMHS	Amber	Red	Amber	Amber	Amber	Red
16-Aug-24		Reaside	Red	Amber	Green	Red	Amber	
16-Aug-24		Tamarind	Green	Green	Green	Green	Green	Green
25-Oct-24		Secure CAMHS	Amber	Red	Green	Amber	Green	Red
25-Oct-24		Womens Secure Blended Service	Amber	Amber	Green	Amber	Green	Amber
25-Oct-24		Youth First	Amber	Amber	Amber	Amber	Green	Amber
25-Oct-24		Offender Health	Amber	Red	Green	Amber	Green	Amber
25-Oct-24		Health Justice Vulnerability Service	Green	Green	Green	Amber	Green	Green
20-Dec-24		Reaside/ Tamarind/FIRST						
7-Mar-24	Specialties	MAS	Amber	Amber	Red	Green	Red	Amber
7-Mar-24		Clinical Health Psychology	Red	Amber	Amber	Red	Red	Red
2-May-24		Deaf		Amber	Amber	Amber	Red	Red
2-May-24		Neuropsychiatry		Amber	Amber	Green	Red	Amber
25-Jul-24		Perinatal		Green	Amber	Green	Amber	Green
25-Jul-24		Mother and Baby & Outreach		Green	Amber	Green	Green	Green
5-Sep-24		Eating Disorders	Green	Green	Green	Amber	Green	Green
7-Nov-24		Art Psychotherapy	Green	Green	Green	Green	Green	Green
7-Nov-24		Veterans	Green	Green	Green	Green	Green	Green
21-Jan-25		Dementia and Frailty Inpatients						
		Care Home Liasion						
		CERTS						
		Birmingham Healthy Minds						
		Bipolar						
		Meriden						
		RDS						
		OPIP						

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**20 November 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance report • PEAR: Community Teams Patient Surveys • Health Inequalities • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control • Winter preparedness • Mental Health Patients in Emergency Departments & Audit Required by ICB • Right Care Right Person Programme • Integrated Performance Report • Clinical Governance Committee Assurance Report • Reaside Clinic Improvement Update • Clinical services Q2 strategy update • Quality Q2 strategy update
Alert:	The Committee were appraised there has been an increase in staffing capacity for nurses, however they noted concerns in relation to the inexperience and noted the need for training and mentoring to support development. Zinnia Centre estate remains a concern including the door alarms following a recent serious incident. The estates team are reviewing the works for completion and have revised the schedule to support this. Incidents resulting in harm continue to increase, the Committee noted this is due to the inclusion of psychological harm data. The Committee will schedule a deep dive to review the incidents to ensure the safety of staffs wellbeing. Forensic risks related to Right Care Right Person were noted as a concern and the Committee will continue oversight on a regular basis to ensure relations with the police continue to strengthen and support service users in crisis.
Assure:	The Committee was assured on the following key areas: • Supervision compliance continues to improve. • Reaside improvement plans have been approved and leadership visibility has increased significantly.

	• Winter planning meetings have been established system wide with support across the ICB. A MADE event has been agreed and is being scheduled for the coming weeks. • PCREF continues to support ongoing improvements.	
Advise:	• Revised Board Assurance Framework was approved and will be submitted for formal ratification at the Board of Directors meeting in December 2024. The previous version has been approved for archive. • Quality Safety Improvement metrics have been revised and will align with gold, siler and bronze reporting. • The PEAR group governance review is underway. • Health Inequalities continues to make improvements, the Committee have continued oversight to ensure this is embedded.	
Board Assurance Framework	The BAF risks for QPES have been revised and approved. The previous BAF risks have been ratified for archive.	
	New risks identified:	
Report compiled by:	Linda Cullen, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**23 October 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance report • Patient Experience Progress Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Patient Experience Thematic Review Q1 • Infection Prevention & Control Winter Planning • Safeguarding Assurance report • Integrated Performance Report • Clinical Governance Committee Assurance Report • Terms of Reference
Alert:	The Committee were appraised during August 2024, the Trust experienced a record number of 94 PALS cases, the highest monthly figure to date. This focus on resolving issues early through the PALS system has been successful. This aligns to the increase in incidents resulting in harm. Inappropriate Admissions: Ongoing incidents of concern have been highlighted regarding service users with violent and criminal backgrounds being admitted to wards, posing risks to both staff and other patients. A deep dive has been commissioned. Learning from Deaths: of the 20 cases reviewed, 10 identified additional learning that has been incorporated into improvement plans. There are ongoing themes emerging related to incidents reported regarding the appropriateness of some admissions to the correct wards. This includes police continuing to refer service users under section 136 who have violent or ongoing criminal charges against them and who are posing a significant danger to staff and other patients. Concerns regarding the use of bedroom seclusion and the practice of locking doors have been raised through the weekly huddles. This has been a long-standing issue of concern for the Trust with multiple discussions through forums including Trust Clinical Governance Committee.
Assure:	The Committee was assured on the following key areas: • Patient experience continues to be a key area of focus with policies being reviewed and updated through co- production with experts by experience

	engaging in all aspects of reviews. Activities continue to be improved following feedback with a key focus on improving physical activities. • Safeguarding deep dive into all learning from ALH is completed, and the safeguarding team have been working with relevant areas to ensure learning is embedded, audited and evidenced. Key areas are CMHTs, SOLAR and Street Triage. This work has been presented at local CGCs and SMB and QPESC and remains ongoing. • Positive engagement from the Trust with the Coroner at a local master class with over 90 colleagues in attendance to identify areas of improvement and partnership working.	
Advise:	• The Terms of Reference were approved. • Continued support for culture of care at Reaside ensuring staff have the accessibility to support from senior leaders. • The Board Assurance Framework has been redrafted and the Committee remain oversight and challenge. • Access to waiting times reporting though the Integrated Performance Report. • Staff story highlighted the need for focus on night staff and need to engage and communicate differently. • There are ongoing themes emerging related to incidents reported regarding the appropriateness of some admissions to the correct wards. This includes police continuing to refer service users under section 136 who have violent or ongoing criminal charges against them and who are posing a significant danger to staff and other patients in acute care settings.	
Board Assurance Framework	The BAF risks for QPES have been redrafted.	
	New risks identified:	
Report compiled by:	Linda Cullen, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**13**						
Date	4 December 2024						
Title	Safeguarding Annual report 2023/24						
Author/Presenter	Melanie Homer, Head of Safeguarding						
Executive Director	Lisa Stalley-Green	**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

Please find attached the safeguarding annual report for 2023/24. Information within this annual report evidences that the Trust has arrangements in place to effectively safeguard children and adults at risk during the period of 1st April 2023 to 31st March 2024. The Trust met the legal requirements in discharging its responsibilities as a health care provider as described within section 11 of the Children Act (2004), Working Together to Safeguard Children (2023), Prevent Duties Counter Terrorism and Security Act (2015), The Care Act (2014) (not an exhaustive list).

The report describes our key safeguarding activity and achievements for 2023-2024.

Introduction

The Trust is committed to working in collaboration with all partners to protect adults and children from harm. As part of these arrangements, the Trust is represented at Birmingham and Solihull Safeguarding Adult Boards and Safeguarding Children Partnerships to cover the two local authorities where the Trust provides services.

The Trust appointed a new Head of Safeguarding who started in post in June 2023 and reviewed the structure of the safeguarding team. As a result, the safeguarding team is now aligned into workstreams of adults at risk, children and young people, domestic abuse and quality and improvement.

This structure has improved consistency and accountability in relation to aligning our Trust priorities to those of the Boards and Partnerships. The appropriate members of the team, according to their workstreams attend all the relevant subgroups across the partnership.

Key Issues and Risks

Aligning our priorities:

- The Safeguarding team have aligned their programme of work to the priorities of the Local Safeguarding Adults Boards (SABs) and Local Safeguarding Children's Partnerships for both Birmingham and Solihull.
- Making Safeguarding everyone's business is key to our Think Family approach, and we have reviewed and refreshed the level 3 training to reintroduce the key messages of Making Safeguarding Personal (MSP).
- The Safeguarding Team have developed teaching sessions on financial abuse and adult self-neglect which have been delivered to a site as a pilot and we will continue to develop this approach of additional safeguarding training for teams face to face in the clinical area in 2024/25.
- Neglect is a priority for both children's partnerships in Birmingham and Solihull.
- The Safeguarding Team have revised and refreshed the level 3 children's training to ensure a focus on childhood neglect, exploring the signs of neglect, barriers to identification and social / cultural factors with an additional focus on mental health and how this may impact upon parenting capacity. Multiagency resources (neglect toolkits and strategies) and 7- minute briefings are shared as part of the training.
- The Safeguarding Team attend all relevant multiagency meetings and sub-groups relating to both adults, children and domestic abuse across Birmingham and Solihull and participate in all multiagency audits as required.
- Consideration of the impact of Domestic Abuse (DA) on children is a theme that runs through all our training. Children being seen as victims in their own right and the Domestic Abuse Bill is specifically highlighted during the DA Training, and it is also reinforced through our Think Family approach.
- The Safeguarding Team have developed a suite of learning materials for staff across the Trust which includes two 7-minute briefings on DA and Routine Enquiry and how to recognise DA in acutely unwell service users to support our staff with their knowledge and skills in recognition and reporting.
- This approach informs our safeguarding practice across the trust and ensures we are present and engaged in the multiagency system wide approach to safeguarding, working with our partners in Police, Social Care and Education, ensuring our service users (and the Trust) are represented locally and BSMHFT is a contributing member to multiagency safeguarding work across our system.

Safeguarding Training at Level 3

- Training figures continue to improve at level 3 for safeguarding children and adults and is monitored by Learning and Development and the Head of Safeguarding.
- The Head of Safeguarding has increased resilience in the current model with all the facilitators in the team being able to deliver training rather than relying on the model of one person in the team being the sole trainer.
- Deep dives into non-compliant staff across the Trust has been started and will continue into 2024/25.

Safeguarding Supervision

- The Trust had not previously been able to report its compliancy figures in relation to safeguarding supervision. A trajectory for improvement was discussed with BSOL ICB and it was agreed that BSMHFT should be at 85% compliancy by Q4 2023/24 with a view to this increasing in 2024/25.
- We are now reporting compliancy quarterly to the BSOL ICB (see page 13 for data).
- Whilst there is currently no statutory guidance around adult supervision, it is recognised as good practice to deliver adult safeguarding supervision sessions and enable our staff to receive advice and support both tailored to their specific needs and to ensure learning, development and reflection on safeguarding case.
- The safeguarding supervision offer and take up is continuing to grow across our adult facing services which is very positive.

Prevent

- NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person being radicalised. Prevent training is part of the wider safeguarding training requirement.
- The Trust Prevent facilitator attends Channel and represents the Trust at Prevent Operational Groups for Birmingham and Solihull and associated Prevent Delivery Groups. The Head of Safeguarding attends any strategic Prevent Executive Boards or meetings as necessary.
- A quarterly report on Prevent is submitted to the Trust Safeguarding Management Board and any concerns would be escalated appropriately through the governance route.

Domestic Abuse

- In 2021 BSOL ICB commissioned a central team, the Interpersonal Violence Team (IVT) to deliver the health function to the Birmingham and Solihull MARACs.
- The IVT was set up to alleviate the pressures on provider teams, ensure information was communicated to the victim's GP and ensure consistency of attendance. This was a system wide improvement piece of work.
- The Trust moved over to the BSOL IVT model March 2024, and a memorandum of understanding was agreed to ensure clear expectations of the working model.
- This has increased capacity of the safeguarding team to improve their visibility and be more forward facing and responsive to teams.
- The Head of Safeguarding and the Named Nurse for Domestic Abuse were successful in securing the substantive funding for an Independent Domestic Violence Advisor (IDVA) in February 2024 working in partnership with Birmingham and Solihull Women's Aid to improve the Domestic Abuse (DA) offer in our Trust, both training, support and recognition and support to staff members who may be experiencing DA.
- The Trust Named Nurse for Domestic Abuse chairs Birmingham MARAC meetings and sits within both Solihull and Birmingham MARAC Governance processes. They also represent the Trust at Birmingham and Solihull MARAC Governance Committee.
- During the reporting period there have been no new DHRs commissioned by the Community Safety Partnerships, however BSMHFT has supported the process by completing and returning 8 scopes.
- The Safeguarding team undertook thematic analysis of all the learning from DHRs and this was presented to SMB and Internal Clinical Governance Committee (CGC) and QPESC (Quality, Patient Experience and Safety Committee).
- The themes identified support the safeguarding team in the development of 7-minute briefings, make improvements to training and support safeguarding supervision sessions across the Trust to ensure we are a learning organisation which is responsive to the needs of our staff and service users.

Safeguarding Adults

- A Named Doctor for Safeguarding Adults was appointed in September 2023, providing two PAs (8 hours) per week to work with the Safeguarding team to support and promote the provision of effective services to safeguard services users of BSMHFT and to support adherence to the relevant legislative frameworks.
- The safeguarding team have increased their visibility by providing face to face support through safeguarding supervision and additional training and development in response to incidents or specific issues related to quality and safety.
- This has been well received and the requests for additional safeguarding support and supervision continues to grow over 2024/25.

- The Safeguarding Team have an improved process for cascading pertinent safeguarding information via comms and have an agreement with them for monthly content via the colleague briefing.
- There were 263 adult safeguarding referrals raised by BSMHFT staff in 2023/24 compared to 210 in 2022/23. This year the referral rate is higher which could indicate an increase in Trust staff awareness of safeguarding issues. This is positive and the number continues to rise.
- BSMHFT have two outstanding SARs awaiting publication. There are no outstanding actions for the BSMHFT Safeguarding Team for these.
- The Safeguarding team undertook thematic analysis of all the learning from SARs which has been presented to SMB, CGC and QPES. This supports the response from the safeguarding team in relation to improving and delivering training, 7-minute briefings and providing safeguarding supervision to ensure we are a learning organisation to improve the safety of our service users and development of staff.

Safeguarding Children

- The Head of safeguarding and the children's work stream staff members attend leaders' assemblies, partnership subgroups and multiagency audit days as appropriate to ensure BSMHFT is represented across BSOL ICS.
- The safeguarding team implemented an oversight / escalation tracker to improve oversight of the most complex child protection cases. There were 53 complex cases in 2023/24 where additional support was given to teams in the Trust. This has not been recorded previously.
- The safeguarding supervision offer was reviewed and strengthened during 2023/24, and we were able to report compliancy data. This offer will continue to be reviewed and strengthened in 2024/25.
- A review of all the learning and actions which resulted from the National review was undertaken to provide assurance that all learning had been appropriately identified and acted upon across various services.
- A safeguarding process has been introduced at the Trust in relation to Initial Child Protection Conferences (ICPC) for both Birmingham and Solihull. In May 2023 an Internal Case Conference Pathway was written, which was initially managed by the Named Nurse for Safeguarding Children and a Safeguarding facilitator and subsequently delegated to a safeguarding administrator when the process was finalised.
- From April 2023 - March 2024, the Safeguarding Team have completed 11 CSPR requests for information (scopes). Only one of these progressed to a CSPR with learning and actions for BSMHFT. This was an out of area request.
- A rapid review meeting is held in all cases to gather facts about the case, ensure immediate safety of any children involved, consider potential for any safeguarding improvements, and decide on next steps. The Safeguarding team have participated in 10 Rapid Review meetings.
- There have been 3 CSPRs published during 2023/24 from incidents which took place in 2022. The Head of Safeguarding and the Head of Communications were actively engaged in media meetings prior to publication.

Launch of Think Family Trust Wide

- Learning from National reviews including Children Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews has shown that children and other adults who live with or have contact with individuals who suffer from mental illness can suffer significant harm and their needs can be overlooked unless they receive the right support at the right time.

- The National Review of Child Protection arrangements following the tragic death of Arthur Labinjo-Hughes in Solihull over lockdown concluded that services needed to improve their ability to adopt a Think Family approach.
- The "Think Family Approach" was launched by the BSMHFT Safeguarding Team in November 2023 with attendance, at Trust Listen Up Live.
- There needs to be continued messaging in relation to Think Family for it to fully embed into everyday clinical practice. The Safeguarding team will be including Think Family as part of the key lines of enquiry (KLOE) for the Safeguarding assurance visits planned for 2024/25.
- The Trust's Think Family approach was presented externally at the Solihull practitioners' event and the BSOL ICB Health Safeguarding Board in 2024 and received positive feedback on the work being undertaken at BSMHFT.

Engaging with Experts by Experience and Think Family

- The safeguarding team worked with our Participation and Engagement Team and invited EBEs to tell us what the most important things they wanted mental health teams to understand in respect of their families. We facilitated a group, and collated their responses and used it to inform/shape our Think Family Standard and approach.
- We have applied for the Trust Quality Mark in relation to the work we did with the recovery college and the Think Family approach.
- **Update July 2024** – The Safeguarding Team have been awarded the Recovery for All Quality Mark for the Think Family standards/safeguarding application.

Investment in the Safeguarding Team

- It was identified through the BSOL ICB Health Safeguarding Board that there was a need for high quality, master's level safeguarding specific study for safeguarding professionals across the ICS.
- Four members of the Trust Safeguarding team were supported to complete the module in 2023/24 with further staff attending in 2024/25.
- The Safeguarding team were also supported to attend additional specialist safeguarding supervision training to enhance and develop skill within the team.
- BSMHFT will host the safeguarding supervision training in 2024/25 and will share spaces with other provider Trusts across the ICS, working together across the health system to improve the knowledge and skills of the safeguarding practitioners.

<u>Conclusion</u>

- In the reporting period, the Safeguarding team has promoted the importance of safeguarding supervision and Think Family being a standard operating process in all aspects of service delivery and sound clinical practice.
- BSMHFT is committed to being a learning organisation and the safeguarding team have progressed and strengthened the training offer through refreshing level 3 training, delivering bespoke training packages to clinical areas and developing a suite of 7-minute briefings which are responsive to learning needs identified in statutory reviews and incidents.
- The safeguarding team have increased their visibility and face to face availability to teams across the Trust to improve and strengthen the support offered to staff by the team to build upon good safeguarding practices.

- Links between the Patient Safety and Safeguarding teams have strengthened in this period and the safeguarding team have worked more closely with the patient safety team and have been actively involved in relevant meetings and the implementation of the Patient Safety Incident Reporting Framework (PSIRF), where safeguarding is an integral component.
- Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. There are a great number of committed staff who work impeccably to support and serve our service users and their families, and the Safeguarding team would like to acknowledge them all.

Recommendation

The Board is asked to note the Annual Report.

Enclosures

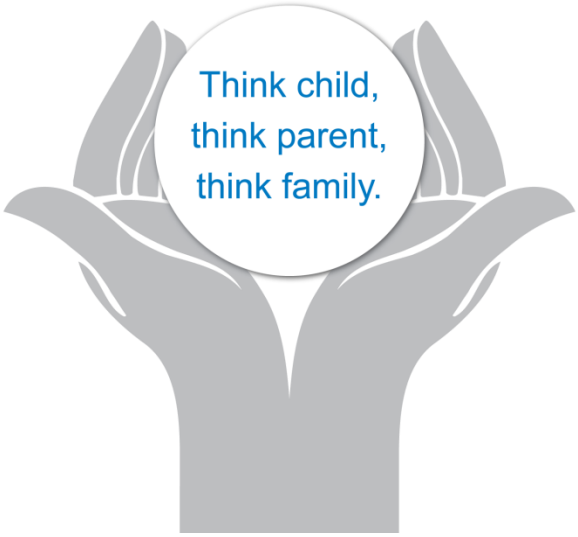
Safeguarding Annual Report 2023/24

Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham & Solihull Mental Health
NHS Foundation Trust

Safeguarding Adults and Children Annual Report

April 2023 – March 2024



Melanie Homer
Head of Safeguarding
July 2024

Contents

1.0 Background/Introduction

1.1 All safeguarding work which is carried out across Birmingham and Solihull Mental Health NHS Foundation Trust (referred to in this report as the Trust) is underpinned by our Trust Values.

1.2 This year's annual report provides an overview of safeguarding activity for the period. It summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how BSMHFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and Care Act 2014.

1.3 Staff are supported to work in partnership and to respond proportionately and appropriately to safeguarding concerns for children, young people, and adults at risk of harm, who access services across the Trust, in accordance with their statutory duties.

1.4 The Trust provides a wide range of mental health services for both children and adults across Birmingham and Solihull which includes rehabilitation, home treatment, community mental health services, assertive outreach, early intervention, inpatient services, day services and mental health wellbeing services.

1.5 The Trust works closely with our safeguarding partners serving two Local Authorities, Birmingham and Solihull.

1.6 The Trust Safeguarding team works closely with the Designated Safeguarding team at Birmingham and Solihull Integrated Care Board (BSOL ICB) and with the other Heads of Safeguarding across the Integrated care System (ICS). This includes fortnightly attendance at BSOL Safeguarding Collaboration meeting and attendance and contributions to the Health Safeguarding Board for BSOL ICB. This strengthens the health approach to Safeguarding across the ICS, supporting consistency, peer supervision and good practice.

2.0 Governance and Accountability Arrangements

2.1 The Chief Nursing Officer/Executive Director of Quality and Safety is the Executive Director for Safeguarding and provides leadership and oversight of safeguarding arrangements across the Trust.

2.2 The Deputy Director of Nursing and Quality and the Head of Safeguarding have the strategic responsibility for the safeguarding children and adult functions, supported by the Heads of Nursing and AHPs.

2.3 Named Nurses for safeguarding provide the statutory safeguarding functions in line with the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSEI, 2019).

2.4 The Safeguarding Strategic Plan is routinely presented at the quarterly Safeguarding Management Board (SMB) and to the Integrated Care Board (ICB).

3.0 Quality Assurance

3.1 Safeguarding is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system. All NHS funded organisations, including provider collaboratives, are required under statute and regulation to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect. (*Safeguarding children, young people, and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2022.)*

3.2 Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that the safeguarding arrangements are robust and are working. (*Safeguarding children, young people and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2022.)*

3.3 These arrangements include:

- Identification of a named nurse and named doctor for safeguarding children and young people.
- Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) Lead.
- Provision of an executive lead for safeguarding children, adults at risk and prevent.
- An annual report for safeguarding children, adults and children in care to be submitted to Trust Board.
- A suite of safeguarding policies and procedures that support the local multi-agency safeguarding procedures.
- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults.

- Effective training of all staff commensurate with their role and in accordance with the following procedures (These procedures are due to be renewed):
    - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019.
    - Looked After Children: Roles and Competencies of Healthcare Staff 2020
    - Adult Safeguarding: Roles and Competencies for Health Care Staff 2018.
- Effective safeguarding supervision arrangements for staff working with children, families, or adults at risk of abuse or neglect.
- Effective safeguarding supervision for the Trust's safeguarding team.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

3.4 The Head of Safeguarding provides evidence against these requirements through submission of the Section 11 and Care Act 2014 compliance audit to the children safeguarding partnerships and adult safeguarding boards for both Birmingham and Solihull.

3.5 Safeguarding activity is monitored and assurance provided to the Safeguarding Management Board (SMB) with oversight by the Chief Nurse/Executive for Safeguarding.

3.6 Safeguarding activity is monitored and reviewed by BSOL ICB via the submission of data and quarterly updates on the safeguarding strategic plan.

4.0 Assurance Framework

4.1 The Trust has an internal assurance process. This includes a quarterly Safeguarding Management Board (SMB) which reports to the Quality, Patient Experience and Safety (QPES) committee. The SMB has a performance and quality assurance role and monitors the annual work plan and safeguarding risk register. The frequency and function of SMB has recently been reviewed and proposals made to move meeting frequency to bi-monthly in future.

4.2 The function of the trust SMB has been reviewed by the new Head of Safeguarding and recommendations made for improvement which will include reporting cycles. The Head of Nursing and AHP for each directorate attends SMB to ensure that safeguarding priorities are embedded at an operational level and this feeds back to their local clinical governance committee.

4.3 There is now attendance from the Safeguarding Named Nurses from the safeguarding team at all the local Clinical Governance Committees (CGCs). This is to improve recognition, reporting and governance processes for safeguarding across the Trust.

5.0 Partnership Working and System Learning

5.1 The Trust is committed to working in collaboration with all partners to protect adults and children from harm. As part of these arrangements, the Trust is represented at Birmingham and Solihull Safeguarding Adult Boards and Safeguarding Children Partnerships to cover the two local authorities where the Trust provides services.

5.2 Trust representatives attend all relevant board and partnership meetings, sub-groups and committees and contribute to partnership and system wide strategic development regarding local priorities, accountability, and for assurance purposes. These priorities and deliverables are incorporated into the Trust's safeguarding business and progress and updates are reported to the SMB.

5.3 The Trust appointed a new Head of Safeguarding who started in post in June 2023 and reviewed the structure of the safeguarding team. As a result, the safeguarding team is now aligned into workstreams of adults at risk, children and young people, domestic abuse and quality and improvement.

5.4 This structure has improved consistency and accountability in relation to aligning our Trust priorities to those of the Boards and Partnerships. The appropriate members of the team, according to their workstreams attend all the relevant subgroups across the partnership.

5.5 The Trust has been actively involved in the planning and delivery of safeguarding conferences hosted by the Boards and Partnerships, working in partnership with our colleagues across the system to ensure collaboration and effective joint working whilst keeping a focus on mental health.

5.6 **Safeguarding Adult Board's (SAB) priorities and how BSMHFT have delivered these locally:**

Birmingham Safeguarding Adults Board (BSAB):

- We have aligned the safeguarding priorities for the Trust with the Birmingham (BSAB) priorities. Making Safeguarding everyone's business is key to our Think Family approach.

- We have recently reviewed our level 3 training content to ensure themes such as professional curiosity, judgement and accountability are

embedded into the training to enhance the knowledge and skills of our staff.

- Making Safeguarding Personal (MSP) is a theme that we have reintroduced and reinforced into the refreshed Level 3 Adult Safeguarding Training – and is embedded within the teaching sessions we are developing.

- Learning through development and assurance is another area where we are seeking to improve quality, and this is embedded within the plans to do site visits and reviews in 2024/25.

Solihull Safeguarding Adult Board (SSAB)

- We have developed teaching sessions on financial abuse and self-neglect which have been delivered to a site as a pilot and we will continue to develop this approach of additional safeguarding training for teams face to face in the clinical area in 2024/25.

- The Named Nurse for Safeguarding Adults attends and actively participates in audit sessions with SSAB and contributes to the priority setting for SSAB.

- SSAB have developed a number of guidelines in relation to safeguarding
    - Safeguarding Practice with Autistic People
    - Mental Capacity and Executive Function

  Members of the safeguarding team were actively involved with the production of these guidelines and we have received positive feedback on our contributions.

- Our continued ambition in 2024/25 is to make safeguarding everybody's business; through continuing to improve awareness of safeguarding across the Trust, ensuring a sound safeguarding culture which translates into frontline practice that benefits our service users, their families whilst also supporting our staff.

5.7 **Local Safeguarding Children Partnership priorities and how we have delivered these locally:**

- Neglect is a priority for both children's partnerships in Birmingham and Solihull.

- We have revised and refreshed our level 3 training to ensure a focus on childhood neglect, exploring the signs of neglect, barriers to identification and social / cultural factors with an additional focus on mental health and how this may impact upon parenting capacity. Multiagency resources (neglect toolkits and strategies) and 7- minute briefings are shared as part of the training.

5.8 **Domestic abuse and violence in families:**

- Consideration of the impact of Domestic Abuse (DA) on children is a theme that runs through all of our training. Children being seen as victims in their own right and the Domestic Abuse Bill is specifically highlighted during the DA Training and it is also reinforced through our Think Family approach.

- We have a dedicated safeguarding hub on line at BSMHFT for staff to access and there is a section specifically on DA and Children, with a video for staff to watch with information on the signs and indicators.

- The Domestic Abuse policy specifically references DA and Children who are victims in their own right following changes to the Domestic Abuse legislation.

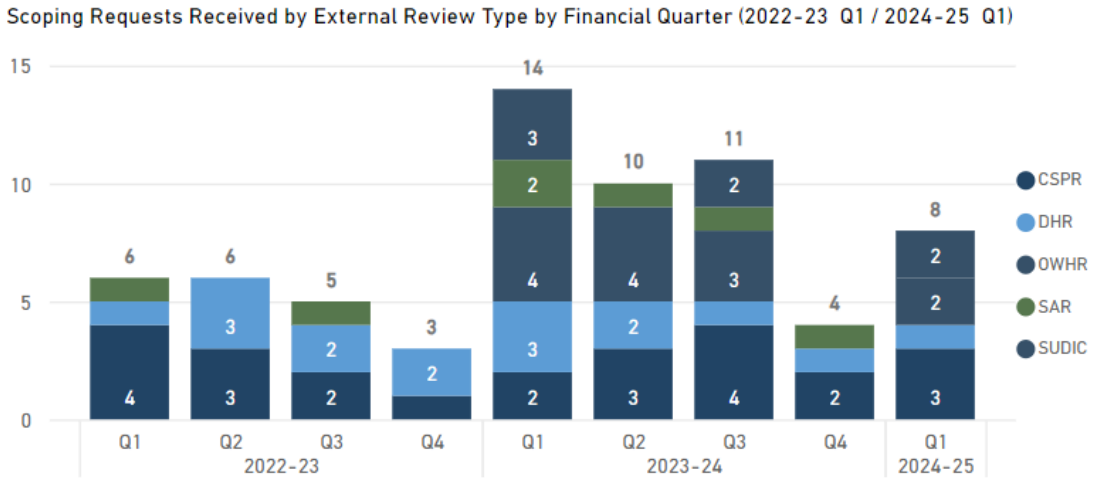
- We have developed two 7-minute briefings on DA and Routine Enquiry and how to recognise DA in acutely unwell service users to support our staff with their knowledge and skills in recognition and reporting.

5.9 The Trust's safeguarding team is engaged and participates in all relevant sub-groups including serious case review subgroup, quality and audit, neglect, domestic abuse and children, children out of sight and invisible to services.

5.10 This informs our safeguarding practice across the trust and ensures we are present and engaged in the multiagency system wide approach to safeguarding, working with our partners in Police, Social Care and Education, ensuring our service users (and the Trust) are represented locally and BSMHFT is a contributing member to multiagency safeguarding work across our system.

5.11 Named Nurses and professionals contribute to multi-agency audits in the local safeguarding adult boards and safeguarding children's partnerships. Learning from these audits is presented at SMB and any relevant actions and subsequent learning is cascaded appropriately trust wide.

5.12 The Trust safeguarding team has supported safeguarding adult reviews; child safeguarding practice reviews; domestic homicide reviews; Offensive Weapons Homicide Reviews (OWHRs) as part of the pilot) and SUDICS.



5.13 The Named Nurses attend the Joint Agency Response (JAR) meetings which are triggered following the sudden, unexpected death of an infant in childhood (SUDIC) when the Trust has information to share. Any relevant learning is acted upon locally with the relevant teams, and Trust wide when appropriate.

5.14 Birmingham was a pilot for Offensive Weapons Homicide Reviews (OWHR) and the safeguarding team worked closely with the Designated Safeguarding team at Birmingham and Solihull Integrated Care Board (BSOL ICB) to ensure appropriate information sharing. The purpose of these reviews is to ensure that when a homicide takes place, local partners identify the lessons to be learnt from the death, to consider whether any action should be taken as a result, and to share the outcome. The pilot is running from April 2023 to October 2024, but the last one received by BSMHFT as part of the pilot was January 2024 to allow time to complete the process. We are anticipating that once the pilot is over that OWHRs will become statute and Health will be expected to be part of this.

6.0 Safeguarding Training Compliance

6.1 The Trust has a training needs analysis (TNA) in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Fourth edition (2019) and Adult Safeguarding Roles and Competencies for Health Staff First edition: August (2018). The TNA outlines the levels of training staff require to be compliant and frequency of training.

6.2 The training plan incorporates safeguarding children, adults, domestic abuse and Prevent training. The aim of the training is to support effective safeguarding practice. There are a variety of training opportunities including in house face-to-face, webinar, e-learning and external training opportunities from the Safeguarding Adult Boards and Safeguarding Children Partnerships.

6.3 In 2022 it was identified when reviewing the Adult Safeguarding Intercollegiate Document 2018 and Children Safeguarding Intercollegiate document 2019 that there was a large number of staff who were not correctly aligned to the appropriate level of safeguarding training. Compliance was re-mapped to job role rather than Agenda for Change banding to meet this standard. An additional 1,147 individuals required Safeguarding Adults level 3 and an additional 1,108 individuals required Safeguarding Children Level 3. Training compliance initially dropped in Q4 2022/23 to Safeguarding Adults L3 65% and Safeguarding children L3 65%.

6.4 To meet the increased demand, additional in-house face to face and webinar training sessions were provided and an e-learning option was created to provide additional training opportunities. Staff were required to be fully compliant by December 2023.

6.5 Training figures for the last year are as below:

Safeguarding Training 2023/24 Compliance Target 85%	Q1	Q2	Q3	Q4
Safeguarding Children L1	94%	95%	94%	91%
Safeguarding Children L2	86%	92%	94%	94%
Safeguarding Children L3	81%	86%	87%	84%
Safeguarding Children L2 Priority Services	83%	91%	95%	97%
Safeguarding Children L3 Priority Services	83%	89%	90%	83%
Safeguarding Adults L1	95%	95%	95%	92%
Safeguarding Adults L2	87%	93%	95%	98%
Safeguarding Adults L3	77%	84%	87%	87%
Prevent	95%	95%	95%	94%

6.6 Compliancy for Safeguarding Children Level 3 reached target (85%) again in Q2 2023/24 and for Safeguarding Adults Level 3 compliancy reached target (85%) in Q3 2023/24. There was a slight dip in Q4 for Safeguarding Children Level 3 due to resource issues in the team.

6.7 Level 1 and Level 2 Safeguarding Adult and Children training is completed via an online package and remains compliant.

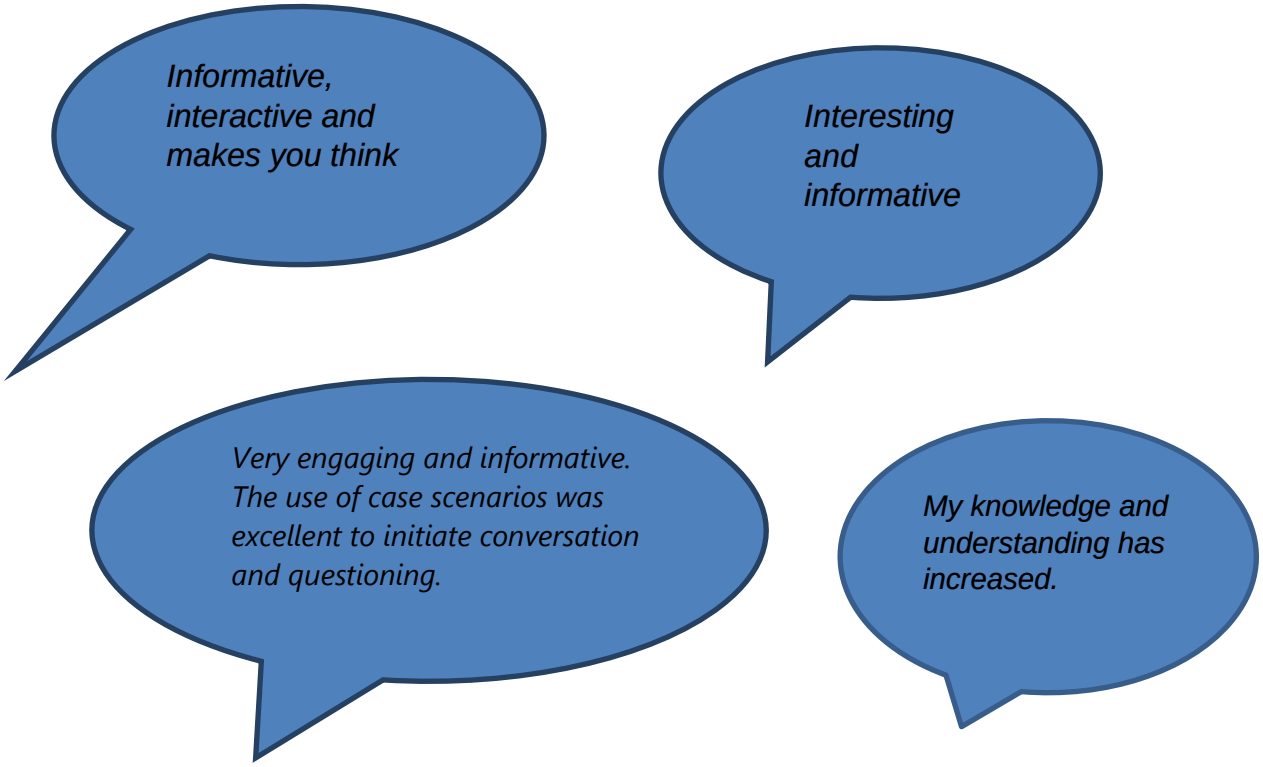
6.8 Level 3 Safeguarding Adult and Children training is delivered face-to-face, by webinar and via online learning. Compliance is monitored regularly by the Head of Safeguarding. Reports are provided at the quarterly Safeguarding

Management Board (SMB) and compliance improved over the year in line with the trajectory.

6.9 The Trust is compliant with WRAP (Workshop to Raise Awareness of Prevent) training.

6.10 The safeguarding adult boards and safeguarding children's partnerships also provide multi-agency training. Trust staff are encouraged to attend.

6.11 The feedback received from delegates who attended the BSMHFT safeguarding training is positive.



7.0 Safeguarding Supervision

7.1 All staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding or child protection issues. This responsibility also applies to staff working primarily with adults. Staff in these settings need to be aware that any adult may pose a risk to children due to their health or behaviour. Staff working in services being delivered to 16 and 17-year-olds also need to have understanding and awareness as outlined. To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding/ child protection training, learning opportunities, safeguarding/child protection supervision and

support to facilitate their understanding of the clinical aspects of child wellbeing and information sharing.

7.2 Whilst there is currently no statutory guidance around adult supervision, it is recognised as good practice to attend adult supervision sessions.

7.3 The Care Act (2014) requires organisations to ensure that skilled and knowledgeable supervision should be focused on the person and not the process. Legislation recognises that dealing with situations involving abuse and neglect can be stressful and distressing for staff. Safeguarding supervision processes should have demonstrable benefits to the work of the organisation, the quality of service and the morale of the workforce which in turn should keep a focus on the service users we care for at the Trust.

7.4 Safeguarding supervision is an accountable process and an opportunity for support, challenge, learning and reflective discussion around safeguarding cases. It provides protected time to think, explain and understand safeguarding concerns, help practitioners to cope with the emotional demands of the job and help workers identify unknown issues or offer a new view on complex issues.

7.5 We know that these cases can be challenging, stressful and emotionally difficult and therefore it is important that we provide our staff access to conversations where they can seek support and advice about how to manage often very complex cases. Having a safe space to talk is an important way to support staff and in turn the service users and patients we care for at the Trust.

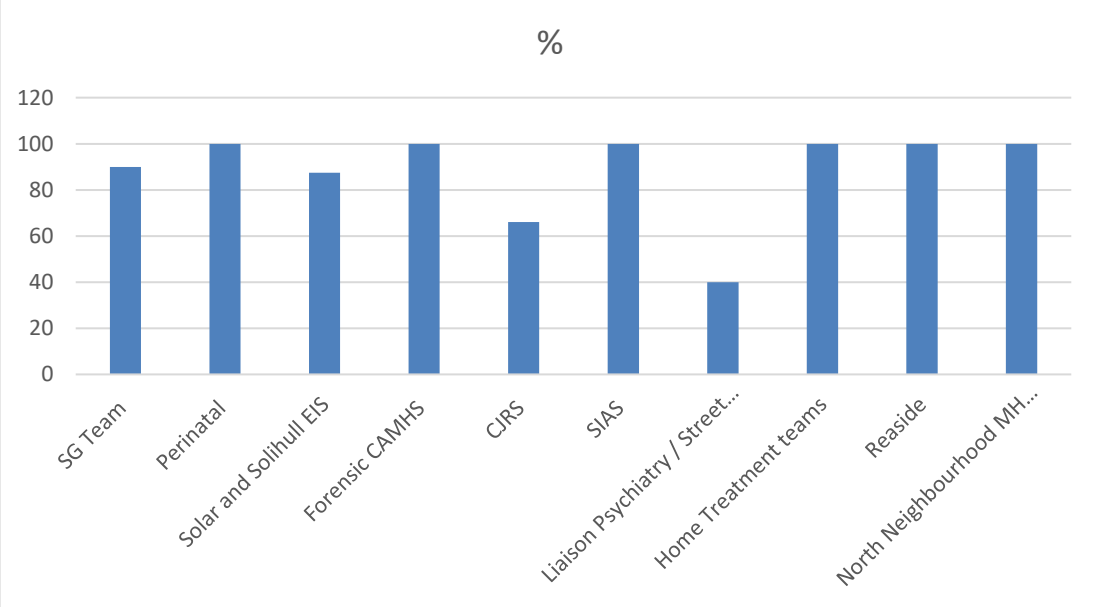
7.6 The Trust is committed to embedding a culture of Safeguarding Supervision and in 2022 funded Safeguarding Supervision training with an external provider for 32 staff members within BSMHFT. Following the success of the course, a further two cohorts were funded and a further 26 professionals signed up for the training throughout summer 2023.

7.7 There was a subsequent review via a smart survey to all the practitioners who attended the training, as the initial plan had been they would go on to deliver safeguarding supervision in their own clinical areas. However, Safeguarding supervision needs to be underpinned by sound safeguarding knowledge and delivered by professionals who are both appropriately trained and confident in their application of knowledge. The majority of those who had received the training were not delivering the supervision in their areas, but it did enhance their understanding of safeguarding and reflective practice and they were able to utilise this in clinical supervision and regular management supervision which is positive.

7.8 The safeguarding team undertook a review of the offer for safeguarding supervision Trust wide and identified priority areas for supervision. These included our level 3 workforce who primarily work directly with children and young people under the age of 18yrs as well as some areas predominantly working with adults. We extended our offer of supervision throughout 2023/24 to include targeted forensic adult services and neighbourhood mental health teams, to promote our Think Family Approach and to support our adult facing staff with early help and safeguarding concerns.

7.9 The Trust had not previously been able to report its compliancy figures in relation to safeguarding supervision. A trajectory for improvement was discussed with BSOL ICB and it was agreed that BSMHFT should be at 85% compliancy by Q4 2023/24 with a view to this increasing in 2024/25.

7.10 Graph illustrating Safeguarding Supervision Compliance across identified teams within BSMHFT for Q4 2023-2024:



7.11 This illustrates that target compliance of 85% was achieved across all teams in Q4 with the exception of urgent care, Liaison Psychiatry, and the Criminal Justice Recovery Service (CJRS). The graph also demonstrates an increased offer of supervision to Adult Forensic services and to the North Neighbourhood Mental health Teams. This offer will be increased for both areas in Q1 2024-2025.

7.12 The safeguarding team will continue to work with teams to ensure a high-quality offer of safeguarding supervision is delivered to the key teams and services.

8.0 Prevent Duty

8.1 The Counter Terrorism and Security Act (2015) places a legal duty on NHS Trusts to consider the Prevent strategy when delivering their services.

8.2 Trust Executive Lead – The Chief Nurse takes overall delegated accountability from the Chief Executive for ensuring the Trust has effective systems and processes in place to ensure the Trust meets its duties in relation to Prevent.

8.3 The Head of Safeguarding is the Prevent Lead for the Trust. They are responsible for the development and review of the Prevent policy for the Trust. They are also responsible for ensuring that appropriate training provision is made available to staff within the Trust.

8.4 Prevent requires healthcare organisations to work with partner organisations to help prevent terrorism, and to safeguard and protect vulnerable individuals who may be at greater risk of radicalisation. This makes safety a shared responsibility.

8.5 NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person being radicalised. Prevent training is part of the wider safeguarding training requirement.

8.6 The purpose of Prevent is for staff to identify and report concerns where they believe children, young people or adults may be vulnerable to radicalism or exploiting others for the purpose of radicalisation.

8.7 The Trust Prevent facilitator submits a quarterly return to NHS England via NHS Digital and to the local BSOL ICB.

8.8 The Trust Prevent facilitator attends Channel and represents the Trust at Prevent Operational Groups for Birmingham and Solihull and associated Prevent Delivery Groups. The Head of Safeguarding attends any strategic Prevent Executive Boards or meetings as necessary.

8.9 A quarterly report on Prevent is submitted to the Trust Safeguarding Management Board and any concerns would be escalated appropriately through the governance route.

8.10 **Prevent and Channel data including comparative data from the previous reporting period**.

8.11 Overall, Prevent enquiries from West Midlands Police have increased during the last two quarters, there is no particular reason for this. Traditionally Prevent enquiry rates fluctuate.

8.12 The table below show the summary of concerns which have been raised over the last year.

Concerns related to Prevent:
Incel opinions expressed at school
Pro -Taliban comments to airport police
Threats to bomb school
Social media support for Hamas
Sibling of an offender under the Terrorism Act
Informed ambulance staff they are able to make a bomb
Threats to stab Mosque attendees
Extreme right wing views including Islamophobia and homophobia
Expressed desire to join Chechnya suicide squad
Nazi memorabilia in home
Visited Pakistan and publicly stated ‘I am the Taliban’
Obtained prison officers address whilst in prison
Intrusive thoughts to kill Muslim males.

8.13 Compliance with training is good. The Home Office have released a new face to face training package, this is currently being piloted. Members of the Health Safeguarding Board have discussed this and currently there are no plans to make face to face training mandatory within health.

9.0 Domestic Abuse

9.1 The cross-government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but not limited to:

- *Psychological and emotional abuse*
- *Physical abuse*
- *Violent or threatening behaviour*
- *Controlling or coercive behaviour*
- *Economic / financial abuse*
- *Sexual abuse*

9.2 The definition includes honour-based abuse, female genital mutilation and forced marriage and it is clear that victims are not confined to one gender, religion, or ethic group.

9.3 The Domestic Abuse Act 2021 sees children under 18 as victims of domestic abuse where they see, hear, or experience the effect of domestic abuse.

9.4 The Trust includes domestic abuse awareness into the Level 3 Safeguarding Adults and Children Training.

9.5 The Domestic Abuse Policy was updated to reflect the changes in the Domestic Abuse Act 2021.

9.6 The Safeguarding Team are supporting the sexual safety workstream at BSMHFT.

9.7 The Head of Safeguarding represents the Trust at multi-agency Strategic Domestic Abuse Boards across Birmingham and Solihull and the Named Nurse for Domestic Abuse acts as deputy.

9.8 The safeguarding team are involved in appropriate meetings across Birmingham and Solihull which includes ‘DA offer for Children’ and BAFGM and associated working groups.

9.9 The Named Nurse for Domestic Abuse is supporting a review of the Birmingham Domestic Abuse Strategy, ensuring that the BSMHFT Domestic Violence and Abuse workplan aligns to this.

9.10 In 2022 the Safeguarding team commissioned Women and Theatre to produce a short video on domestic abuse. This was finalised in 2023 and is now used in Level 3 adult safeguarding training and is central to an activity completed within the training on routine enquiry. This also links to Think Family. This video evaluates consistently well.

10.0 Multi-Agency Risk Assessment Conference (MARAC)

10.1 In 2021 BSOL ICB commissioned a central team, the Interpersonal Violence Team (IVT) to deliver the health function to the Birmingham and Solihull MARACs.

10.2 The IVT was set up to alleviate the pressures on provider teams, ensure information was communicated to the victim's GP and ensure consistency of attendance. This was a system wide improvement piece of work.

10.3 The Trust moved over to the BSOL IVT model March 2024 and a memorandum of understanding was agreed to ensure clear expectations of the working model.

10.4 The Safeguarding team continue to receive key information in relation to MARAC and due to increased capacity, that the move to the IVT model brings, are able to follow up the concerns about our service users more robustly with Trust teams. This also informs our delivery of targeted safeguarding supervision if hot spots or particularly challenging cases are identified.

10.5 The Head of Safeguarding and the Named Nurse for Domestic Abuse were successful in securing the substantive funding for an Independent Domestic Violence Advisor (IDVA) in February 2024 working in partnership with Birmingham and Solihull Women's Aid. This will build upon the work already started in 2023/24 when a fixed term post was introduced.

10.6 IDVAs provide emotional and practical advice, guidance, and support to help women who are victims of domestic abuse. There are plans for 2024/25 in relation expanding the role of the IDVA to include a pilot drop-in clinic on female acute wards, targeted training for staff and confidential support to female staff who are experiencing domestic abuse.

10.7 The Trust Named Nurse for Domestic Abuse chairs Birmingham MARAC meetings and sits within both Solihull and Birmingham MARAC Governance processes. They also represent the Trust at Birmingham and Solihull MARAC Governance Committee.

11.0 Domestic Homicide Reviews (DHRs)

11.1 Community Safety Partnerships are legally required to carry out a Domestic Homicide review (DHR) as part of the Domestic Violence, Crime and Victims Act (2004). A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence or neglect by:

- A person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship, or:
- A member of the same household as himself or herself.
- This may also include deaths by suicide when the victim is believed to have been experiencing domestic abuse.

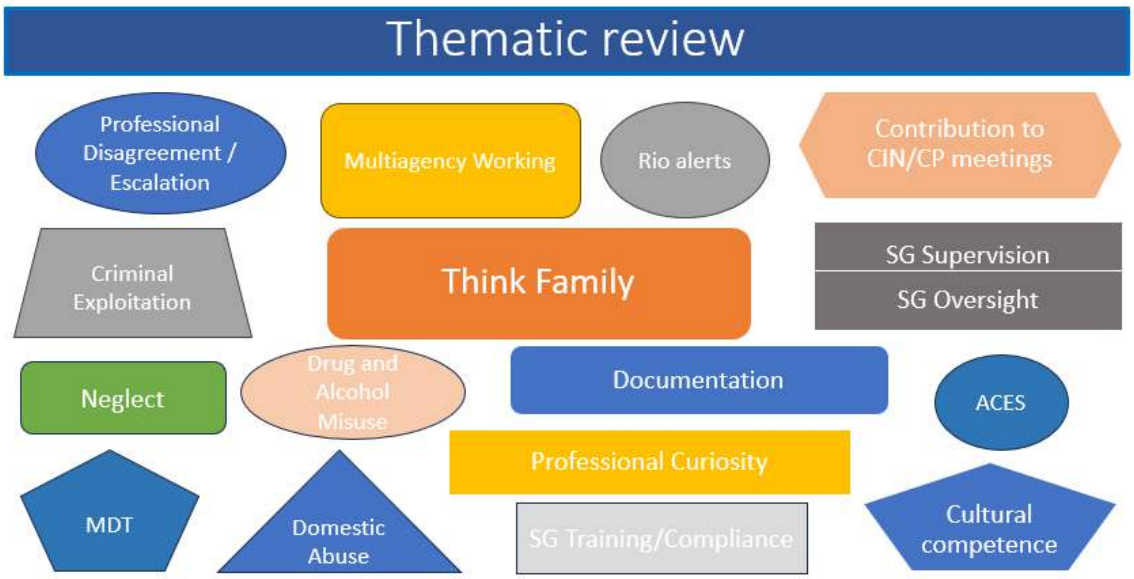
11.2 DHRs were introduced by Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force 13 April 2011.

11.3 During the reporting period there have been no new DHRs commissioned by the Community Safety Partnerships, however BSMHFT has supported the process by completing and returning 8 scopes.

11.4 The Safeguarding team has incorporated the learning from previous DHRs into safeguarding training and dedicated domestic abuse training will continue to be developed and delivered during 2023/24.

11.5 The Safeguarding team undertook thematic analysis of all the learning from DHRs and this was presented to SMB and Internal Clinical Governance Committee (CGC) and QPESC (Quality, Patient Experience and Safety Committee).

11.6 The themes identified (see picture below) support the safeguarding team in the development of 7-minute briefings, make improvements to training and support safeguarding supervision sessions across the Trust to ensure we are a learning organisation which is responsive to the needs of our staff and service users.



12.0 Safeguarding Adults

12.1 The Care Act (2014) defines safeguarding as “protecting an adult’s rights to live in safety free from abuse and neglect”.

12.2 Adult safeguarding duties apply to an adult, aged 18 or over, who:

- Has needs for care and support, (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of, abuse and neglect and
- As a result of their care and support needs, is unable to protect themselves from the risk or experience of abuse and neglect.

12.3 An adult at risk may be a person who:

- Are elderly and frail due to ill health, physical disability, or cognitive impairment.
- Has a learning disability.
- Has a physical disability and or sensory impairment.
- Has mental health needs.
- Has a long-term illness or condition.
- Misuses substances or alcohol.
- Is a carer.
- Is unable to demonstrate capacity to make a decision as is in need of care and support.

12.4 A Named Doctor for Safeguarding Adults was appointed in September 2023, providing two PAs (8 hours) per week to work with the Safeguarding team to support and promote the provision of effective services to safeguard services users of BSMHFT and to support adherence to the relevant legislative frameworks.

12.5 The Named Doctor works closely with the Head of Safeguarding and the Named Doctor for Safeguarding Children and Young People to achieve staff and service developments and meet key Trust targets.

12.6 An additional band 7 safeguarding facilitator was recruited to, specifically to work in the adult safeguarding workstream and support the delivery of safeguarding practice at BSMHFT.

12.7 The safeguarding team have increased their visibility by providing face to face support through safeguarding supervision and additional training and development in response to incidents or specific issues related to quality and safety.

12.8 The Safeguarding team have provided significant enhanced support to the North Acute inpatients.

12.9 The safeguarding team are providing safeguarding supervision to Reaside Hospital including the forensic community team. The offer and provision of bespoke support will continue to grow and develop over the forthcoming year of 2024/25.

12.10 The safeguarding team have devised and delivered bespoke teaching packages which include back to basics on adult safeguarding, financial abuse, self-neglect and adultification with other topics being planned for 2024/25.

12.11 The Safeguarding Team have an improved process for cascading pertinent safeguarding information via comm's and have an agreement with them for monthly content via the colleague briefing.

13.0 Safeguarding Adult Reviews (SARs)

13.1 Under the Care Act 2014, there is a statutory requirement under Section 44 to undertake Safeguarding Adult Reviews (SARs).

13.2 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

13.3 The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

13.4 A SAR is commissioned when there is reasonable cause for concern about how Safeguarding Adult Board (SAB) members or other agencies providing

services worked together to safeguard an adult if:

- The adult dies and the SAB knows or suspects the death resulted from abuse or neglect.
- Whether or not it knew about or suspected the abuse or neglect before the adult died.
- The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

13.5 The Named Nurse for Adult Safeguarding is a member of the SAR subgroup in Solihull; however, provider organisations are not invited to be members on the Birmingham SAR subgroup.

13.6 BSMHFT have two outstanding SARs awaiting publication. There are no outstanding actions for the BSMHFT Safeguarding Team for these.

13.7 From April 2023 - March 2024, the Safeguarding Team have completed five requests for information (scopes), In the same time period, BSMHFT Safeguarding team made two SAR referrals, one to Birmingham and one to Solihull. However, it was felt that neither met the criteria for a SAR.

13.8 SAR professional guidance is available on the Trust Safeguarding pages through a link to the Birmingham and Solihull Safeguarding Adult Board websites. Cases for SAR consideration are submitted by the Trust Safeguarding Adult Lead.

13.9 The Safeguarding team undertook thematic analysis (see image below) of all the learning from SARs which has been presented to SMB, CGC and QPES. This supports the response from the safeguarding team in relation to improving and delivering training, 7-minute briefings and providing safeguarding supervision to ensure we are a learning organisation to improve the safety of our service users and development of staff.

14.0 Safeguarding Children:

14.1 All staff within health services have a key role to play in safeguarding and promoting the welfare of unborn babies, children, and young people. Children are defined by the Children's Act (1989) as those being under the age of 18.

14.2 All staff who come into contact with children and their families have a responsibility to safeguard and promote the welfare of children and should know what to do if they have concerns about a child.

14.3 This responsibility also applies to staff working at the Trust who work primarily with adults who are our service users but have dependent children who may be at risk of abuse or neglect due to their parent/carer health or behaviours.

14.4 Many families can experience challenges in bringing up their children and parenting capacity can be influenced or compromised through parental mental illness, learning disability, substance misuse, and domestic violence. In some circumstances staff may have limited or no contact with children. However, in these circumstances practitioners must ensure a Think Family approach to keep a focus on children and the wider family.

14.5 The Head of safeguarding and the children's work stream staff members attend leaders assemblies, partnership subgroups and multiagency audit days as appropriate to ensure BSMHFT is represented across BSOL ICS.

14.6 The safeguarding team implemented an oversight / escalation tracker to improve oversight of the most complex child protection cases. There were 53 complex cases in 2023/24 where additional support was given to teams in the Trust.

14.7 The safeguarding supervision offer was reviewed and strengthened during 2023/24 and we were able to report compliancy data. This offer will continue to be reviewed and strengthened in 2024/25.

14.8 A review of all the learning and actions which resulted from the National review was undertaken to provide assurance that all learning had been appropriately identified and acted upon across various services.

14.9 BSMHFT had identified that they were not always aware of children and families subject to child protection plans. This was also a finding in the National Review and subsequent Joint Targeted Area Inspection (JTAI).

14.10 A safeguarding process has been introduced at the Trust in relation to Initial Child Protection Conferences (ICPC) for both Birmingham and Solihull. In May 2023 an Internal Case Conference Pathway was written, which was initially managed by the Named Nurse for Safeguarding Children and a Safeguarding facilitator and subsequently delegated to a safeguarding administrator when the process was finalised.

14.11 An ‘open door’ policy is offered by the Trust Safeguarding team for queries to support practitioners and managers at each stage of the process and safeguarding alerts are added to RiO by the safeguarding administrative staff.

14.12 The importance of participation is promoted within safeguarding supervision sessions, training and when an invitation arrives.

14.13 There is continued work underway to ensure the Trust is notified of children subject to child protection plans and have relevant information relating to Review Child Protection Conferences (RCPC) consistently from both Solihull and Birmingham Children’s services.

15.0 Child Safeguarding Practice Reviews (CSPRs)

15.1 A CSPR takes place after a child is seriously injured and abuse or neglect is thought or known to be involved. It looks at lessons that can be learned to help similar incidents from happening in the future. The reviews are recommended at a local level and then reviewed by the national panel that decides if learning should be disseminated at a local or national level.

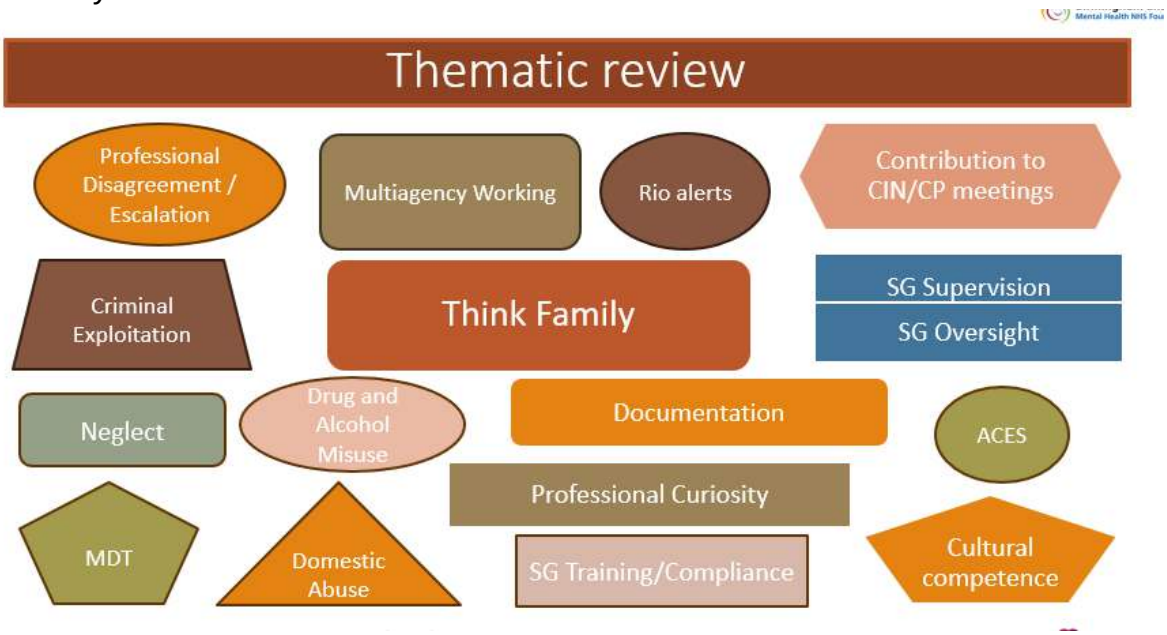
15.2 Birmingham and Solihull Children Partnership CSPR sub-groups are attended and represented by a member of the Safeguarding team and reviews are supported by the Safeguarding team and clinical teams who are involved with the case, to support the process.

15.3 From April 2023 - March 2024, the Safeguarding Team have completed 11 CSPR requests for information (scopes). Only one of these progressed to a CSPR with learning and actions for BSMHFT. This was an out of area request.

15.4 A rapid review meeting is held in all cases to gather facts about the case, ensure immediate safety of any children involved, consider potential for any safeguarding improvements, and decide on next steps. The Safeguarding team have participated in 10 Rapid Review meetings.

15.5 There have been 3 CSPRs published during 2023/24 from incidents which took place in 2022. The Head of Safeguarding and the Head of Communications were actively engaged in media meetings prior to publication.

15.6 The Safeguarding team undertook thematic analysis (see below image) of all the learning from CSPRs and this was presented internally to SMB and CGC and QPES. These themes support the team to ensure their training, supervision and 7-minute briefings are responsive to the learning identified and best supports the development of our staff which in turn should improve safety for children.



15.7 The Safeguarding Management Board receives updates on all learning reviews and actions are monitored by the Local Safeguarding Children Partnerships.

16.0 Launch of Think Family Trust Wide

16.1 Learning from National reviews including Children Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews has

shown that children and other adults who live with or have contact with individuals who suffer from mental illness can suffer significant harm and their needs can be overlooked unless they receive the right support at the right time.

16.2 The National Review of Child Protection arrangements following the tragic death of Arthur Labinjo-Hughes in Solihull over lockdown concluded that services needed to improve their ability to adopt a Think Family approach.

16.3 The “Think Family Approach” was launched by the BSMHFT Safeguarding Team in November 2023. This was a campaign which was shared and profiled across all of the Trust’s internal communications channels.

16.4 The Think Family approach also supports adult service users who might also be at risk from other members of their family (for example through domestic abuse or financial abuse) or from others outside of the family.

16.5 The Think Family Approach involves:

- Asking service users about their family and recording accurately in medical records.
- Talking to and involving where appropriate, family members, friends, and carers.
- Considering the impact of mental illness (and substance abuse if this is a feature) on children and families.
- Working in partnership with other professionals to form a full picture of need.
- Accepting that an individual’s issues often exist within a context of wider vulnerabilities and always being curious about this.

16.6 The Trust Safeguarding Team developed a simple Think Family Standard which breaks down what clinical teams need to do so that Think Family is embedded in their everyday good clinical practice.

16.7 Adopting a Think Family approach means that we can work together with service users, families, and other professionals towards the best possible outcomes for our service users.

16.8 A suite of materials were produced and made available to Trust staff which includes:

- Colleague briefing article (the colleague briefing is a weekly briefing from the Executive)
- Think Family standard
- Leaflets and posters
- Six-minute video on the Think Family approach

- Short power-point outlining the concept of Think Family for all staff.
- Featured as part of one of the weekly staff communication sessions delivered online by member of the Trust Board.

16.9 The Safeguarding team will monitor the uptake of the guidance, support a Think Family approach through reflective supervision and offer targeted support through local clinical governance committees.

16.10 There needs to be continued messaging in relation to Think Family in order for it to fully embed into everyday practice. The Safeguarding team will be including Think Family as part of the key lines of enquiry (KLOE) for the Safeguarding assurance visits planned for 2024/25.

16.11 The Trust's Think Family approach was presented externally at the Solihull practitioners event and the BSOL ICB Health Safeguarding Board in 2024 and received positive feedback on the work being undertaken at BSMHFT.

"Think Family-Look Closer- See More"

17.0 Engaging with Experts by Experience and Think Family

17.1 The safeguarding team worked with our Participation and Engagement Team and invited EBE's to tell us what the most important things they wanted mental health teams to understand in respect of their families. We facilitated a group, and collated their responses and used it to inform/shape our Think Family Standard and approach.

17.2 Each mandatory training session attendee at Level 3 receives the collated responses in form of a power point. This information is also available on our safeguarding hub for staff to access.

17.3 We have applied for the Trust Quality Mark in relation to the work we did with the recovery college and the Think Family approach.

18.0 Learning from External Reviews

18.1 BSMHFT Safeguarding team participates in external reviews, such as DHR, SAR and CSPR. Learning from these reviews - which includes our own single agency learning and wider lessons - is important to continually develop practice and to reduce the risk of similar issues arising in the future.

18.2 The Safeguarding team undertook thematic analysis of all the learning from CSPRs, DHRs and SARs and this has been presented internally to SMB and CGC and QPES.

18.3 Emerging themes are considered, allowing us to be responsive, and as a result policies, guidelines and training have been updated in a timely manner.

18.4 A suite of 7-minute briefings have been developed on topics such as neglect, self-neglect, child protection case conferences, routine enquiry into domestic abuse, professional curiosity, capturing the voice of the child, parental substance misuse, bruising in children, child exploitation and hidden men.

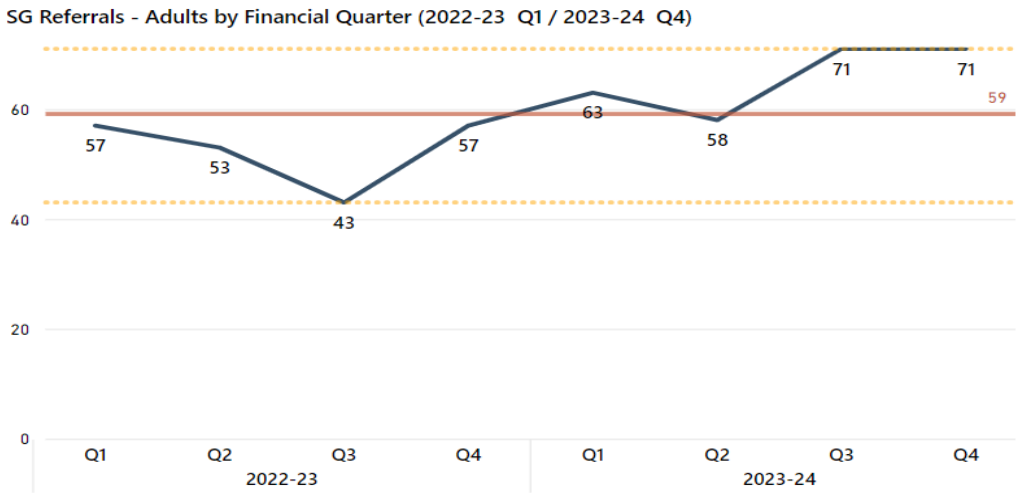
18.5 The briefings are available on the Trust Safeguarding connect page and are utilised in training and safeguarding supervision and for cascading to teams across the Trust with the expectation they will be used in team meetings, clinical supervision, and management supervision. 7-minute briefings are also disseminated regularly via Trust Colleague Briefings.

18.6 Assurance that learning has been embedded into practice is key to providing evidence and this is achieved by audits related to specific areas of practice. There are plans for the safeguarding team to undertake assurance visits to clinical areas in 2024/25 to seek assurance that safeguarding is embedded into clinical practice and to identify areas which may need additional support from the team.

19.0 Safeguarding Adult Incident Reporting Data

19.1 All service user safeguarding incidents are reported on the internal incident reporting system (Eclipse). The incidents are robustly reviewed and screened by the Safeguarding team to identify cases where suspected abuse or neglect has been indicated. This supports staff in their decision-making to consider any safeguarding concerns and to make the appropriate local authority safeguarding referrals.

19.2 There were 263 adult safeguarding referrals raised by BSMHFT staff in 2023/24 compared to 210 in 2022/23. This year the referral rate is higher which could indicate an increase in Trust staff awareness of safeguarding issues.



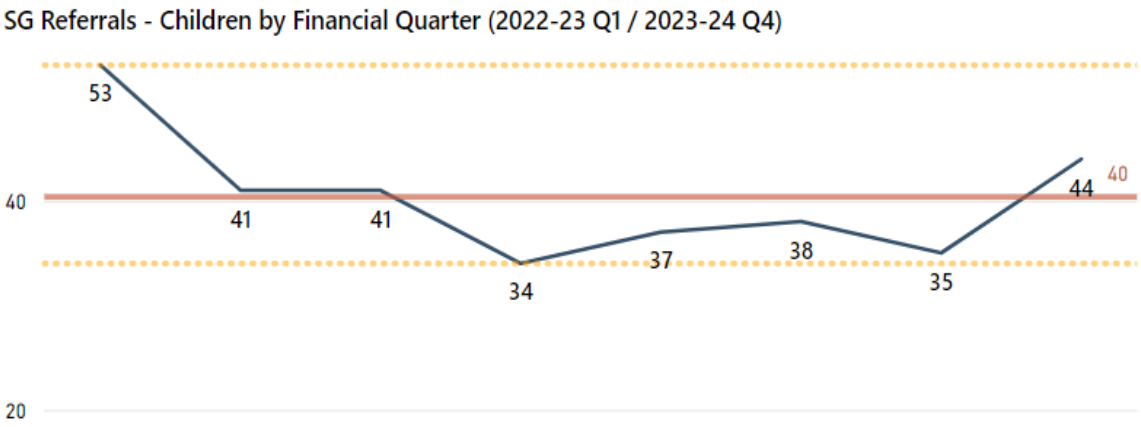
19.3 The nature of safeguarding referrals is recorded with physical and psychological abuse being the highest category followed by financial and domestic abuse.

19.4 Acute Care raised the highest number of safeguarding referrals (77) followed by the Dementia and Frailty Team (65).

19.5 In areas where there are low numbers of reporting, the Safeguarding team are doing targeted safeguarding awareness work which will continue to be strengthened in 2024/25.

20.0 Safeguarding Children Incident Reporting Data

20.1 There were 154 children safeguarding referrals raised by Trust staff in 2023/24 compared to 168 in 2022/23. The overall number of referrals is lower than what would be expected for the size of the Trust which indicates continued promotion of the importance of making safeguarding referrals and reporting these via the eclipse system is needed.



20.2 The nature of safeguarding referrals is recorded with emotional abuse being the highest category reported, followed by physical abuse and then neglect.

20.3 The main reason for referrals into children's services (both Birmingham and Solihull) is physical abuse, followed by neglect. However, as we are a mental health Trust this may account for why our highest reason for referral is emotional abuse.

20.4 Solar, BSMHFT's Emotional Wellbeing and Mental Health Service for Children, Young People and Families in Solihull raised the highest number of safeguarding referrals (41).

20.5 In areas where there are low numbers of reporting the Safeguarding team is doing ongoing targeted safeguarding awareness work.

21.0 Investment in the Trust Safeguarding Team

21.1 It was identified through the BSOL ICB Health Safeguarding Board that there was a need for high quality, master's level safeguarding specific study for safeguarding professionals across the ICS.

21.2 The School of Nursing and Midwifery at the University of Birmingham introduced a module of study: Safeguarding in Health.

21.3 The overall aim of the Safeguarding in Health module is to set the benchmark for health safeguarding provision in Birmingham and Solihull and beyond. It is directed at health professionals with a substantive safeguarding role.

21.4 The programme offers an innovative blend of strategic safeguarding, contemporary safeguarding evidence and trends and active application to practice.

21.5 Four members of the Trust Safeguarding team were supported to complete the module in 2023/24 with further staff attending in 2024/25.

21.6 The Safeguarding team were also supported to attend additional specialist safeguarding supervision training to enhance and develop skill within the team.

21.7 BSMHFT will host the safeguarding supervision training in 2024/25 and will share spaces with other provider Trusts across the ICS, working together across the health system to improve the knowledge and skills of the safeguarding practitioners.

22.0 Conclusion

22.1 In the reporting period, the Safeguarding team has promoted the importance of safeguarding supervision and Think Family being a standard operating process in all aspects of service delivery and sound clinical practice.

22.2 BSMHFT is committed to being a learning organisation and the safeguarding team have progressed and strengthened the training offer through refreshing level 3 training, delivering bespoke training packages to clinical areas and developing a suite of 7-minute briefings which are responsive to learning needs identified in statutory reviews and incidents.

22.3 The safeguarding team have increased their visibility and face to face availability to teams across the Trust to improve and strengthen the support offered to staff by the team to build upon good safeguarding practices.

22.4 Links between the Patient Safety and Safeguarding teams have strengthened in this period and the safeguarding team have worked more closely with the patient safety team and have been actively involved in relevant meetings and the implementation of the Patient Safety Incident Reporting Framework (PSIRF), where safeguarding is an integral component.

22.5 Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. There are a great number of committed staff who work impeccably to support and serve our service users and their families and the Safeguarding team would like to acknowledge them all.

Report to Board of Directors							
Agenda item:	**14**						
Date	4 December 2024						
Title	Medical Directorate Annual Board Update – Medical Appraisal, Revalidation and Job Planning.						
Author/Presenter	Kerry Rowley Dr Fabida Aria						
Executive Director	Dr Fabida Aria	**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

Trust Board are requested to note the content of this report, receive assurance, and **approve** the signing of *Annex A - Designated Body Annual Board Report and Statement of Compliance* (provided as appendix 1).

Introduction

This report is presented to Trust Board to update and provide assurance on Medical Directorate work in relation to medical appraisal, revalidation, and job planning.

Key Issues and Risks

The Allocate Software contract for medical appraisal and job planning licensing was renewed in December 2021 for a 3-year period. The total contract price was £96,391, however additional licenses have needed to be purchased during this time due to an increase in the number doctors being appointed to the Trust - cost in the region of an additional £8500 per annum.

The management of the medical appraisal and job planning contract no longer sits directly with the Medical Directorate. The current contract is due to expire on 24th December 2024, with renewal discussions ongoing between the Trust and Allocate Software, following regular prompting and requests from the Medical Directorate Manager. At the point of writing this report, the contract renewal has still not been finalised and signed.

The increase in number (and turnover) of fixed term contract and LAS doctors with a designated body connection to the Trust, who are being employed to reduce agency spend has had a significant impact on the Medical Appraisal and Revalidation Team and Medical Director Manager, due to an increase in the number of doctors now needing to be managed for appraisal, revalidation and job planning purposes. Our staffing model has been reviewed and restructured to create additional capacity to support this increase in workload. It is anticipated to incorporate a new Medical Appraisal and Job Planning Lead role to oversee the daily administrative functions of the Medical Appraisal and Job Planning portfolio.

Additionally, we are advised that it is proposed for a cohort of doctors from a neighbouring Trust to be TUPEd across to our organisation as part of a change in service arrangement.

Since our last update a number of doctors have stepped down from being a Medical Appraiser, or have retired from the Trust. Discussions remain ongoing on how best to incentivise our Medical Appraiser and Auditor roles.

Additionally, it is noted that once again job planning has presented some challenges. However, it must be recognised that as an organisation not all directorates have Clinical Leads in situ to support the job planning workstream, but that we remain focussed and are making continuous incremental progress.

Recommendation

Trust Board are requested to note the content of this report, receive assurance, and **approve** the signing of *Annex A - Designated Body Annual Board Report and Statement of Compliance* (provided as appendix 1).

Enclosures

Appendix 1: Annex A - Designated Body Annual Board Report and Statement of Compliance.

Medical Directorate Annual Update – Medical Appraisal, Revalidation and Job Planning.

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

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

1. Situation

The Medical Directorate are required to report into Trust Board annually regarding medical appraisal, revalidation and job planning.

2. Background

The report is presented to Board members to update on key events and achievements of the Medical Directorate pertaining to the medical workforce, in particular medical appraisal, revalidation and job planning.

3. Assessment

Medical Appraisal and Revalidation:

The previously presented Framework of Quality Assurance (FQA) was in place for Responsible Officers to provide assurance to their own organisations board. The pause of the FQA during the Covid -19 pandemic allowed a review of its content. A revised framework has since been considered by a working group, utilising feedback from Responsible Officers to ensure that it is a supportive document for organisations.

An updated version of the framework launched in April 2024, and now includes aspects of quality improvement. The new framework has therefore been retitled Framework for Quality Assurance and Improvement (FQAI). It is anticipated that the revised framework will support designated bodies in providing assurance to their boards and to increase focus on good practice.

As part of the revised framework, it is still necessary for us to submit a copy of our Designated Body Annual Board Report and Statement of Compliance to NHS England, which has also been revised and is now significantly more comprehensive than previous years.

Trust Board are requested to note the content of this report, receive assurance, and **approve** the signing of *Annex A - Designated Body Annual Board Report and Statement of Compliance* (provided as appendix 1).

Medical Job Planning:

Electronic medical job planning has been in situ within the Trust since February 2015, and remains an annual contractual requirement for medical staff who fall within scope of the Trust's policy.

E-Job Plan, part of Allocate Software's HealthMedics Optima is designed to help facilitate the process of job planning as set out by the national consultant contract, allowing users to populate, review and sign off job plans all in one place. The system provides organisations with the facility to manage and report on current and historic information at an individual, departmental, or organisational level, presenting a valuable opportunity to maximise efficiency through increased transparency.

Medical job plans are measured in Programmed Activities (PA's). PAs are blocks of time, usually equivalent to four hours, in which contractual duties are performed. There are four basic categories of contractual work:

- Direct clinical care (DCC).
- Supporting professional activities (SPAs).
- Additional responsibilities.
- External duties.

A job plan will set out how many PAs a doctor is working and how many will be used undertaking these different types of work. A significant proportion of a job plan may be spent on DCC. Direct clinical care work is any work that involves the delivery of clinical services and administration directly related to them.

E-JobPlan provides consistency in the format of job plans, accurate calculations for PAs and on call work including prospective cover, and the ability to reflect the most complex work patterns through the combination of annualised and timetabled activities.

Medical job planning remains very important and needs to accurately reflect the amount of work that our medical colleagues are undertaking for the Trust, both direct clinical care and supporting professional activities. We recognise that it has been an extremely busy period, and this may feel like an additional task at a time of pressure, but it is only with this information that we can start to make progress towards job plans becoming a truly prospective annual event, capturing work which is needed and very much valued.

In terms of timeline, job plans are prospective for the financial year ahead, and were required to have been completed and fully signed off by the end of March 2024 in readiness to commence 1st April 2024.

It is noted that once again job planning has presented some challenges. However, it must be recognised that as an organisation not all directorates have Clinical Leads in situ to support the job planning workstream, but that we remain focused and are making continuous incremental progress.

We remain optimistic that our doctors are getting into a routine of completing their annual job plan, and in an attempt to improve things further we have implemented a series of additional meetings which have a specific emphasis on management of real time issues, e.g engagement concerns, to provide sign off manager updates and to sign off any 'in year' changes to job plans.

The 2024/2025 round identified 234 doctors who were required to complete a job plan. Progress for this round was as follows:

Work Area	Number of Job Plans Requiring Completion	Number of Job Plans Completed and Fully Signed Off	Number of Job Plans remaining Incomplete and Locked Down
Acute Care	38	18 (47.4%)	20 (52.6%)

Integrated Community Care and Recovery	81	21 (25.9)	60 (74.1%)
Medical Director Team	1	1 (100%)	0 (0%)
Older Adults and Specialties	55	47 (85.5)	8 (14.5)
Secure Care and Offender Health	37	21 (56.8)	16 (43.2)
Undergraduate Medical Education	5	5 (100%)	0 (0%)
Urgent Care	17	11 (64.7)	6 (35.3)
	234	124 (53%)	110 (47)

The 2025/2026 job planning round commenced in November 2024, following an annual review and data cleanse of the electronic system. Jobs plans are required to be completed and fully signed off by the end of 31st March 2025

Our internal auditors and Local Counter Fraud Services have concluded with their joint audit for 2024/2025. The assignment was scoped to provide assurance with regard to how Birmingham and Solihull Mental Health NHS Foundation Trust ensure that current job plans are in place for its medical staff and how it actively monitors to ensure there is no conflict with medical staff NHS time / duties.

We are now in receipt of an updated draft report and discussions continue around agreement of content.

Annex A

Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 - Qualitative/narrative
Section 2 - Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of **Birmingham and Solihull Mental Health NHS Foundation Trust** can confirm that:

1A (i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Dr Hilary Grant retired from the organisation at the end of June 2022. Dr Fabida Aria joined BSMHFT as Executive Medical Director on 1st August 2022. In the interim, Dr Giles Berrisford, Deputy Medical Director (Professional Practice, Legal and Transformation) undertook Responsible Officer duties in line with the Responsible Officer Regulations.
Comments:	Dr Aria is now established in their role as Executive Medical Director and Responsible Officer.
Action for next year:	Due to the increased number of short-term designated body connections, we plan to review if a second Responsible Officer would be beneficial to the organisation.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / ~~No:~~	The Trust fully supports the provision of sufficient funds, capacity and other resources. However, we are still experiencing difficulties in appointing and retaining Medical Appraisers and Auditors.
Action from last year:	Due to an increase in the number of fixed term contract and LAS doctors being appointed to the Trust, there will be a requirement to further review the current staffing model in terms of additional administrative support, Medical Appraisers and Auditors so as to be able to effectively support this increase in workload beyond this current financial year.
Comments:	A new Appraisal and Revalidation Administrator has been appointed to replace the previous post holder who has since retired. Additionally, one of the Business Support Officer roles has been revised to incorporate medical appraisal and revalidation support to the Appraisal and Revalidation Administrator. It is also anticipated to introduce a Business Support Officer Lead role to oversee the daily administrative functions amongst other tasks. The job description is currently awaiting Agenda for Change matching, and it is hopeful that we can appoint to the role in the first quarter of 2025. Work continues around our approach on how best to incentivise Medical Appraisers and Auditors. Since our last update, some doctors have stepped down from being an Appraiser or have retired from the Trust. However, by the end of 2024 six new appraisers will have been formally trained by Miad Healthcare, with the possibility of a seventh joining the team.
Action for next year:	We plan to further review options for incentivisation of Medical Appraisers and Auditors with the hope of further appointments, in addition to recruiting to the role of Business Support Officer Lead post.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No action from last year.
Comments:	There is robust monthly monitoring of all licensed practioners with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust which is further enhanced by the triangulation of information at the pre-employment check stage.
Action for next year:	No further action required at this stage.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	No action from last year.
Comments:	Following the Covid pandemic The Medical Appraisal policy was updated to incorporate the revised approach for Medical Appraisal. The policy is due for review imminently.
Action for next year:	Review the Medical Appraisal and Revalidation policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Arrange a reciprocal peer review with our MERIT partners
Comments:	It was anticipated that a reciprocal organisational peer review would be arranged however we have been unsuccessful in agreeing this with our MERIT partners. We had also identified an alternative organisation that were willing to participate in a reciprocal arrangement, but we have not yet been successful in arranging reviews.
Action for next year:	Re review options for reciprocal peer review. The Medical Directorate Manager is now part of a peer group themselves, so will discuss this with their group to ascertain appetite for an arrangement to be put in place with another organisation from the peer group.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	No previous action identified.
Comments:	Robust processes are currently in place to identify locum and short-term workers within the organisation. Annual appraisal is provided to those doctors with a designated body connection to BSMHFT, in addition to regular 1-1 meetings, supervision meetings, provision of fundamental and other relevant training and access to governance activities and meetings.
Action for next year	No further actions required at present.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	We are planning to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SUIs, complaints, mortality case note reviews and disciplinary matters.
Comments:	A mechanism for the transfer of information relating to complaints, SUIs and Learning from Deaths has been established which ensures that all doctors have access to this information for the process of medical appraisal. Refresher training for existing appraisers and new appraiser training for new appraisers is provided and updates on the revised approach for appraisal. Regrettably we have not yet been able to implement a process for an annual Responsible Officer to Responsible Officer communication.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	We are planning to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SUIs, complaints, mortality case note reviews and disciplinary matters,
Comments:	We have a process in place. However, we wish to implement the above action to underpin our existing process.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No action from last year.
Comments:	The Medical Appraisal policy was reviewed and ratified by our Trusts Transforming our Culture and Staff Experience Sub Committee in 2021. The policy was updated to incorporate the revised approach for Medical Appraisal. This policy is now due for review again.
Action for next year:	Review Medical Appraisal and Revalidation policy.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	No actions from last year.
Comments:	Following a number of appraisers stepping down from appraiser duties, and the appointment of 6 new appraisers, the Trust retains 29 appraisers to conduct medical appraisals as part of their job plans, which is an overall increase of 2 appraisers based on last year's numbers. It is also anticipated that an additional doctor will be joining the appraiser team in January 2025.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	We plan to further review options for incentivisation of Medical Appraisers with the hope of further appointments.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No previous actions
Comments:	Appraiser Peer Support Sessions are held twice per annum and are attended by our cohort of Medical Appraisers. Appraiser Refresher Training is currently being undertaken by our existing appraisers. Additionally, we are planning to implement appraiser 1-1 feedback sessions. The Trust's Medical Appraisal policy is currently in date but is due for review imminently. We continue to scope options for the inclusion of a Lay Member into our Medical Appraisal processes, with our next step to be for us to contact our recruitment team to ascertain information on putting out an external advert for a Lay Member role on an honorary basis. As detailed elsewhere in this report, further scoping is required in an attempt to implement reciprocal organisational peer review.
Action for next year:	Implement Medical Appraiser 1-1 feedback sessions. Review and update (where required) the Trust's Medical Appraisal and Revalidation policy. Contact the Trust's recruitment team to ascertain options for appointment of a Lay Member role on an honorary basis. Continue to scope options for reciprocal organisational peer review.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	No actions from last year.

Comments:	We have established monthly revalidation meetings and a quarterly Appraisal and Revalidation Committee in situ. Their remit is to provide assurance to the Board that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is undertaking its statutory responsibilities to ensure that all doctors with a designated body connection to the organisation can be successfully revalidated, as well as supporting the decision-making process for revalidation recommendations in complex cases. In addition, we are attempting to implement a reciprocal organisational peer review arrangement and plan to appoint to an honorary Lay Member role to support our medical appraisal processes.
Action for next year:	Due to changes in personnel, meeting arrangements need to be reviewed to ensure that all current diarised meetings can remain quorate. Contact the Trust's recruitment team to ascertain options for appointment of a Lay Member role on an honorary basis. Continue to scope options for reciprocal organisational peer review.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	No action from last year.
Comments:	From 12th April 2022, GMC extended the routine revalidation notice period from four to twelve months. This new arrangement offers flexibility to our Responsible Officer to submit recommendations to revalidate doctors when they are ready, and to help our organisation better manage any peaks or troughs in workload. Additionally, this arrangement provides organisations with the opportunity to communicate with, and support doctors that have missing supporting information, allowing them to resolve this before their submission date. There have been no missed submission dates.
Action for next year:	No further action identified.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No action from last year.
Comments:	All positive revalidation recommendations are made immediately following the Trust's Revalidation Meeting, with doctors being notified in writing the same day. Conversations relating to deferrals or non-engagement are held with the doctor prior to any submissions being made. Additionally, there is a process in place to notify our GMC Liaison Officer prior to revalidation for any doctors where non engagement may be of concern.
Action for next year:	No further action.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No action from last year.
Comments:	The Trust currently have an Appraisal and Revalidation Committee in situ which links into clinical governance via the Executive Medical Director/Responsible Officer.
Action for next year:	No further action required at present

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No previous action
Comments:	The Trust has established systems for the sharing of information between the Investigation, Complaints, Learning from Deaths and People Teams. The Trust also has in situ a Decision-Making Group and follows the MHPS process. We also plan to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs, complaints, mortality case note reviews and disciplinary matters.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No action from last year.
Comments:	Our appraisal process is managed via an electronic system, with any additional information relating to SUIs, complaints and Learning from Deaths information being collated and triangulated locally within the appraisal team prior to being shared with the appraisee. It is noted that at this point, receiving this information should not be of 'surprise' to the appraisee, as this information will already have been shared by the relevant Complaint and Patient Safety Teams etc beforehand, as part of the Trust's fact finding and investigation processes. Whilst we have established processes in place in relation to the triangulation of SUIs, complaints and Learning from Deaths, we also wish to implement a 'nil return form' confirming zero SUIs, Complaints and Learning from Deaths data for those appraisees with no events to report for inclusion into their appraisal documentation.
Action for next year:	Implement a 'nil return form' in relation to SUIs, Complaints and Learning from Deaths data.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns

policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No action from last year.
Comments:	The organisation follows the MHPS which is underpinned by Trust policy.
Action for next year:	No further action required.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	No actions from last year.
Comments:	The People Team report into People Committee and Board. The Medical Director, Deputy Medical Director and Senior People Partner (Medical Workforce) have regular meetings with our GMC Liaison Officer to discuss current and potential concerns. We use the MHPS Framework to identify and the Decision-Making Group to address required actions.
Action for next year:	No identified actions.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No previous action identified.
Comments:	A robust method for the use of Medical Practice Information Transfer Forms (MPIT) is in use within the Trust.

	We are also in the process of scoping a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs, complaints, mortality case note reviews and disciplinary matters.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	No previous action.
Comments:	We have previously benchmarked our governance and performance against 'The Effective Clinical Governance for the Medical Profession document'.
Action for next year:	Re review our governance and performance against 'The Effective Clinical Governance for the Medical Profession document'.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	No action from last year.
Comments:	We have benchmarked our governance and performance against 'The Effective Clinical Governance for the Medical Profession' document.
Action for next year:	Review progress against 'The Effective Clinical Governance for the Medical Profession' document.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No action from last year.
Comments:	The Trust encourages the medical workforce to participate in: • Development programme for new consultants • Monthly Medical Advisory Committee meeting for senior doctors • Monthly Senior Leadership Team meetings • Monthly Consultant CPD Meetings • Monthly masterclasses
Action for next year:	No further action required

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No actions from last year
Comments:	Our Medical Resourcing Team are responsible for the undertaking of pre-employment and background checks prior to doctors commencing in post with the Trust. The use of robust documentation to enhance the sharing of information between our Teams continues to work successfully.
Action for next year:	No actions required for next year

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	No actions from last year
Comments:	The organisation has policies and procedures in place to support a safe and secure environment, establishing basic principles for the recognition and response to potential or actual situations.

	Managing incidents in such a structured and cohesive manner underpins the ability for all staff to work is a safe and secure environment.
Action for next year:	No further action required

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	No action from last year
Comments:	We have a Trust policy in place to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within the organisation that is inclusive, compassionate, and committed, keeping in line with the Trusts values, the NHS People Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010.
Action for next year:	No action required.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	No previous action.
Comments:	Our raising concerns and Freedom to Speak up Policy ensures that any concerns raised within the Trust are handled sensitively and appropriately, outlining a clear procedure for reporting if other avenues have failed, are inappropriate or where barriers may exist.
Action for next year:	No action required.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	No action from last year.
Comments:	Our appraisal process is managed via an electronic system, with any information relating to complaints information being collated and triangulated locally within the appraisal team prior to being shared with the appraisee.
Action for next year:	We plan to implement a 'nil return form' to include information in relation to complaints.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	No action from last year.
Comments:	We have policies in situ to support the approach to be taken by the Trust when dealing with incidents and matters of alleged misconduct, and to identify the most appropriate way of dealing with such matters, so that we encourage improvement and learn lessons. The policy provides clarification of the considerations which managers should give to an event and, if appropriate, what processes and employee's rights are applicable when dealing with such matters, to ensure matters are dealt with fairly and consistently and in a supportive manner.
Action for next year:	No further action required.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	No action from last year.

Comments:	The Medical Directorate Manager is now a member of a Peer Support Group, whereby topics such as Medical Appraisal and Revalidation are discussed. Administrative staff involved in supporting medical appraisal and revalidation undergo training in addition to attending national and regional events. Our Responsible Officer attends networking meetings and events. The Deputy Medical Director (Medical Staff Professional Practice, Recruitment, Retention, Strategic Leadership for Service Development) will attend Responsible Officer Training in March 2025. Our Medical Appraisers undergo relevant training in additional to regular refresher training. Medical Appraisers are invited to attend Appraiser Peer Support sessions twice per annum Further scoping is required in an attempt to implement reciprocal organisational peer review.
Action for next year:	Deputy Medical Director (Medical Staff Professional Practice, Recruitment, Retention, Strategic Leadership for Service Development) to attend Responsible Officer Training in March 2025. Re review options for reciprocal peer review.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General
The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on **31 March 2024**	233 Please note that this figure includes a proportion of newly appointed doctors who were connected to us on this date, but who did not require to undertake an appraisal with us during the 2023/2024 appraisal year.

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	195 out of 197 doctors
Total number of appraisals approved missed	31, with 29 of these doctors having since completed their appraisal. One doctor remains on long term sickness absence with the remaining doctor currently being in discussion with the Responsible Officer with regards to their deferred appraisal.
Total number of unapproved missed	13 doctors, with all now having since completed their appraisal

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	46
Total number of late recommendations	0
Total number of positive recommendations	43
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	14 Trust case investigators were trained in 2022
Total number of trained case managers	14 case managers were trained in 2022 (as above)
Total number of new concerns registered	4 cases met a threshold for registration and where a Decision-Making Group has taken place.
Total number of concerns processes completed	4
Longest duration of concerns process of those open on 31 March	320 days
Median duration of concerns processes closed	163 days
Total number of doctors excluded/suspended	Nil
Total number of doctors referred to GMC	Nil

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	There were 39 new designated body

	connections during 2023/2024.
Number of new employment checks completed before commencement of employment	Every new starter will complete the following checks: • ID Check • Right to Work / Visa status • DBS • Professional Registration • Qualifications • Occupational Health • Completion of NHS Declaration Form A • Employment References

2F Organisational culture

Total number claims made to employment tribunals by doctors	Nil
Number of these claims upheld	n/a
Total number of appeals against the designated body's professional standards processes made by doctors	Nil
Number of these appeals upheld	n/a

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Dr Aria is now established in their role as Executive Medical Director and Responsible Officer. Due to the increased number of short-term designated body connections, we plan to review if a second Responsible Officer would be beneficial to the organisation. The increase in number (and turnover) of fixed term contract and LAS doctors with a designated body connection to the Trust who are being employed to reduce agency spend has had a significant impact on the Medical Appraisal and Revalidation Team due to an increase in the numbers of doctors now needing to be managed for appraisal and revalidation purposes. Our staffing model has been reviewed and restructured to create additional capacity to support this increase in workload. It is anticipated to incorporate a new Business Support Officer Lead role to oversee the daily administrative functions amongst other duties within the Medical Director portfolio. Additionally, we are advised that it is proposed for a cohort of doctors from a neighbouring Trust to be TUPEd across to our organisation as part of a change in service arrangement. Since our last update, some doctors have stepped down from being an Appraiser or have retired from the Trust. However, by the end of 2024, six new appraisers will have been formally trained by Miad Healthcare, bringing our total to 29 appraisers - with the possibility of one further appraiser joining the team in January 2025. This number equates to 2 more appraisers than reported last year. However, this figure remains lower than subsequent years. Although numbers are lower, the reported number strikes a sensible balance between undertaking a sufficient number of appraisals to maintain proficiency and completing so many as to unbalance the appraiser's scope of work.
Actions still outstanding
Work continues around our approach on how best to incentivise Medical Appraisers and Auditors. It was anticipated that we would be able to arrange a reciprocal peer review arrangement with our MERIT partners, however this has proven to be unsuccessful. The Medical Directorate Manager is now part of a peer group and so will discuss this with the group to ascertain appetite for an arrangement to be put in place. We continue to plan to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SUIs, complaints, mortality case note reviews and disciplinary matters. We are scoping options for the inclusion of a Lay Member into our Medical Appraisal processes, with our next step to be for us to contact our recruitment team to ascertain information on putting out an external advert for a Lay Member role on an honorary basis. Additionally, now that additional capacity has been created within the team, we are optimistic of implementing appraiser 1-1 feedback sessions. The Deputy Medical Director (Medical Staff Professional Practice, Recruitment, Retention, Strategic Leadership for Service Development will attend Responsible Officer Training in March 2025.

Current issues

In addition to what has been documented as part of this report, this year's review has highlighted that whilst we provide training for our Case managers and Case Investigators, we do not hold any records of training provided prior to 2022.

Prior to completing this report, it was identified that our organisation performed below its own expected standards in relation to the management of appraisal deferral requests. Thirteen doctors undertook their appraisal outside of the expected timeframe whilst having no agreed deferral in place. Two doctors have been accounted for in terms of them being on unexpected long term sickness absence, with the second doctor being affected by industrial action. However, eleven doctors had no documented reason for undertaking their appraisal late. To mitigate further occurrences, an administrator has since undergone retraining. To date improvement is noted with regards to appropriate record keeping, and monitoring remains in place by the Medical Directorate Manager.

Furthermore, it is also recognised that there has been a general increase in the number of appraisal deferral requests. Typically, the reasons being Medical Appraiser capacity, short term sickness absence and clinical capacity issues. We are aware that whilst we must do our upmost to support our doctors, ideally, we would like to reduce the overall number of appraisal deferral request submissions. It is hoped that with the correct forward planning, a revised cohort of medical appraisers and administrative staff retraining this can be addressed without too much difficulty.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Due to the increased number of short-term designated body connections, we plan to review if a second Responsible Officer would be beneficial to the organisation.

We plan to further review options for incentivisation of Medical Appraisers and Auditors with the hope of further appointments, in addition to recruiting to the role of Business Support Officer Lead post.

Review the Medical Appraisal and Revalidation policy.

Re review options for reciprocal peer review. The Medical Directorate Manager is now part of a peer group themselves, so will discuss this with their group to ascertain appetite for an arrangement to be put in place with another organisation from the peer group.

Implement a process for an annual Responsible Officer to Responsible Officer communication.

Due to changes in personnel, meeting arrangements need to be reviewed to ensure that all current diarised meetings can remain quorate.

Implement a 'nil return form' in relation to SUIs, Complaints and Learning from Deaths data.

Re review our governance and performance against 'The Effective Clinical Governance for the Medical Profession document'.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

In conclusion we recognise the enormous amount of work that has been undertaken to date with regards to Medical Appraisal and Revalidation. However, we are aware that further improvements are required.

Focus going forwards will be on the following:

- Completion of all outstanding actions.
- Address identified issues.
- Complete actions for next year.

Section 4 – Statement of Compliance

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body:	Birmingham and Solihull Mental Health NHS Foundation Trust

Name:	Roisin Fallon-Williams
Role:	Chief Executive Officer
Signed:	
Date:	

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**20 November 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework Risks • People Dashboard • People Strategy Update • Health Inequalities Report • Transforming our Culture and Staff Experience Group Assurance Report • Shaping our Future Workforce Committee Assurance Report • Safer Staffing Report • Terms of Reference
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The Committee was alerted to the number of senior staff vacancies (187) which was raised as a key issue. The Committee was assured that this had been placed on the risk register and actions were monitored monthly by the Safer Staffing Committee. • The Committee was concerned that bank usage was not reducing at pace and discussed the balance between continued high bank use against investment in substantive staff over the year. Although there had been a slight reduction in use of bank staff, the Committee required further assurance that the trajectory would continue. • Sickness absence overall had reduced from 6.1% in September to 5.4% in October. The Committee remained concerned about the health and wellbeing of staff as anxiety, stress and depression was reported as the top reason for sickness absence. The Committee received partial assurance on the work being done to address this concern through HR clinics, supportive return to work conversations and access to Occupational Health and psychological support. The Committee would continue to monitor this.
Assure:	Assurance was provided on the delivery and monitoring of the People strategic goals. The terms of reference were approved by the Committee, subject to minor amendments. The Committee received assurance on the positive Health Inequalities work which supported improvement in workforce representation at senior management level.
Advise:	The Committee was encouraged by the significant improvement in agency reduction, and received some assurance on the workforce planning and proactive

	management of nursing agency use, which was not reducing at the same rate as medical agency use. The Committee was advised of the implementation framework for managers to extend the roll out of 'stay' conversations across the Trust. The framework would be implemented by the end of the year and would provide a more structured guidance on how effective conversations should be held as part of the Trust's retention strategy.	
Board Assurance Framework	The Committee had identified the following revised risks: • Inability to attract, retain or transform our workforce in response to the needs of our communities. • Failure to create a positive working culture that is anti-racist and anti-discriminatory. The Committee approved the risks for ratification at Board of Directors in December, and formally approved the old risks for closure and archiving.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**16**					
Date	4 December 2024					
Title	Guardian of Safe Working Hours Q2 2024/25 Report					
Author/Presenter	Hari Shanmugaratnam, Guardian of Safe Working Hours					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**	✓	**Assure**	

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

- No immediate safety concerns were raised during this quarter.
- Exception reporting rates have increased. 32 unique exception reports were raised during this quarter, of which 22/32 related to overtime working.
- 2 fines were levied against the Trust for breaches in safe working hours.
- The number of outstanding reports carried forward has decreased to 4.
- The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (51%). All on call locum vacancies during this period were filled.

Recommendation

The Committee/Board is asked to:

Enclosures

*** Report

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

April – June 2024

High level data

Number of doctors / dentists in training (total): 144

Number of doctors / dentists in training on 2016 TCS (total): 144

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

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

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	5	4	8	1
F2	0	0	0	0
CT1-3	3	23	23	3
ST 3-6	4	5	9	0
GPVTS	0	0	0	0
Total	12	32	40	4

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	3	23	23	3
ST North	0	1	2	0
ST South	1	2	3	0
ST Forensic	2	2	4	0
Total	7	28	32	3

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	2	0	6	1
F2	0	0	0	0
CT1-3	1	2	20	3
ST3-6	0	2	7	0
GPVTS	0	0	0	0
Total	3	4	33	0

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 32 exception reports were raised in total.

Of the 32 exception reports; 2 related to breaches of continuous rest requirements overnight during non-resident on calls and 24 related to working overtime. 2 were related to breaches of natural breaks and 4 were related to educational breaches.

c) Work Schedule Reviews

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

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST3-6	0
GPVTS	0
Total	0

d) Locum bookings and vacancies

Locum bookings JULY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	6	6	45.50	45.50
Rota 2	5	5	45.00	45.00
Rota 3	3	3	36.00	36.00
Rota 4	15	15	144.00	144.00
Rota 5	8	8	74.50	74.50
Rota 6	28	28	255.50	255.50
ST4-6 North & East	29	29	336.50	336.50
ST4-6 Rea/Tam	6	6	112.00	112.00
ST4-6 South & Solihull	18	18	181.00	181.00
Total	118	118	1230.00	1230.00
Locum bookings AUGUST 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	11	11	110.00	110.00
Rota 2	8	8	81.00	81.00
Rota 3	10	10	114.00	114.00
Rota 4	17	17	152.50	152.50
Rota 5	9	9	63.50	63.50
Rota 6	9	9	87.00	87.00
ST4-6 North & East	14	14	131.50	131.50
ST4-6 Rea/Tam	2	2	40.00	40.00
ST4-6 South & Solihull	13	13	147.00	147.00
Total	93	93	926.50	926.50

Locum bookings SEPTEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	2	2	16.50	16.50
Rota 2	0	0	0	0
Rota 3	12	12	130.50	130.50
Rota 4	4	4	40.50	40.50
Rota 5	6	6	57.50	57.50
Rota 6	2	2	17.00	17.00
ST4-6 North & East	7	7	55.00	55.00
ST4-6 Rea/Tam	0	0	0	0
ST4-6 South & Solihull	16	16	155.00	155.00
Total	49	49	472.00	472.00

Locum bookings JULY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	65	65	600.50	600.50
ST4-6	53	53	629.50	629.50
Total	118	118	1230.00	1230.00

Locum bookings AUGUST 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	64	64	608.00	608.00
ST4-6	29	29	318.50	318.50
Total	93	93	926.50	926.50
Locum bookings SEPTEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	26	26	262.00	262.00
ST4-6	23	23	210.00	210.00
Total	49	49	472.00	472.00

Locum bookings JULY 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	77	77	787.50	787.50
Sickness	15	15	160.50	160.50
Off Rota	10	10	105.00	105.00
Emergency Leave / Compassionate	5	5	53.00	53.00
Maternity / Paternity Leave	2	2	25.00	25.00
Exam Leave	0	0	0	0

Acting Up Consultant	9	9	99.00	99.00
Total	118	118	1230.00	1230.00

Locum bookings AUGUST 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	21	21	162.00	162.00
Vacancy	31	31	322.50	322.50
Sickness	15	15	159.00	159.00
Not Contactable	0	0	0	0
Off Rota	23	23	230.50	230.50
Comp Leave	0	0	0	0
Maternity / Paternity Leave	1	1	12.50	12.50
Emergency Leave	0	0	0	0
Acting Up Consultant	2	2	40.00	40.00
Total	93	93	926.50	926.50

Locum bookings SEPTEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Maternity/Paternity	5	5	52.50	52.50
Vacancy	25	25	219.50	219.50
Sickness	7	7	63.00	63.00
Off Rota	9	9	101.00	101.00
Emergency Leave	3	3	36.00	36.00
Total	49	49	472.00	472.00

Fines levied

two fines have been levied in Q2. Ideas for disbursement of previously accrued fines will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has increased, with 32 unique reports submitted during the quarter. Similar to Q1, the majority of exception reports related to overtime (working beyond scheduled hours) or not achieving natural breaks rather breaches of core rest requirements overnight.

The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (51%). All on call locum vacancies during this period were filled.

Liaison Psychiatry at the Queen Elizabeth Hospital

The Guardian of Safe Working, Dr Hari Shanmugaratnam, has been made aware of the

issues as part of the handover from the previous Guardian of Safe Working. It has been agreed that Dr Shanmugaratnam and Dr Krishnamurthy will meet again to discuss the issue further.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. Exception reporting rates have increased. 32 unique exception reports were raised during this quarter, of which 83% related to overtime working.

Two fines were levied against the Trust for breaches in safe working hours, the first quarter this has happened since Q3 of 2022-23.

Out of the reports closed, only 7.5% were within 48 hours and 17.5% were within 7 days. This is in part due to several historical reports which had not been dealt with have finally been closed. Also there was issues relating to a supervisor who works in FTB being able to get access to the BSMHFT allocate system which related to 37.5% of the reports which were closed.

The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (51%). All on call locum vacancies during this period were filled.

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

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	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**21 November 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Cyber Assurance Framework • Finance Report • Winter Planning Report • Trust Strategy Updates: Sustainability and Clinical Services • Significant Transactions Policy
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Group position at Month 7 was a reported £624k surplus. This was mostly driven by expenditure on non-Trust beds and slippage on savings delivery. This was partly offset by agency reduction ahead of plan and a favourable interest receivable position. The Committee received assurance that the Trust was on target to deliver the planned surplus by year-end. • Out of area spend remained a key concern. • The Committee raised concern in relation to bank spend and vacancy rates, particularly as the Trust takes on additional services in the future and the potential impact this would have. • The Committee was not assured as to how the Trust would achieve the expected recurrent cost savings and financial sustainability for 2025/26 and beyond. • The Committee discussed financial recovery plans which the Trust was reviewing as part of the systemwide approach.
Assure:	The Committee approved the Significant Transactions Policy. The Committee was assured by clear performance metrics outlined in the winter planning report. The new Cyber Assurance Framework was received, and the Committee noted the key requirements and standards that would need to be met. The

	Committee took assurance from the action plan in place to achieve the standards.	
Advise:	The Sustainability Strategy update highlighted some issues that would be referred to Commissioning Committee, including increased grip and control as the MHPC strategy and Board Assurance Framework were developed. The Committee received some assurance in relation to the Clinically Ready for Discharge pathway and improvements in patient flow.	
Board Assurance Framework	The Committee was assured by the revised Board Assurance Framework and discussed the draft detail of the three new risks: • Failure to maintain a long-term, 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 reviewed and was recommended to Board of Directors for approval in December.	
	New risks identified: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**23 October 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 • Winter Planning Report • Business Development and Partnerships Report • Cyber and Digital Assurance Report • Committee Terms of Reference
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Group position at Month 6 was a reported £62k deficit. This was mostly driven by continued significant out of area expenditure and slippage on savings delivery. The Committee received assurance that the Trust was on target to deliver the planned surplus by year-end. • Currently the cash position was a reported £98m, however the forecasted position reported a reduction in cash balance to under £10m by the end of the financial year.
Assure:	The Committee was assured by the recent Business Development and Partnerships Report, noting the number of tenders in progress. It was acknowledged that the refreshed Trust strategy would support clarity on the purpose of future tenders. The Committee approved the terms of reference.
Advise:	The Committee received a presentation on the system-wide financial recovery plan, which detailed the scale of the mental health services opportunity within Birmingham and Solihull. The Committee acknowledged the positive way forward and was encouraged by continued integrated partnership working. Further updates would be received. The Committee received a detailed report on the collaborative winter plan, noting the key points in relation to community and crisis, inpatients and discharge, and mental health patients in emergency department settings.

	The Committee was assured by the key milestones and actions and would receive further updates to monitor progress.	
Board Assurance Framework	The Committee was assured by the revised Board Assurance Framework and discussed the draft detail of the three new risks: • 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 reviewed and would be continued to be refined for approval in November, ahead of approval by the Board of Directors in December.	
	New risks identified: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Report to Board of Directors							
Agenda item:	**18**						
Date	4 December 2024						
Title	Finance Report Month 7						
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy Director of Finance Dave Tomlinson, Executive Director of Finance						
Executive Director	Dave 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					
Alert	✓	**Advise**	✓	**Assure**	

Revenue position:

The month 7 consolidated Group position is a surplus of 624k. This is £857k adverse to plan, mainly driven by expenditure on non-Trust beds 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 non-Trust bed run rate and utilisation of remaining balance sheet flexibility.

Alert:

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

- **Non-Trust Beds overspend** – The 2024/25 non Trust beds expenditure plan is £14m. Year to date expenditure at month 7 was £13m. The current full year forecast is £23m (£9m overspend).

- **Savings** – The 2024/25 savings target is £17.8m. The month 7 savings achieved is £8.7m year to date, this is a slippage of £0.8m. It is currently forecast that the full target will be achieved, with £7.7m being via non recurrent savings. All corporate and operational areas have been asked to identify 2% savings plans for 2025/26. Out of a total of £6m plans identified to date, 64% are recurrent and cash releasing.

- **Trust cash position** – The group cash position is healthy at £99m, however, the cash flow forecast for the Trust based on a series of assumptions, indicates that Trust cash could reduce to below £10m by the end of the financial year.

Advise:

- **Temporary staffing** – The 2024/25 temporary staffing plan is £41.5m. Temporary staffing is £2.5m underspent at month 7 year to date, driven by agency reduction ahead of plan.

- **2024/25 Pay award** – The consolidated pay award uplifts for all staff groups, except resident doctors were paid in month 7. The additional income and offsetting expenditure budget relating to the 2024/25 pay award has been recognised in month 7 in line with NHSE guidance.

- **Financial Recovery** – The BSOL Financial Recovery Board has determined a series of actions for all system partners, to help address the BSOL system financial position (£77m deficit at month 7). Those partners with a deficit forecast have been required to produce a financial recovery plan. In October 2024, NHSE have produced a document to share key learnings and guidance from their Intervention and Investigation work.

Capital position:

The month 7 Group capital expenditure is £4.2m year to date, this is £0.1m behind plan.

Cash position:

The Group cash position at the end of month 7 was £99m, with £26m relating to the Trust.

Recommendation

The Board is asked to receive the report for information.

Enclosures

Month 7 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.**

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2024 to 31st October 2024

Month 7
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Revised Plan	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	661,355	383,791	381,296	(2,495)
Other Income	21,117	12,318	16,040	3,721
Total Income	**682,472**	**396,109**	**397,336**	**1,226**
Expenditure				
Pay	(300,247)	(174,861)	(170,556)	4,305
Other Non Pay Expenditure	(341,092)	(196,965)	(204,957)	(7,993)
Drugs	(7,150)	(4,171)	(4,523)	(352)
Clinical Supplies	(539)	(314)	(373)	(58)
PFI	(14,388)	(8,393)	(8,500)	(107)
EBITDA	**19,056**	**11,405**	**8,427**	**(2,978)**
Capital Financing				
Depreciation	(9,765)	(5,696)	(5,605)	91
PDC Dividend	(16)	(10)	(10)	-
Finance Lease	(8,479)	(6,713)	(6,753)	(39)
Loan Interest Payable	(972)	(567)	(580)	(13)
Loan Interest Receivable	1,899	1,108	3,148	2,040
Surplus / (Deficit) before taxation	**1,722**	**(474)**	**(1,373)**	**(899)**
Taxation	(380)	(222)	(177)	44
Surplus / (Deficit)	**1,342**	**(695)**	**(1,550)**	**(855)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	3	3	-
Adjust PFI revenue costs to UK GAAP basis	722	2,173	2,171	(2)
Adjusted financial performance Surplus / (Deficit)	**2,069**	**1,480**	**624**	**(857)**

Month 7 2024/25 Group Financial Position

The month 7 consolidated Group position is a surplus of £624k. This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£2.2m year to date).

The month 7 outturn is £857k adverse to the year to date plan. This is mainly driven by significant expenditure on non-Trust beds 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 non-Trust bed run rate and utilisation of balance sheet flexibility.

The additional income and offsetting expenditure budget relating to the 2024/25 pay award has been recognised in month 7 in line with guidance from NHSE.

The Group month 7 position is mainly driven by a surplus of £489k in the Trust, £238k surplus for Summerhill Services Limited (SSL), a break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £148k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Birmingham and Solihull ICS position

The draft month 7 BSOL system position is a deficit of £77m which is £59m adverse to plan. This is mainly driven by £76m deficit for UHB, £5m deficit for BWCH and £5m surplus for BSOL ICB.

Month 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	217,550	-	95,456	253,391	(185,101)	381,296
Other Income	15,901	16,790	-	-	(16,651)	16,040
Total Income	**233,451**	**16,790**	**95,456**	**253,391**	**(201,752)**	**397,336**
Expenditure						
Pay	(160,700)	(7,320)	(1,115)	(1,586)	164	(170,556)
Other Non Pay Expenditure	(52,333)	(4,780)	(95,152)	(252,640)	199,947	(204,957)
Drugs	(4,726)	(1,211)	-	-	1,414	(4,523)
Clinical Supplies	(373)	-	-	-	-	(373)
PFI	(8,500)	-	-	-	-	(8,500)
EBITDA	**6,820**	**3,480**	**(810)**	**(835)**	**(227)**	**8,427**
Capital Financing						
Depreciation	(3,717)	(1,657)	-	-	(231)	(5,605)
PDC Dividend	(10)	-	-	-	-	(10)
Finance Lease	(6,737)	(223)	-	-	207	(6,753)
Loan Interest Payable	(580)	(1,184)	-	-	1,184	(580)
Loan Interest Receivable	2,539	0	958	835	(1,184)	3,148
Surplus / (Deficit) before Taxation	**(1,685)**	**415**	**148**	**(0)**	**(250)**	**(1,373)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(177)	-	-	-	(177)
Surplus / (Deficit)	**(1,685)**	**238**	**148**	**(0)**	**(250)**	**(1,550)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	3	-	-	-	-	3
Adjust PFI revenue costs to UK GAAP basis	2,171					2,171
Adjusted financial performance Surplus / (Deficit)	**489**	**238**	**148**	**(0)**	**(250)**	**624**

Commissioning overview

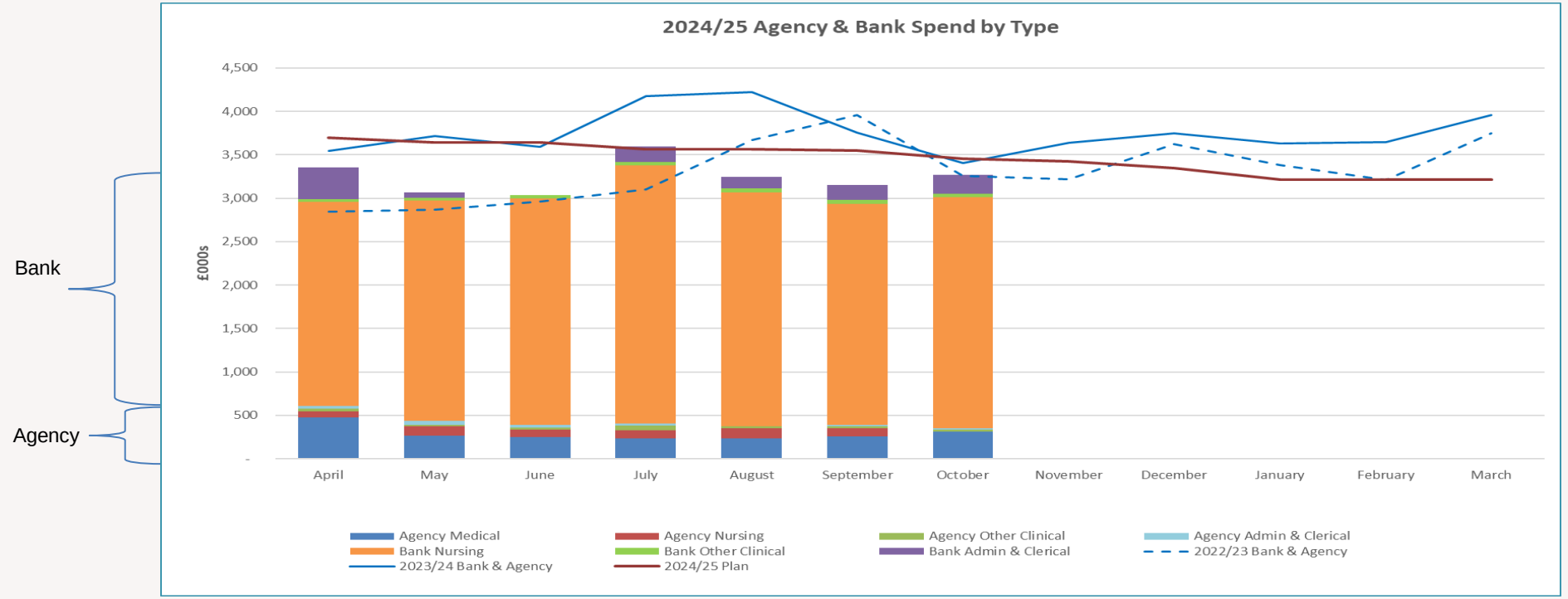
Mental Health Provider Collaborative (MHPC)

- 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 £442m (adjusted for pay award funding from month 7).
- Month 7 position break even
- Month 7 cash balance £26m.
- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

Reach Out

- £165m annual income in current plan (adjusted for pay award funding from month 7).
- Month 7 position £148k surplus – in line with agreed contribution to Trust overheads.
- Month 7 cash balance £42m.
- Key risks:
- Clinical concerns around expected growth in out of area numbers and EPC costs.

Temporary staffing expenditure

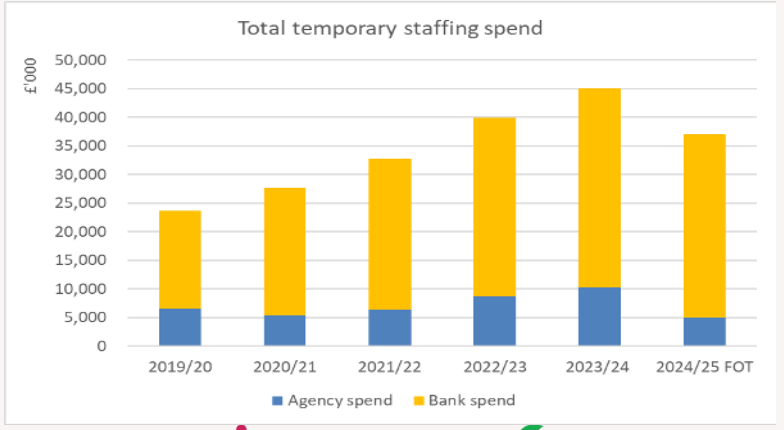


Month 7 temporary staffing expenditure is £22.6m, this is £2.5m less than plan.

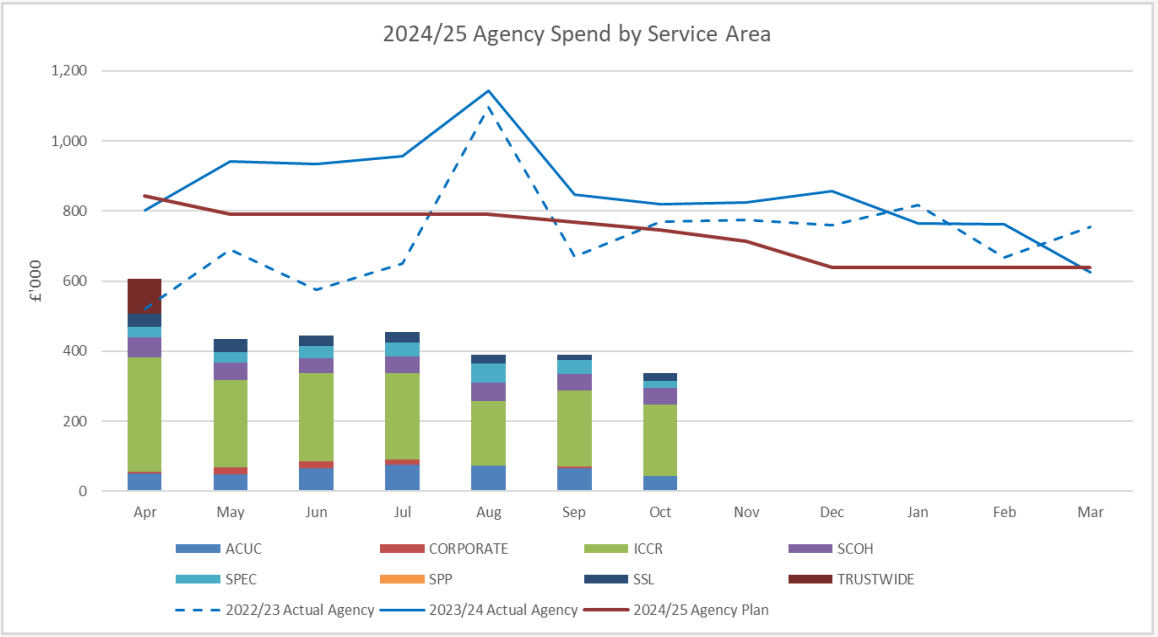
Bank expenditure £19.7m (87%) – the majority of bank expenditure relates to nursing bank shifts - £18.3m

Agency expenditure £2.9m (13%) – the majority of agency expenditure relates to medical agency - £2m.

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



Agency expenditure



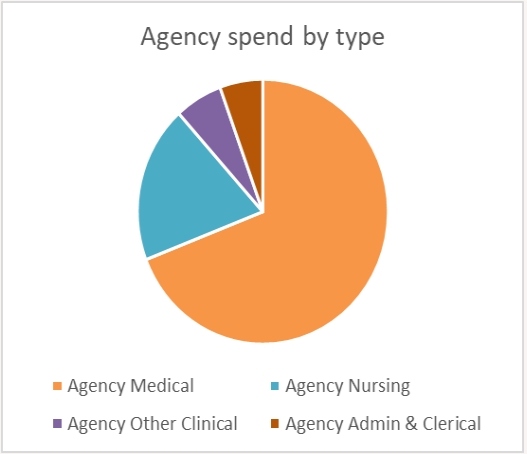
KPIs	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Agency spend as % of pay bill (YTD)	3.2%	2.2%	2.0%	1.9%	1.9%	1.8%	1.7%
Above price cap bookings - medical	0	14	14	12	11	9	9
Above price cap bookings -nursing	0	5	5	7	7	7	5
Admin & Estates bookings - Trust	0	1	0	0	0	0	0
Admin & Estates bookings - SSL	0	6	6	6	5	4	4

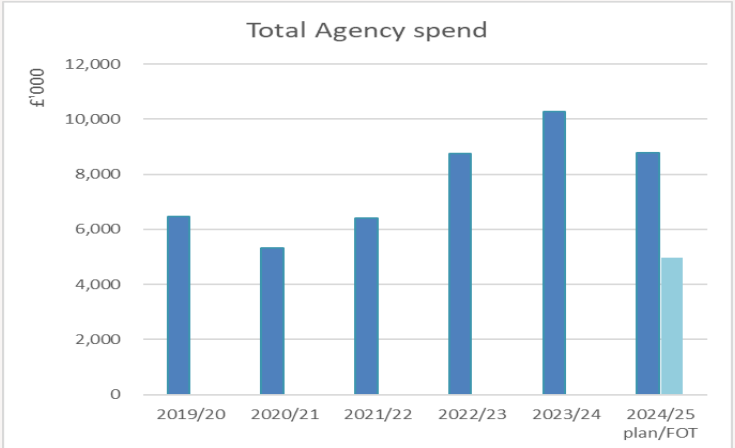
Agency expenditure

- The month 7 year to date agency expenditure is £2.9m. This is an underspend of £2.6m.
- Year to date agency expenditure is 1.7% of the total pay bill which is £2.5m below the NHSE threshold (3.2% of pay bill).
- The full year forecast spend is £5m which is £3.8m less than plan and £5.2m less than last year.

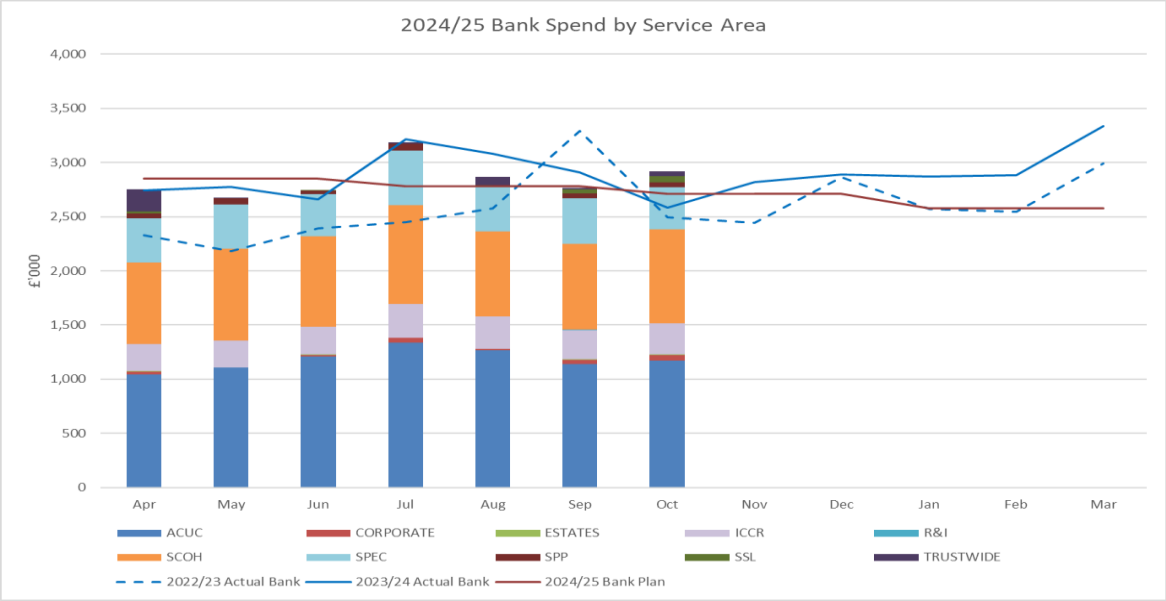
	2024/25 YTD
	£'000
Agency Expenditure	2,940
NHSE Ceiling	5,458
Variance to NHSE ceiling	2,518

		% of total sub category pay
Agency Medical	2,032	8.37%
Agency Nursing (Registered)	560	1.38%
Agency Nursing HCA	6	0.03%
Agency Other Clinical	181	0.62%
Agency Admin & Clerical	163	0.44%
Agency Expenditure	2,940	





Bank expenditure analysis

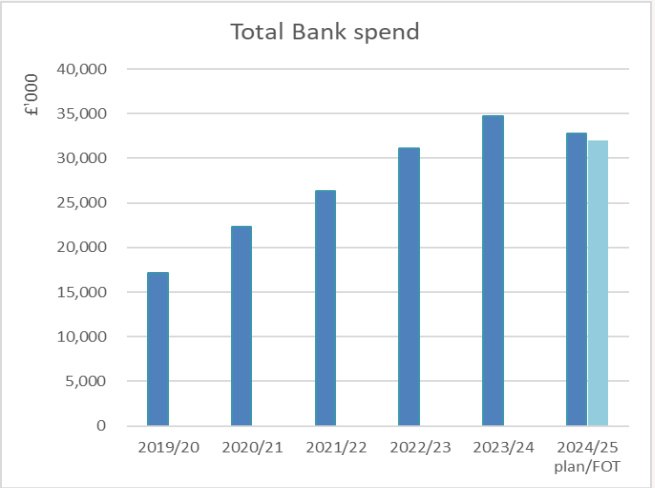


Type	YTD £'000	% of spend
Bank Nursing	18,374	93.4%
Bank Other Clinical	259	1.3%
Bank Admin & Clerical	1,048	5.3%
Grand Total	**19,681**	**100%**

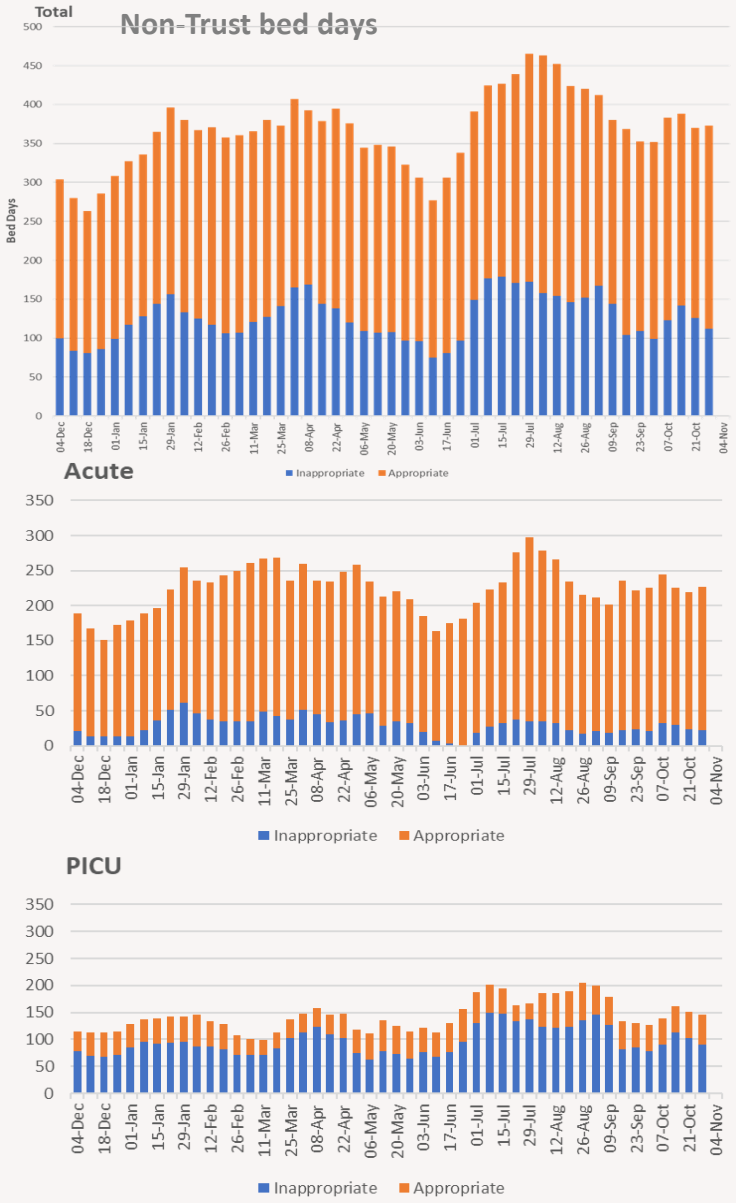
Operational service areas	YTD Bank spend £'000	Bank as % of service area pay
Acute & Urgent Care	8,277	26%
Secure & Offender Health	5,786	19%
Specialties	2,933	28%
ICCR	1,914	5%

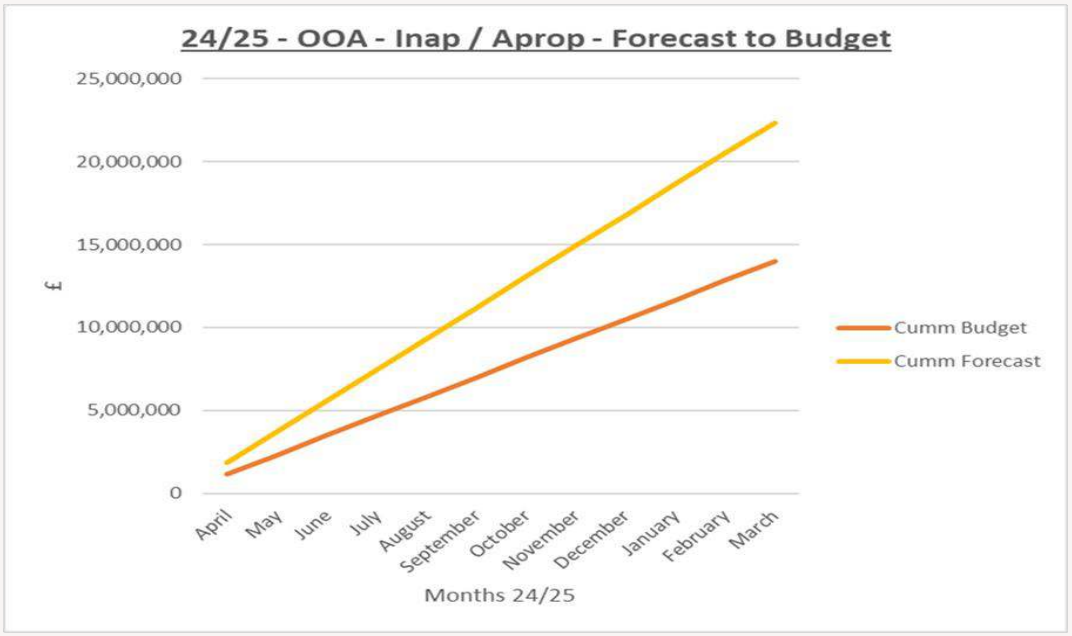
Bank expenditure

- The month 7 year to date bank expenditure is £19.7m. This is £80k less than plan and £289k less than at month 7 2023/24.
- Bank expenditure in October is £151k more than in September, the increase is attributable to the impact of the pay award which is being paid from month 7 onwards for bank staff.
- Total year to date bank spend is 11.5% of total pay (plan is 11.3%).
- Over a quarter of the total pay spend in both the Specialties and Acute and Urgent Care service areas relates to bank.



Non-Trust Beds overspend





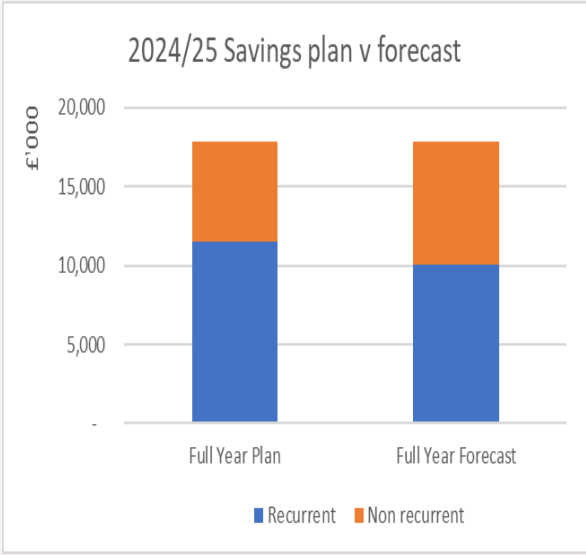
- The total 2024/25 plan for non-Trust bed expenditure is £14m.
- Month 7 year to date expenditure is £12.9m which is £4.7m adverse to plan.
- There has been a 3% increase in non-Trust bed days usage in October compared to September.
- The current full year forecast is £23m (£9m overspend), this is a total deterioration in forecast of £1m compared to last month.
- BSMHFT will be the named commissioner for the new inpatient bed contract, soon to go out to tender – this approach has been endorsed by BSMHFT Commissioning Committee.

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent						
Pay - Recurrent	1,144	3,791	2,647	3,489	7,057	3,568
Non-pay - Recurrent	4,674	1,383	(3,291)	8,013	3,013	(5,000)
Income - Recurrent	-	-	-	-	-	-
Total recurrent efficiencies	5,818	5,174	(644)	11,502	10,070	(1,432)
Non recurrent						
Pay - Non-recurrent	242	242	-	416	416	-
Non-pay - Non-recurrent	1,261	233	(1,028)	2,162	2,261	99
Income - Non-recurrent	2,178	3,094	916	3,735	5,068	1,333
Total non-recurrent efficiencies	3,681	3,569	(112)	6,313	7,745	1,432
Total Efficiencies	**9,499**	**8,743**	**(756)**	**17,815**	**17,815**	-

Savings 2024/25	Plan £'000	Forecast £'000
Recurrent/Non-recurrent		
Recurrent	11.5	10.1
Non-recurrent	6.3	7.7
Total	17.8	17.8
Developed Status		
Fully Developed	8.9	15.3
Plans in Progress	5.0	0.0
Opportunity	2.1	0.6
Unidentified	1.8	1.9
Total	17.8	17.8
Risk Status		
High Risk	8.9	2.5
Medium Risk	0.0	1.5
Low Risk	8.9	13.8
Total	17.8	17.8

- The 2024/25 efficiency target is £17.8m. This comprises £11.5m recurrent and £6.3m non recurrent targets.
- As at month 7, the savings achieved is £8.7m, this is £0.8m less than plan. The majority of the slippage relates to the out of area savings target and the unidentified savings target. This is partly offset by agency reduction delivering ahead of plan and non recurrent balance sheet flexibility release.
- The current forecast is that the full savings target will be achieved, with a £1.4m shortfall against the recurrent target being offset with £1.4m additional non recurrent savings.
- The total non recurrent forecast achievement is £7.7m. This will roll forward as a savings target for 2025/26. For further detail on 2025/26 savings progress, please see next page.



2025/26 Savings

- In May 2024, the Executive Team agreed that all corporate and operational areas should develop 2% savings plans in preparation for 2025/26. The plans should be recurrent and cash releasing. The total savings requirement for 2025/26 is not yet known but is expected to be circa £20m.
- The 2% savings target of £5.9m has been calculated based on 2025/26 start point budgets, adjusted for ring-fenced budgets that cannot be reduced, such as PFI.
- Plans totalling £6m have been identified to date, with 64% being recurrent and cash releasing.
- The savings plans returned to date are in the CQEIA assessment phase. It has been requested that all CQEIAs be completed by 20.11.24, with a final position and review of completed CQEIAs to be determined at Sustainability Board on 28.11.24. For the detail of savings plans identified by service area, see Appendix C.

	2% savings target	Total plans identified	Cash releasing savings plans	
	£	£	Recurrent £	Non recurrent £
Specialties	990,253	934,051	739,051	70,000
ICCR	1,359,960	1,502,582	1,082,582	210,000
ACUC	1,086,126	1,190,000	1,190,000	0
SCOH	1,290,192	1,910,000	200,000	0
Operational total	**4,726,531**	**5,536,633**	**3,211,633**	**280,000**
Chief Executive	32,522	0	0	0
Medical	201,426	0	0	0
Resources	288,109	525,855	477,435	0
Nursing & Quality	203,478	0	0	0
Strategy, People & Partnerships	161,162	102,000	0	0
Research & Innovation	12,965	0	0	0
Estates	176,296	0	0	0
Corporate total	**1,075,957**	**627,855**	**477,435**	**-**
Total	**5,802,488**	**6,164,488**	**3,689,068**	**280,000**

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-24 £m's	NHSI Plan YTD 31-Oct-24 £m's	Actual YTD 31-Oct-24 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	218.0	216.5	217.8
Prepayments PFI	1.2	1.2	2.0	1.2
Finance Lease Receivable	0.0	-	(0.0)	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	219.2	218.5	219.0
Current assets				
Inventories	0.4	0.4	0.4	0.4
Trade and Other Receivables	21.4	21.4	31.0	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.6	98.8	93.1
Total Curent Assets	114.0	113.4	130.2	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(81.0)	(80.0)
Tax payable	(5.8)	(5.8)	(7.7)	(5.8)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.1)	(1.1)	(1.1)	(1.1)
Provisions	(1.3)	(1.3)	(1.2)	(1.3)
Deferred income	(45.2)	(45.2)	(58.7)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(152.2)	(136.0)
Non-current liabilities				
Deferred Tax Liability	(0.1)	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(23.0)	(22.2)	(21.2)	(20.8)
PFI lease	(78.3)	(81.9)	(80.4)	(78.8)
Finance Lease, non current	(6.8)	(4.5)	(4.3)	(5.8)
Provisions	(3.0)	(3.0)	(2.7)	(3.0)
Total non-current liabilities	(111.2)	(111.8)	(108.6)	(108.5)
Total assets employed	88.6	84.8	87.8	89.4
Financed by (taxpayers' equity)				
Public Dividend Capital	114.7	115.1	115.8	115.1
Revaluation reserve	48.0	48.0	48.0	48.0
Income and expenditure reserve	(74.1)	(78.3)	(76.0)	(73.7)
Total taxpayers' equity	88.6	84.8	87.8	89.4

SOFP Highlights

The Group cash position at the end of October 2024 is £98.8m.

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

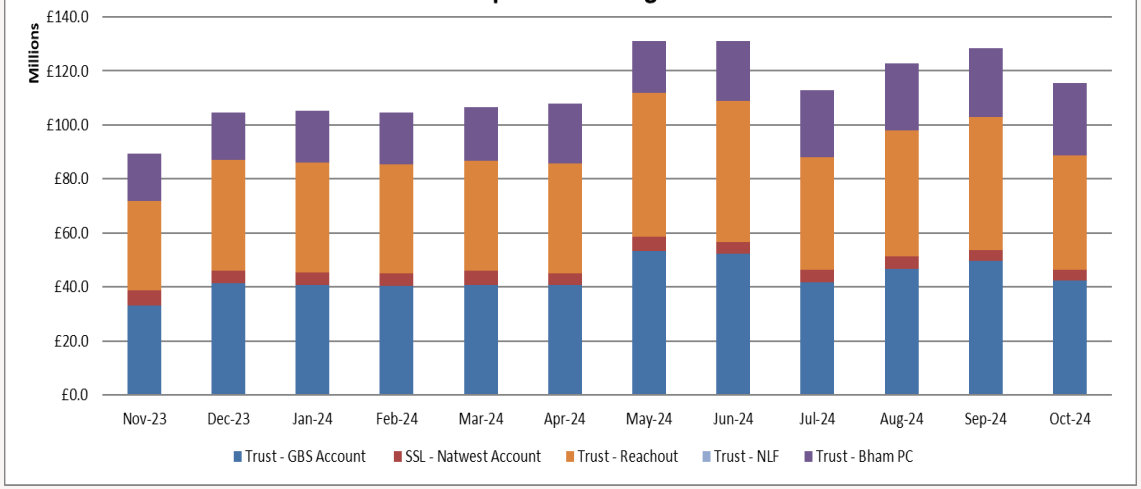
Ratios

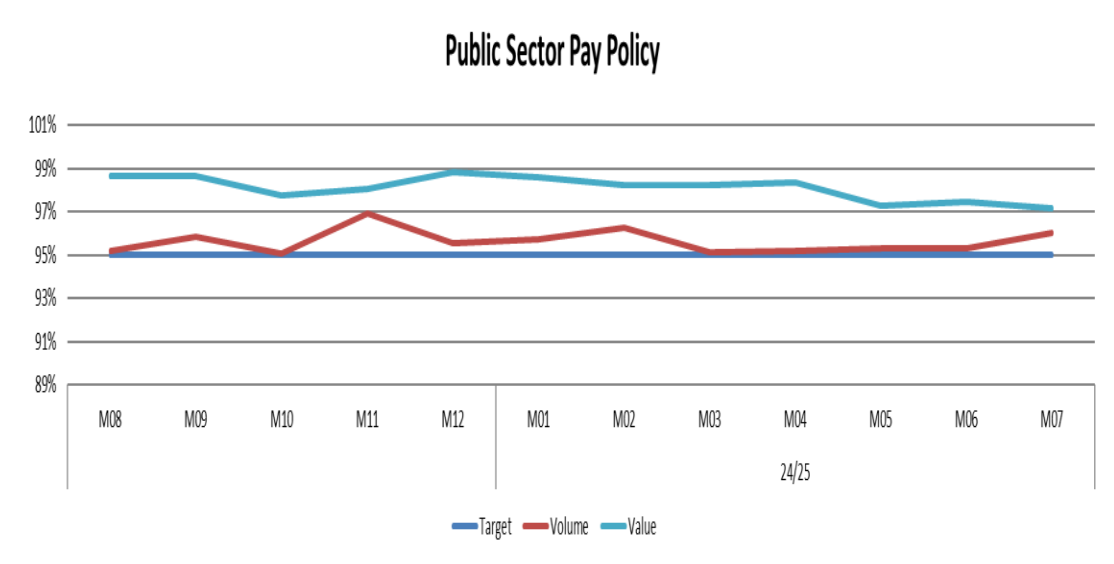
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	£m's
Current Assets	130.2
Current Liabilities	-152.2
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 October 2024 is £98.8m. This comprises of Trust £26m, SSL £4m, Reach Out Provider Collaborative £42.4m and Mental Health Provider Collaborative £26.4m.

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.

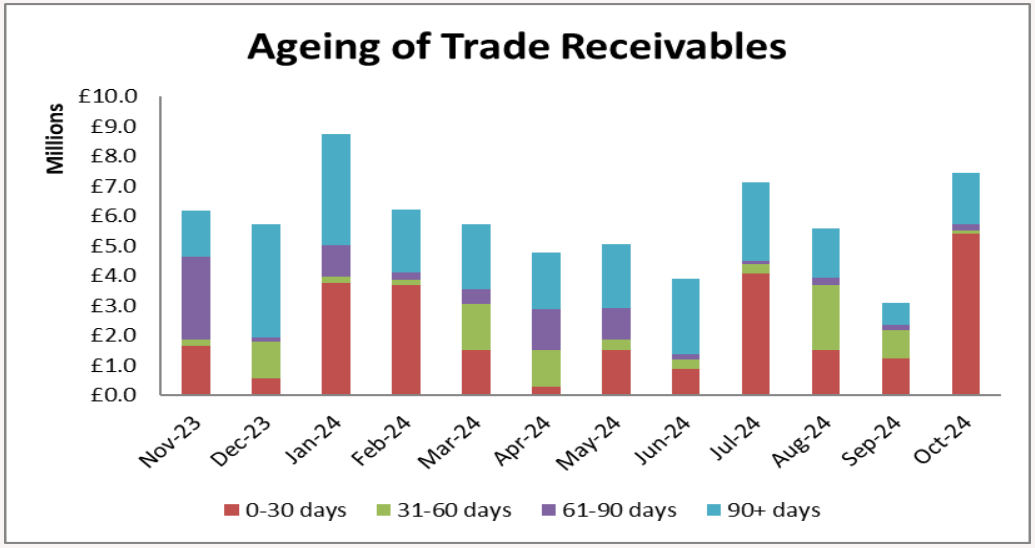
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

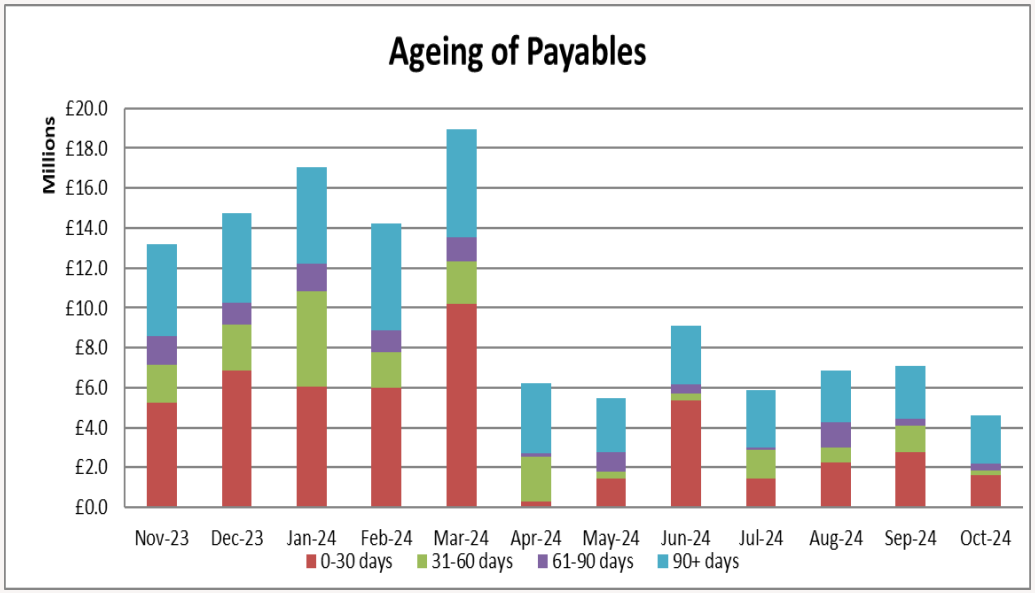
This performance was consistent throughout 2023/24 and the aim is to maintain this during 2024/25.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables :

- **0-30 days-** Overall Balance £5.4m, significant increase due to catch up of monthly & quarterly invoices. *Awaiting authorisation:* BWC £1m, SWBH £559K , Midlands PT £2.9m.
- **31-60 days-** Overall Balance £121k, decrease in balance mainly due to debt of £759k moving up to 90+ days. *Awaiting authorisation:* approx. 10 account balances. *In query*: various small values. Remaining balance mainly relates to staff overpayments (on payment plans).
- **61-90 days-**Overall Balance £188k, slight increase in balance. *Awaiting authorisation:* £163k paid in Nov 24. *In query*: various small balances. Remaining balance mainly relates to staff overpayments (on payment plans).
- **Over 90+ days-**Overall Balance £1.7m, significant Increase**.** *Awaiting authorisation: UHB £309k overall account escalated to management,* BWCH £95k, BCHC £25k. *In query:* SWFT £759k, UOB £79k, Access to Work £18k, Parexel £47k, Kings College £42k, Ethypharm £87k, Glouc HC Trust £121k, various other small balances. Remaining balance mainly relates to staff overpayments (on payment plans).

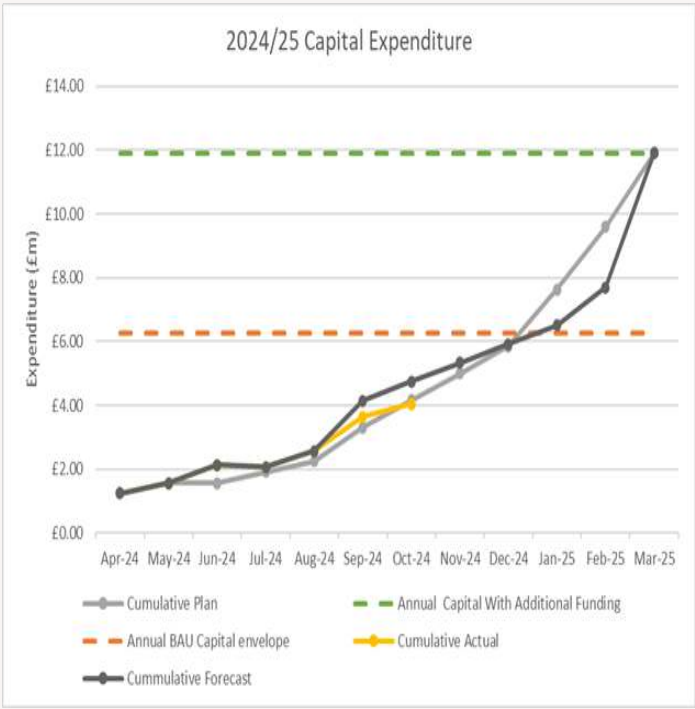
Trade Payables:

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** £1m: NHS Property £147k-historic invoices with Estates & Facilities, UHB £617k in query with the contracting team, SWBH-£110k awaiting approval.
- **Non-NHS Suppliers** (63+) £1.4m: 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 November 2024.

Month 7 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	1.1	2.1	-1.0
Stautory Standards & Backlog Maintenance	2.0	2.0	0.0	0.8	0.5	0.4
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	0.2	0.0	0.2
Doorsets	0.7	0.7	0.0	0.5	0.4	0.1
Total BAU Capital Plan	**6.3**	**6.3**	**0.0**	**2.7**	**3.0**	**-0.3**
R&D Medical Equipment - grant funded	**0.7**	**0.7**	**0.0**	**0.4**	**0.0**	**0.4**
Acute & Urgent Care - UEC capacity PDC funded	**0.8**	**0.8**	**0.0**	**0.2**	**0.0**	**0.2**
Total lease expenditure	**2.6**	**2.3**	**-0.3**	**0.3**	**1.0**	**-0.7**
Minor Works - £1.6m notional system allocation - TBC	*1.6*	*1.8*	*0.2*	0.5	*0.0*	*0.5*
Gross Capital Expenditure (excluding lease remeasurements)	**11.9**	**11.8**	**-0.1**	**4.15**	**4.02**	**0.13**



Group Capital Expenditure

Month 7 year to date Group capital expenditure is 4m, this is £0.1m behind the capital plan re-submission on 12.6.24. The capital plan of £11.9m included £1.6m related to a notional share of additional system capital allocation. The BSOL System Investment Committee has agreed priorities for utilisation of the system 2024/25 capital bonus of £17.3m. This includes £1.8m for planning works for the Highcroft development. Discussions are ongoing to determine what can be incurred this financial year.

Additional 2024/25 national capital allocations were released by NHSE to address capital infrastructure risk. BSMHFT bids totalling £650k have been successful.

Report to Board of Directors

Agenda item:	19						
Date	4 December 2024						
Title	Trust Strategy Mid-Year Update 2024/25						
Author/Presenter	Abi Broderick, Head of Strategy, Planning and Business Development Louise Butler, Strategy and Business Development Manager						
Executive Director	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships	**Approved**	**Y**	✓	**N**		

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

Summary of Report

Alert		**Advise**		**Assure**	✓

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

Each year we agree goals for each strategic priority. The goals for 2024/25 were developed through engagement with teams, service leads and experts by experience and this included reviewing the previous year's goals, any internal or external changes that might impact plans and any new drivers we need to respond to. We also engaged the four professional committees around the draft goals. The goals were approved by Committees and Board in May and June and are reported on quarterly to Committees and bi-annually to Board.

For 2023/24, across our four strategic priorities we had 35 goals in total at the end of Quarter 2. The report contains narrative about our achievement against the milestone plans for each of these goals, including a rating of red, amber or green which reflects the status of the goal against the set milestones and indicates if it is where we expected it to be at the mid-year point.

The purpose of this report is to:

Part A – Provide an update on the goals at the end of Quarter 2 of 2024/25 for assurance about how we are delivering the strategy.

Part B – Provide an update on our plans for refreshing the Trust Strategy ready for launch by April 2026.

Detailed reports relating to each strategic priority were taken to the relevant Board sub-committees on 20/21 November as follows:

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

Recommendation

The Board is asked to note the strategy update, gain assurance from the good progress made, and note the high-level plan for the refresh of the Trust strategy.

Enclosures

Strategy Update 2024/25

Our Trust Five Year Strategy

2024/25 Goals – mid-year update

Trust Board
4 December 2024

compassionate inclusive committed

1. Purpose of this report

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Each year we agree goals for each strategic priority. The goals for 2024/25 were developed through engagement with teams, service leads and experts by experience and this included reviewing the previous year's goals, any internal or external changes that might impact plans and any new drivers we need to respond to. We also engaged the four professional committees around the draft goals. The goals were approved by Committees and Board in May and June and are reported quarterly to Committees and bi-annually to Board.

As we are now in year four of the five year strategy, we are also now developing our plans for refreshing the strategy during 2025 and early 2026. This will include a comprehensive context analysis, including a baseline assessment, as well as widespread engagement.

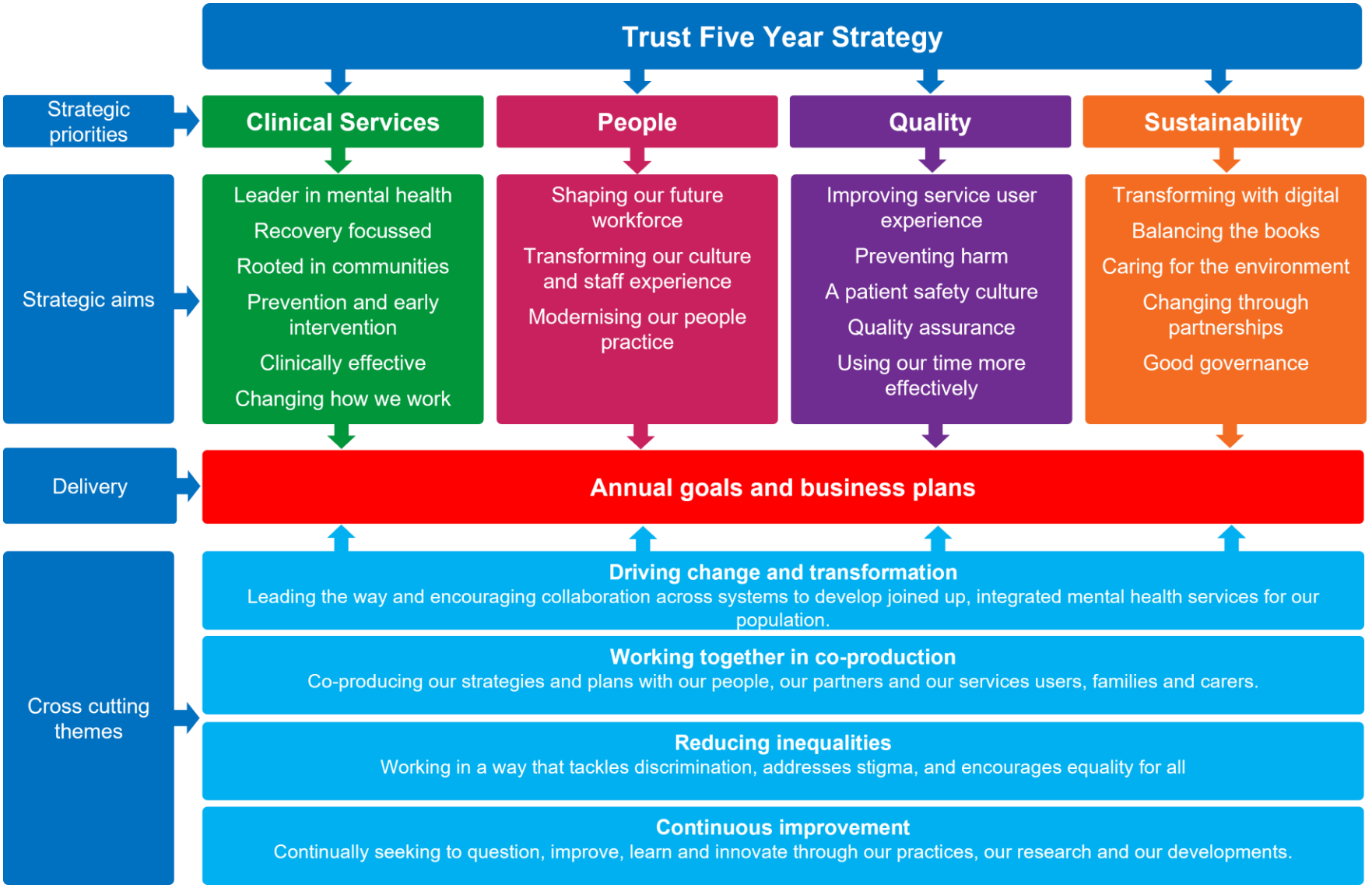
The purpose of this report is to:
Part A: Provide an update on 2023/24 goals as at the end of Quarter 2 for assurance about how we are delivering the strategy.
Part B: Provide an update on our plans for refreshing the Trust Strategy ready for launch by April 2026.

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

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

2. Our Trust Strategy

Birmingham and Solihull Mental Health NHS Foundation Trust



compassionate inclusive committed

Part A:
2024/25 mid-year review

3. 2024/25 goals at a glance

*** Addressing inequalities is woven throughout our strategic goals for 2024/25***

Clinical Services (14 overarching goals)

Recovery focussed
- Support to ensure involvement of families and carers
- Consistent approach to developing peer support roles

Rooted in communities
- Community transformation programme year 4
- Access to beds and eliminating out of area placements
- Targeted work in divisions to reduce inequalities
- Access to joined up place-based health and care
- 24/7 neighbourhood mental health service pilot *[ADDED Q2]*

Prevention and early intervention
- Transform urgent care pathways
- Transforming and improving children and young people's services
- Service/pathway development to meet agreed trajectories
- Specialist pathways to better meet needs of specific groups

Clinically effective
- Co-produced and personalised care plans to improve outcomes
- Better support for learning disability and autism
- Equip all staff with knowledge of trauma informed approaches

***NB: Leader in mental health** and **Changing how we work** are enablers that run across the other strategic aims.*

People (8 overarching goals)

Shaping our future workforce
- Reduce vacancy and turnover rates
- Reduce bank usage and agency spend
- Increase fundamental training compliance

Transforming our culture and staff experience
- Reduce sickness levels
- Increase number of staff who would recommend the Trust
- Maintain staff engagement scores using relevant digital solutions
- Reduce disproportionality of racialised groups in people processes

Modernising our people practice
- Work with finance and ESR team to improve data quality and reduce response times to common casework

Quality (6 overarching goals)

Improving service user experience
- All QI projects and programmes to be co-produced with EBEs

Preventing harm
- Assurance of safeguarding practice and Think Family approach

Patient safety culture
- Use a variety of channels to identify and share learning Trust-wide
- Access to high quality supervision for all clinical staff

Quality assurance
- Effective use of data to identify gaps and improve quality

Using our time more effectively
- Implement our Quality Improvement Strategy

Sustainability (8 overarching goals)

Transforming with digital
- Operationalise the digital strategy and improvement plan
- Improve information and insights through business intelligence

Caring for the environment
- Refresh strategy to ensure estates and facilities are fit for the future.

Changing through partnerships
- Ensuring the right partnerships to improve access, experience and outcomes and address inequalities.
- Children and young people's services transfer *[ADDED FROM Q3]*

Balancing the books
- Confirm ambition and timescale to achieve recurrent financial balance with identified cost savings.

Good governance
- Ensure Trust processes and systems are IG compliant
- Establish and implement performance accountability process

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4. Trust goals: an overview at end of Q2

Birmingham and Solihull Mental Health NHS Foundation Trust

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

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

There were **35 Trust goals in total** at the end of Q2, which is year 4 of our strategy. A summary of the overall status at the end of Quarter 1 and Quarter 2 is shown below. It is encouraging that **92% of goals were rated 'Green' or 'Amber'** at the end of Q2, which means they are where we expected them to be in relation to their milestone plans or have moderate issues impacting delivery that are being addressed to bring them on track.

Strategic aim	Red		Amber		Green	
	Q1	**Q2**	Q1	**Q2**	Q1	**Q2**
Clinical Services (14 goals)	0	1	3	5	10	8
People (8 goals)	0	1	0	1	8	6
Quality (6 goals)	1	1	1	2	4	3
Sustainability (7 goals)	0	0	2	1	5	6
Total	1	**3**	6	**9**	27	**23**
	3%	**8%**	18%	**26%**	79%	**66%**

See some examples of key achievements and impact of our goals throughout this report

5. Overview at end of Q2 (continued)

Birmingham and Solihull Mental Health NHS Foundation Trust

⚠ Red goals ⚠

Three goals were rated 'Red' (8%) at the end of quarter 2 which means they are not where we wanted them to be in relation to their milestone plans. These are shown below:

Strategic priority	Goal	vs Q1 rating
Clinical services	*Implement plans to ensure timely and appropriate access to inpatient beds within Birmingham and Solihull and eliminate inappropriate out of area (OOA) placements,* which was due to the number of inappropriate out of area placements being above trajectory and forecasted costs remaining above target.	↓
People	*Aim to increase our fundamental training average compliance by 3%*, where the anticipated 1% increase from Q1 was not achieved due to a drop in compliance linked to grace periods ending, reduced capacity in the AVERTS team and high DNA rates and an influx of new starters who require face to face training.	↓
Quality	*Ensure effective use of data to identify gaps and improve quality,* where work on the development of a quality dashboard has not yet commenced due to competing priorities and portfolio expansion for the lead due to current workforce vacancies.	↔

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

6. Strategic priority: Clinical services

✓ Progress update

🔍 Focus areas for Q3

Rooted in communities

Goal: Continue to progress year 4 of the transformation of community services across all geographical areas within the BSOL footprint.

✓
- Single MDT triage trial commenced.
- Review of NMHT demand and capacity completed.
- Benefits from Solihull pilot of NMHT and CMHT closer working being considered for wider roll out.
- Work on caseloads, step down and booking system part of Longbridge pilot.
- Offer regarding ARRs roles agreed.

🔍
- Single MDT triage trial in South to be reviewed and to commence in other localities.
- NMHT workforce plan.
- Review Solihull pilot and move to business as usual.
- Development of demand and capacity planning dashboard.

Goal: Implement plans to ensure timely and appropriate access to inpatient beds within Birmingham and Solihull and eliminate inappropriate out of area (OOA) placements

✓
- Draft inpatient bed strategy implementation plan submitted to the Provider Collaborative.
- No admission occurring without a 'gatekeeping' conversation with a relevant consultant.
- Work to understand common causes of delays and enable smooth transition from acute to community.
- Work continues on design of new Highcroft wards.
- Older adults – daily meetings to support with people waiting for admission and consider alternatives and social worker being recruited to support assessments.
- Development of business case for expansion of ICRT

🔍
- Review and refresh out of area workstreams to improve progress against trajectories.
- Review inpatient bed plan internally and with the Provider Collaborative and revise as necessary.

Goal: Make it easier for service users to access joined up place based health and care services in their local communities

✓
- Longbridge project: Joined up triage and allocation meetings between CMHT,NMHT,BHM and Living Well has commenced and mapping of process for PIFU (Patient Initiated Follow Up).
- Developing report to help prioritisation/proactive follow up of CMHT patients with recent contact with other mental health services.
- Working with system colleagues re plans for Integrated Neighbourhood Teams (INTs) and Locality Hubs and options for further integration.
- Ongoing involvement in Community Care Collaborative steering group and implementation plan.

🔍
- Review outcomes from Longbridge pilot and confirm roll out in other localities.
- Consider recommendations from evaluation of INTs.
- Liaise with PCNs with no ARRs worker to address barriers.

Goal: Improve access, experience and outcomes for local people through delivering a 24/7 neighbourhood mental health service pilot in East Birmingham (NEW GOAL IN Q2)

✓
- Phase 1 recruitment undertaken and most posts appointed to via secondment.
- Temporary based from Omnia GP practice identified.
- Community asset mapping underway.

🔍
- Continue work to identify permanent base.
- Complete community asset mapping.
- Phase 1 staff attending a week of training end of November.
- Develop and agree communications plan.
- Further engagement and co-design with VCFSE and local communities.

1 of just 6 selected pilots nationally

7. Strategic priority: Clinical services

Rooted in communities

Goal: Undertake targeted work to reduce unfair and avoidable inequalities in access, experience and outcomes within Birmingham and Solihull.

- All operational divisions have finalised health inequalities plans and localised governance.
- Divisional plans were reviewed following a 'critical friends' session held in Q1 with PCREF partners and are being implemented, with just a few examples below:

Birmingham Healthy Minds log of staff who speak different languages, to reduce wait times and improve outcomes

Secure Care train the trainer programme on cultural humility and safety to deliver across services

ICCR work to improve referrals to our culturally appropriate advocacy offer

Veterans service completed focus groups to best understand needs of female veterans who were identified as under-presented in the service

Cultural competency QI project pilot at Zinnia CMHT has developed e-learning and a co-produced 'communication passport' to be added to RiO to facilitate culturally appropriate, personalilsed care

- Work is ongoing within Community Transformation in collaboration with VCFSE partners to co-design targeted support across our 8 communities of focus, including for example:

Joined up approach with public health on a mental health action plan for the Chinese community

Developing women's, men's and adolescent co-production groups for the Somali community

Self-help groups being delivered for the LGBT+ community and discussion around Talking Therapies for LGBT+

Trauma informed engagement training co-produced for sex workers

We supported Nishkam Centre's successful bid for Fairer Futures funding to improve support for West Birmingham communities

Identifying peer support opportunities and roles within the communities of focus.

Developing joined up approach with local authority to co-production with Gypsy Romany Travellers

Muslim women's, men's and parents' groups established

- Continue to track progress vs plans.
- As the divisional plans become more robust, local ownership will be delivered through divisional FPP committees, and each division will be expected to provide deep dive assurance every 4 months at the Trust Health Inequalities Group.
- Review outcomes of VCFSE pilots and confirm areas of future funding needed.

8. Strategic priority: Clinical services

Prevention and early intervention

Goal: Transform our urgent care pathways and services to eliminate inappropriate attendances and waits in acute care settings.

- Workshops and engagement re Right Care Right Person.
- Preparation for next phases including updating policies for S117 leave, assessment for admission under MHA, missing patients and place of safety 136.
- Improved phone technology and skill mix for Call before you Convey.
- Flow chart/risk assessment for Place of Safety developed and risk assessment tools/escalation flowchart for decisions on police involvement.

- Online training commencing October 2024.
- Staff development in PDU to increase utilisation.

Goal: Develop our services and pathways to ensure that we meet the required access and outcomes performance standards and trajectories.

- Birmingham Healthy Minds (QE) recruitment on schedule.
- Perinatal community access rate recovery plan agreed, QI projects commenced to reduce DNAs through home assessments and increase access for under 25s.
- New centralised booking system for Memory Assessment released some capacity, service improvement plan looking at different operating models and capacity and demand.
- Collaboration with VCFSE and Recovery College on memory assessment waiting well sessions.
- Continuation meetings with QE directors to review clinical health psychology provision.
- Long waiters plan being implemented in Neuropsychiatry.

- Continue with implementation of agreed recovery and service improvement plans highlighted above.
- Consider 'post-diagnosis' Recovery College session based on success of the waiting well sessions and consider other teams with significant waiting lists whose service users and carers might benefit from this approach to waiting well.

Goal: Transforming and improving services for children and young people (CYP)

- Draft model of care on ICB website for comment.
- BSMHFT and Birmingham Women's and Children's boards approved in principle to move to single provider and oversight for transition agreed – new goal to be added to Sustainability goals.
- Working on 18-25 offer under Community Transformation transitioning to business as usual.
- Continuing to engage with the CAMHS provider collaborative re new guidance for Tier 4 options.

- Transformation of services to commence following transfer to single provider.
- Continue to engage with CAMHS provider collaborative.

BHM within 6 and 18 week wait time trajectories

18 new band 5/7 staff starting with BHM in Sept/Oct

187 service users and carers have attended MAS waiting well Recovery College sessions

"I feel like I'm not alone any more…everyone explained it so well now I can start moving forward."

"The session has been very helpful for me as my husband's carer, it has helped me to understand a little bit of what we are dealing with."

9. Strategic priority: Clinical services

Prevention and early intervention (contd)

Goal: Make sure we have specialist pathways to better meet the specific needs of a range of groups in our population

- **Bipolar and psychosis** screening and referral tool completed and approved and 3 month pilot commencing in November 2024.
- For **complex emotion and trauma** pathway, roll out continued of Trustwide personality disorder training and complex case panel created to offer consultation and advice on personality disorder.
- Local/city-wide pilot of online managing emotions programme.
- Further meetings with mainstream services to showcase the **Veterans s**ervice and what it offers.
- Veterans clinical leads are attending case review meetings regularly to ensure consistency and quality of clinical decision making.
- Pathway work agreed for **Deaf service** and future plans created, referral form developed, promoted and being used,
- Following a meeting with ICT and Finance, will be able to progress to the next stages of the service's patient digital screen (media wall) project by end of March 2025.
- Business case for community forensic step-down accommodation as part of **women's secure** pathway developed and submitted.

- Review managing emotions pilot and confirm whether it should be business as usual.
- Engage with national Op Courage service leads and clinical leads forums to share best practice.
- Hold patient safety summit in deaf service in response to a recent quality review and to inform the pathway.
- Next step in women's secure step-down depending on outcome of the business case.

Recovery focussed

Goal: Provide support to ensure families and carers are routinely and appropriately involved in care planning and decisions

- Mapping of family and carer pathway to DIALOG+ in progress.
- Scoping exercise/gap analysis for refresh of family and carer strategy.

- Continued involvement in DIALOG+ implementation group to inform the pathway.
- Finalise gap analysis.

Goal: Develop a consistent approach for developing clear roles for peer support workers across the Trust to bring about positive recovery and experience outcomes

- Imroc finalising report into peer support activity across all BSOL providers.
- Workforce recruitment plan for peer support hub completed and initial roles recruited.
- First cohort of accredited peer support training completed.
- Planning for recruitment fair and communication strategy.

- Imroc to report findings on data, synergies, gaps, good practices and challenges for peer support across BSOL.
- Co-production sessions for system partners on future peer support workforce.
- Peer support hub offer to be confirmed and marketing for sale of the service to commence.

12 recurrent roles on Trac

10 non-recurrent roles job evaluated

2 new peer support workers and educator onboarded

10. Strategic priority: Clinical services

Clinically effective

Goal: Better support for service users with learning disability or autism

- Autism crisis support pathway proposals approved and a group of Experts by Experience identified to help work on the crisis support pathway.
- Dynamic Support Register established (but slow to roll out)
- Oliver McGowan training now on traffic lights meaning compliance can be monitored.
- Governance around quality assurance and LeDeR (Learning from Lives and Deaths) programme agreed and implemented.
- NICE review with directorate clinical teams begun.
- Role of LDA steer group and governance structure now clearly established along with roles and responsibilities of its three working groups.
- Workforce LDA training survey designed to identify training needs.
- Linking more strategically into Community Transformation Programme work.
- Experts by experience linked to all key areas of governance including the LDA steer group and its working groups.

We met the inpatient cohort and planned trajectory for Q2

- Work towards NHSE inpatient discharges trajectory.
- Agree CeTR (Care, Education and Treatment Review) model across the Provider Collaborative.
- Agree sensory friendly building risk assessment criteria
- Begin collaborative working training needs analysis piece for complex case management.
- Begin monitoring of Oliver McGowan training compliance.
- The use of Dialog+ to enable better care links to other existing documentation.
- Continue to grow remit and pool of EbEs.

Goal: Ensure that our service users' care plans are co-produced and personalised to improve outcomes and quality of life

- Dialog+ officially live for community teams on 4 November 2024 CPA Care Plan, Care Plan Part B and Care Support becoming read only, but still visible, on 25 November.
- Inpatient mapping workshops in October, with further planned
- Regular communication and engagement ongoing including production of videos, testimonies and launch material.
- Appointment of Band 7 DIALOG+ Clinical Training Lead
- Usage of DIALOG+ across community gradually increasing during the quarter.

39.5% of community CPA caseload had DIALOG+ care plans on 14 Oct. up from from 25.8% in June.

- Continued engagement and training for medical workforce.
- Review phase 1 and plan for phase 2.

Goal: Equip all clinical staff across the Trust with knowledge of trauma informed approaches

- ICCR training consultant recruited and will support roll out.
- Secure Care and Offender Health (SCOH) – all wards buildings have had a trauma informed walk through and good practice and improvements are being identified.
- A co-developed, co-delivered training package produced at Tamarind which will be also utilised across Reaside and a brief training package has been developed for the FIRST team with community focus.
- Roll out of trauma informed training across acute and urgent care included in the inpatient bed strategy plan and due by March 2025.

- Identify best training provision for ICCR.
- Continue with roll out in SCOH in line with implementation plan.
- Update on work in other divisions.

11. Strategic priority: People

Progress update

Focus areas for Q3

Shaping our future workforce

Goal: Aim to reduce the vacancy rate to 11% with a target of 9% turnover

- Centralised nurse recruitment receiving positive feedback and helped reduce band 5 gap.
- Grow your Own SOP in place with monthly drop ins available.
- KPI report now includes breakdown of vacancy WTE/ % for staff groups creating greater visibility to help identify areas of focus.
- Flexible Working policy reviewed and new detailed report developed for flexible working reporting.
- Agreement to implement stay conversation during Q3 in high-risk areas.
- Completed a mid-year review of workforce planning.
- On track in terms of substantive workforce growth and agency reduction however bank fluctuates and often above plan.
- Funding for a data quality role will be used to address huge gaps in the EDI data on ESR.

Overall vacancy gap below trajectory and recovery plans in place for areas where it is above

- Increase number of pure apprentices.
- Newly Qualified Nurses to commence, reducing vacancy rate.
- Implementation of the People Promise areas.
- Agree evaluation/ measurement/review process.
- Commence and support 2025/26 planning with divisions and professional leads..
- Develop and begin implementation of an action plan.

Goal: Reduce bank usage by 10% and agency spend to 3.2% of total paybill

- Acute and Urgent Care bank reduction underway, to be rolled out across divisions, increasing oversight on bank and rostering.
- Direct engagement has saved £50k to date.
- Increased monitoring on 3 acute wards.
- Additional bank use due to acuity and e-rostering impacts ability to remain below plan.

To date we have reduced agency spend by 1.9% of total paybill vs annual target of 3.2%

- Enhanced vacancy and bank controls to be introduced in Q3.
- Roll out of acute and urgent care tool across all divisions
- Implementation of action plans for bank reduction projects.

Goal: Aim to increase our fundamental training average compliance by 3%

- As of 30 September, compliance was 93.1% and the anticipated 1% increase from the previous quarter was not achieved due to an anticipated drop in compliance linked to grace periods ending.
- Reduced capacity within the AVERTS team to carry out new SRS training and high DNA rates are also affecting compliance.
- In addition, in September the Trust experienced an influx of new starters who require face to face training.

- Work to achieve an increase of 1% or more of fundamental training compliance from previous quarter

12. Strategic priority: People

Transforming our culture and staff experience

Goal: Reduce sickness levels by 1%

- Commenced triangulation of information from last year's staff survey and questionnaire.
- Health and wellbeing strategy has been drafted.
- Options appraisal on post incident support offer has been completed and shared with all divisional leads and heads of nursing.
- Awaiting feedback on whether divisional or central model will be chosen.
- Business case is being developed to set up the core team for post-incident support.
- HR toolkit training progressing with soft launch of disciplinary training, although there is a slight delay in investigating officer and grievance training due to capacity.

- Launch new health and wellbeing strategy.
- Finalise the business case for preferred model of post incident support and carry out a pilot.
- Launch remaining modules of the HR toolkit training.

Goal: Reduce the disproportionality of racialised groups involved in people processes.

- This goal is focussed on Acute and Urgent Care and Secure Care and Offender Health.
- Continue to work in identified areas, facilitation of away days/training/anti racist framework and listening spaces.
- Attendance in FPP committees and senior leadership team meetings.
- Bespoke intervention requested and delivered.

- Uptake of training offers in both divisions.
- Active engagement with EDI and organisational development offers.

Goal: 65% of staff would recommend BSMHFT as a place to work in the staff survey 2024/25

- Improvements in workforce inequalities include commencement of cultural humility safety train the trainer programme, phase 2 of active bystander training to incorporate sexual safety and launch of the international educated nurses support network.
- Leading Self training commissioned to support leadership development and will roll out from January 2025.
- Immediate actions from the findings of audits of employee relations processes completed, longer term changes to follow.
- Restorative just and learning culture session run at Senior Leaders' Forum and information sessions being organised within Secure Care and Acute and Urgent Care for Q3.

- Monitor divisional inequalities plans and review inclusive recruitment.
- Review access/experience/outcomes data sets.
- Roll out the leading others model.
- Carry out scheduled audits for health and wellbeing and disciplinary policies and analyse the findings.
- Engage and deliver across high exposure/risk areas.

13. Strategic priority: People

Transforming our culture and staff experience (contd)

Goal: Maintain staff engagement scores at 55% in the staff survey 2024/25 utilising relevant digital solutions

- Staff engagement strategic framework agreed.
- Most common support request is around team cohesion.
- Business partner model now provides consistent figure for support to address these team cohesion issues.
- Appraisal compliance is at 80%.
- Values based appraisal QI project is currently testing change ideas with two teams using QI methodology.
- Learning and Development are continuing to provide 1:1 support and the appraisal flowchart process to support staff has been approved to ensure queries are directed to the right team.

Appraisal compliance increased by 2.4% vs Q1.

- Development of a manager's briefing teams channel for middle level management to share key updates and build a support network.
- Development of an admin and clerical staff network alongside the work aimed at improving the experience of more junior staff.
- Review corporate support offer data and identify themes
- Appraisal compliance to increase by 1% on previous month's figure.
- Review of change ideas from appraisal QI project and implement successfully tested changes as business as usual.

Modernising our people practice

Goal: Work collaboratively with finance and ESR team to improve data quality and reduce response times to common employee relation casework by 30 days

- Honorary Contract workstream underway.
- Established occupation codes (position details) in ESR, next steps to write out to managers of non-pay staff to query job roles, titles, areas of work to build specific positions for groups of honorary workers.
- Agreement to fund a fixed term post for data quality work.
- Ask Ava chatbot usage measurement ongoing.
- Questionnaire sent out Trustwide requesting other topics people would like to see on Ask Ava but only 8 responses received.
- TSS chatbot preparatory work underway; topics being produced by team based on gathered call/ email data and team/ expert knowledge.

- Implementation of the system wide action plan for ESR.
- Review Ask Ava output in line with People Policies.
- Start development of TSS Chatbot.

14. Strategic priority: Quality

✓ Progress update

🔍 Focus areas for Q3

Improving service user experience

Goal: All quality improvement (QI) projects and programmes to be co-produced with experts by experience (EBEs)

✓
- Demand for QI trained EBEs increasing as number of QI projects is steadily increasing.
- A co-produced and co-delivered bespoke QI training session took place in September 2024, with more sessions to follow in early 2025 due to demand.
- Working in partnership with the Trust Participation and Involvement team to involve EBEs in the Culture of Care QI programme on 4 inpatient wards.
- Planning for a second Recovery College QI session.
- EBE involvement a focus for QI training sessions and project startup meetings.
- Discussions re widening QI EBE opportunities to include children and young people and inpatients.
- Quality improvement facilitators (QIFs) are visible and accessible in areas and are activity supporting and engaging teams with QI tools and methodology.

c70% of current QI projects have EBE involvement

🔍
- Support newly trained QI EBEs to embed into project teams, and buddy with existing QI EBEs.
- Explore children and young people's involvement in QI.
- Mutually share EBE resources with R&D team.

6 new EBEs trained in September and added to the QI EBE pool in September

Preventing harm

Goal: Provide assurance of safeguarding practice and the adoption of the Think Family approach.

✓
- A timetable has been agreed for pilot sites for Safeguarding assurance visits.

🔍
- Implementation of pilot site safeguarding assurance visits by the Safeguarding Team.

A patient safety culture

Goal: Use a variety of channels to identify and share learning outcomes Trust wide

✓
- Safety Summits have been reviewed. renamed as Safety and Quality workshop and the governance arrangements have been strengthened to monitor improvements
- Work has begun on an improvement plan to enhance quality review processes within the deep dives.

🔍
- Identify/implement methods for sharing and learning from the safety and quality workshops.
- Complete the improvement plan for the deep dives.
- Define clear objectives, key performance indicators (KPIs), and timelines for implementing improvements.
- Secure buy-in from senior leadership and relevant stakeholders for the improvement plan.

Goal: Ensure all clinical staff have routine access to high quality, meaningful clinical supervision

✓
- Scoping psychological professions key stakeholders.
- Questionnaire sent out to heads of professions/divisions for scoping about reflective practice groups.
- Updating Clinical Supervision Policy.
- Nursing/AHP staff to attend clinical supervision training by NHS Professionals from November 2024, to upskill them to deliver supervision. Aim for 90 trained clinical supervisors by March 2025.
- Ongoing discussions with Professional Nurse Advocate (PNA) lead on how PNAs can be utilised for supervision.

🔍
- Develop a reflective practice group guideline/ toolkit.
- Add clinical supervision data to workforce KPI dashboard.
- Consider a record of Trust reflective practice facilitators.
- Identify further roles allocated for supervision on ESR.
- Seek input from professional groups to the revised policy.
- Start delivery of training.

15. Strategic priority: Quality

Quality assurance

Goal: Ensure effective use of data to identify gaps and improve quality

- Planned work still not commenced on quality dashboard due to other immediate work priorities.
- Roll out of Audit Management and Tracking tool (AMaT) progressing with training rolled out as well as attendance at PGME.
- All medium priority NICE guidance reviews (55) are now on the new system. High priority reviews are next to be added.
- Inspections module reviewed and we are looking to move some inspection-related actions onto the system.
- Initial workshops looking at how we can add service evaluations.
- Nursing audits are still being overseen by the Senior Clinical Effectiveness Manager. ICCR continue to use the system well. Pharmacy team are adding their audits and Infection Prevention and Control are also in the early phase. Specialities division due to start in November.

446 staff registered on AMaT

200 staff trained on AMaT to date in 2024

All 85 completed local clinical audits added from old system plus 25 open audits

- Define requirements and objectives for quality dashboard
- All retrospective and new clinical audits / NICE reviews to be on AMaT system.
- Facilitate nursing directorate engagement and oversight of nursing audits and 2-3 of 4 divisions to have majority of nursing audits on AMaT.
- Progress move of some inspection-relation actions to AMaT.
- Continue supporting Research team with configuring service evaluations on AMaT.

Using our time more effectively

Goal: Implement our Quality Improvement (QI) Strategy

- Second dynamic space event held with PMO and other colleagues to refine processes for managing and prioritising change and improvement aligned to the Trust Strategy.
- Asked to support the BSOL ICB Leadership Course (PBL) with the development of QI training across the system.
- Positive feedback on the Trust induction QI session with the participation element of an active PDSA challenge.
- Plan to review all QI Academy modules in next 12-18 months with the new QI Lead in post, starting with the BSOL ICB course.
- On track with planning for a QI engagement event.
- Social media engagement remains high with excellent regular project reports posted on X (formerly Twitter).
- Other communications includes monthly QI letter, Connect page updated regularly and Colleague Briefing articles every Friday.
- International Medical Graduate Project was first in the poster presentations at RCPsych Event in Belfast in October.
- Invited to present at NHS Impact National Conference in September on our QI journey with excellent feedback from the chair and attendees.
- On track with NHS Impact assessments due, and Quality Management System plan for Q2-3 agreed by the Executive Team.

3,100 staff now trained in QI in some format

- Continue with developments started in Q1 and 2.
- Deliver ICB training sessions in December 2024.
- Build on plans for QI engagement event.
- Develop case study for NHS Impact on the Trust's QI journey following presentation at the national conference.

16. Strategic priority: Sustainability

Progress update

Focus areas for Q3

Transforming with digital

Goal: Operationalise the Digital Strategy and deliver the digital improvement plan, in line with the strategy.

- Of the 4 programmes of work agreed in line with the strategy:
  1. Infrastructure SAN (storage area network) - large scale upgrade of storage network – on track.
  2. Clinical systems – EPMA (electronic prescribing), Illy and FTB phase 2 – on track.
  3. Office 365 – improve return on Office 365 investment and move to national tenant. Tools have been procured and tested with the chatbot the only outstanding action with NHS England.
  4. Productivity and efficiency – use of robotic process automation (RPA), chatbots, artificial intelligence (AI) and emergent technology – slightly delayed due to resources overlapped with programme 3.
- Increased storage network on target for March deadline with migration to start in Q4 after testing.
- Increased cyber security/resilience – patch management process now well established with Shodan and Canary cyber security tools deployed.
- Migration plan to national Office 365 tenant agreed and tools deployed, with 3 months remaining to solve any minor technical issues.
- HR chatbot 'Ask Ava' is live and in use.

Maintained position in top 10 trusts for cyber security

- Continue to deliver against work programmes, with annual review and quarterly updates to FPP.
- Enact change to storage network and ensure configuration on track for migration.
- Implement additional security updates and tools.
- Full migration plan to national Office 365 tenant to be agreed, settings signed off and testing undertaken.
- Quarterly system release of Office 365 products for wider use within the Trust.

Goal: Develop our business intelligence capability to improve the information and insights available for developing services and user experience

- Established improved out of area productivity plan monitoring, supporting locality approach and development of intensive community support offer.
- Provided support to various CMHT-based caseload and appointment management improvement initiatives
- continued to contribute to development of care planning, outcomes and clinical pathways, supporting consultation sessions on the Rio inpatient care planning forms re-design.
- Completed development of new version of the integrated performance dashboard to go live in October 2024.
- Progress on automation infrastructure limited due to the migration to the national Office 365 tenant.

- Publish Insight reporting to support financial understanding of pharmacy prescribing.
- Adapt and enhance corporate reporting based on revised inpatient care planning and pathway data recording.
- Agreement and rollout of revised Trust measures for the integrated performance dashboard.

17. Strategic priority: Sustainability

Changing through partnerships

Goal: Making sure we have the right partnerships in place to progress our shared ambitions to improve access, experience and outcomes and address inequalities for our diverse population and staff.

- Work ongoing on the Mental Health Provider Collaborative (MHPC) strategy development, with the focus to date being on comprehensive analysis of external drivers, local challenges and opportunities.
- Rethink Mental Illness concluded final report of the Experience of Care Campaign and The Centre for Mental Health have produced a further iteration of the Health Needs Assessment.
- Strategy Reference Group formed to oversee and co-design the strategy with representatives from across the system.
- Learning Disability and Autism (LD&A) Executive Steering Group mobilised and partnership agreement being reviewed to incorporate LD&A into the MHPC.
- Working to address delays in securing transformation resources for long term sustainable development plan for Reach Out Provider Collaborative for secure care.
- Women's secure services transformation plan was submitted to national team.

- Develop a high-level MHPC strategy blueprint from the themes identified from work to date and design a series of co-production/engagement sessions.
- Complete a review of the Service Development Fund for LD&A, set commissioning intentions for 2025/26 and recruit additional capacity into the LD&A commissioning team.
- Transformation resources to be secured for Reach Out, joint planning with ICBs to commence and development of a new clinical model.
- Women's service transformation plan to be agreed with NHSE.

Balancing the books

Goal: Confirm underlying financial position, ambition and timescale for achieving recurrent balance, with identified proposals for generating cash releasing cost savings

- Discussions around 2025/26 budget model commenced.
- Discussions held with other NHS organisations re financial reporting tools that allow for scenario planning, session booked for supplier to showcase opportunities, although capacity and funding have been constraints in identifying options for improved local reporting.
- Savings plans received from all operational portfolios and a number of corporate areas.

- Budget modelling to include provider and commissioner scenarios.
- Link in with annual planning process to include updated scenarios around financial plans.
- Commence review of savings plans and clinical quality and equality impact assessment process, and confirm which plans are to be progressed.

Caring for the environment

Goal: Development of a refreshed Estates and Facilities Strategy to ensure our estates and facilities are fit for the future

- Dynamic Space workshop held in May with staff, experts by experience and stakeholders participating.
- Themes identified from the workshop to develop the engagement plan for the strategy.
- Discussions at key Trust committees and meetings.
- Travel survey and car parking audits completed.

- Wider engagement via a range of methods to inform a draft strategy.
- Report on findings from the travel survey and parking audits.
- Explore how the estates strategy can support mainstreaming of the existing green plan.

18. Strategic priority: Sustainability

Good governance

Goal: Ensure Trust processes and systems are information governance compliant

- New CAF-DSPT (Cyber Assessment Framework – Data Security and Protection Tool) launched nationally in September 2024
- Internal Trust mapping exercise completed including comparison of new requirements against previous DSPT and to utilise existing evidence where appropriate.
- Leads identified for CAF-DSPT actions, and CAF-DSPT Implementation Group established which reports into Information Governance Steering Group (IGSG).
- Outline of new requirements and development of action plan shared at October's IGSG meeting.

- Initial CAF 2024/25 Trust baseline to be submitted by end December 2024 in line with national requirements.

Goal: Establish and implement a performance accountability process so that we can take proactive action where improvement is required

- Learning from deep dives held to date informing continuous development.
- RAG rating completion of service lines being routinely agreed at meetings and summaries of key actions and RAG ratings agreed are routinely reported to Trust FPP.

- Hold service area deep dive meetings including completion of RAG rating for each of the Trusts domain areas of Quality, Sustainability, People and Performance.
- Learning to inform ongoing development.

19. Key risks and issues identified

Clinical services

- GP engagement and buy in around community model.
- Capacity and resource to deliver transformations and improvements.
- Need to improve integrated working across pathways.
- We are still not meeting performance trajectories in some areas despite improvements being made.
- Forecasted costs for out of area beds remain above target due to limited access to private contracted beds.
- Interface and engagement with local authority re rehab delayed transfers of care.
- Permanent premises solution for 24/7 pilot.
- Limited step-down provision in some areas due to there being no ARRs or NMHT provision.
- Birmingham Healthy Minds moving from block contract to cost and volume contract from Quarter 3.

People

- Clinical areas not identifying enough band 5 vacancies for Internationally Educated/Newly Qualified Nurses
- Capacity and resource to deliver transformations and improvements.
- Vacancies increasing due to increase in establishment.
- Gaps in ESR data
- Lack of oversight of bank bookings
- Increasing DNA rates and waiting lists for training.
- Identifying a post incident support model that complements Occupational Health provision whilst meeting the needs of staff
- Several ESR related projects being undertaken by different people/teams

Quality

- Potential increasing demand for EBEs from QI project teams if fewer EBEs are trained/participate.
- Capacity and resource to deliver transformations and improvements, particularly at a senior level to drive some key improvements due to team changes/vacancies.
- Clinical Supervision training cost.
- Cultural shift and behavioural change challenges re clinical supervision.
- Nursing audits being entered on AMaT
- Need for full engagement and to be sighted ward to board for the QMS/NHS Impact work to be successful.

Sustainability

- Wider roadmap for utilisation of Office 365 products has not been fully developed.
- Competing priorities, capacity and resource to deliver transformations and improvements.
- Risk that some systems cannot operate on the Office 365 national tenant, although this has significantly reduced. Sustained growth from prisons resulting in long waiting times for admission and increased out of area placements for Reach Out.
- Risk that transformational savings ideas will not be identified.
- Risk of silo working continuing rather than achieving a more holistic view to deliver key performance objectives.

Part B:

Plans for refreshing the Trust Strategy

20. It's time for another 'brew up'

As we approach the end of Year 4 of our Trust Five Year Strategy, we are developing our approach and plan for refreshing the strategy ready for April 2026. We are working to the following principles:

- We want to have the same level, if not more, engagement than we did in developing the current strategy. We aim to replicate and build on the success of the 'help us brew up our Trust Strategy' campaign, which made the strategy meaningful for colleagues across the Trust and is still remembered and referenced to this day.
- We will take multi-channel approach to engagement, including face to face conversations with teams at Trust sites, service and profession-based focus groups, online surveys, comment cards, online and offline materials and use of existing Trustwide communications channels.
- We will be encouraging and equipping local leadership to engage with frontline teams.
- We will maintain and grow the involvement of Experts by Experience, ensuring that we retain the Recovery for All Quality Mark for the Trust Strategy, demonstrating the principles of recovery and co-production throughout the strategy development.
- Last time we started with a blank page, this time we will celebrate our successes from the past 5 years and identify what more we need to do.
- We will take the learning from the development of the current strategy and take more time, using the whole of the 2025/26 financial year to refresh our strategy.

21. Our high-level timeline

December 2024	Approach agreed with the Executive Team
January/February 2025	Dedicated session with Trust Board focusing on ambitions, direction of travel and assumptions
January/February 2025	Strategy Steering Group established
February 2025	Engagement session with Senior Leaders' Forum
January – March 2025	Desktop/context analysis and pre-planning, including baseline assessment
April – July 2025	'It's time for another brew' engagement campaign
August – October 2025	Collate feedback, identifying themes and produce high level draft of the refreshed strategy
October – November 2025	'Taste our brew' campaign to test the draft strategy
November 2025 – January 2026	Produce and design final draft strategy
February – March 2026	Approvals through Trust governance
April 2026	Launch of the refreshed strategy

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 December 2024**
Date(s) of Committee Meeting(s) reported	**24 October 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Commissioning Board Assurance Framework • SSL Risk Register • Internal Audit Progress Report • Internal Audit Action Tracking Report • Internal Audit Reviews: Clinical Governance Committee Effectiveness Follow-Up, Complaints Follow-Up, Emergency Preparedness, Resilience and Response Follow-Up • Local Counter Fraud Specialist Progress Report • Patient Transport Contract Procurement • Single Tender Waivers Report
Alert:	The Committee discussed the Commissioning Board Assurance Framework and requested that the Risk Management Group had oversight of the development of the risk register. It was noted that the Board Assurance Framework would be fully developed following the production of the strategy for the Mental Health Provider Collaborative.
Assure:	The Committee was assured on the following areas: • The Committee received the **Clinical Governance Committee Effectiveness Follow-Up Report** and was assured by significant improvements made and number of actions closed within the last few months. Additional assurance was received through the Executive Director of Quality and Safety/Chief Nurse on the amount of work that was being undertaken to streamline, simplify and create a sustainable governance system for the Clinical Governance Committee, including strengthening divisional and service level meetings for robust ward to board governance. • Positive assurance was received on the action tracking report. Good progress had been made to respond and close recommendations in line with deadlines. • Positive assurance was received through the Local Counter Fraud Specialist Report, highlighting good progress against plan and

	significant engagement with the organisation around fraud awareness.	
Advise:	The follow-up reviews on **Complaints** and **Emergency Preparedness, Resilience and Response** highlighted some positive progress against recommendations.	
Board Assurance Framework	The Committee reviewed the revised Board Assurance Framework and was satisfied with the progress made so far, noting that the BAF provided greater clarity and strategic oversight. The Corporate Risk Register was currently undergoing development and would be linked closely to the Board Assurance Framework.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	21					
Date	4 December 2024					
Title	Modern Slavery and Human Trafficking Statement					
Author/Presenter	Kat Cleverley, Company Secretary					
Executive Director	Dave 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					
Alert		**Advise**		**Assure**	✓

The Trust has a statutory obligation to produce a Modern Slavery and Human Trafficking statement in line with Section 54(1) of the Modern Slavery Act (2015).

Key points to note include:

- The statement is reviewed every two years.
- The statement will be formally approved by the Board and signed by the Chair and CEO.
- The Trust is required to publish the statement on its website.

Recommendation

The Board is asked to approve the statement for publication on the Trust's website.

Enclosures

Modern Slavery and Human Trafficking Statement

Modern Slavery Act 2015

Modern Slavery and Human Trafficking Policy Statement

Introduction

At Birmingham and Solihull Mental Health NHS Foundation Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by this Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Organisation's structure

The Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care to those people living in Birmingham and Solihull who are experiencing mental health problems. We serve a culturally and socially-diverse population of over a million spread over 172 square miles, and have an income of over £290m, making our Trust one of the largest mental health foundation trusts in the country. We also provide services to people who live further afield because of some of the specialised services we provide.

Our Trust has over 4000 dedicated staff who are continually working to help people get better and challenge the stigma associated with mental illness. Our Trust operates from over 50 sites in a variety of settings, from community based mental health teams through to acute wards and day centres.

Our supply chains

The Trust supply chain is predominantly orientated with the majority of its supplier base within the United Kingdom (UK) with our extended supply chain linking into the wider European Economic Area (EEA). NHS Supply Chain is the Trust's largest goods provider and incorporates the principles of the Modern Slavery Act within its code of conduct and ensures these products comply. Our procurement processes align with the codes of conduct and are robustly scrutinised by the Trust.

Our policies on Modern Slavery and Human Trafficking

We are fully aware of the responsibilities we have towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for modern slavery and human trafficking. Staff are expected to report concerns about modern slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures.

Due diligence processes for Modern Slavery and Human Trafficking

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Are working towards the Department of Health and Social Care NHS Procurement and Commercial Standards, which requires a Corporate Social Responsibility (CSR) policy defining the procurement approach to sustainability, modern slavery and all other appropriate ethical standards and approaches.

- Undertake appropriate pre-employment checks on directly employed staff and access temporary staff only through the NHS England approved frameworks, ensuring suppliers comply with the same pre-employment checks.
- Uphold best practice and professional codes of conduct relating to procurement and supply, through procurement team membership to the Chartered Institute of Procurement and Supply (CIPS). With qualified members undertaking the annual CIPS Ethical Procurement and Supply e-learning course.
- Utilise contractual clauses to ensure that supplier supply chains are monitored and that there is zero tolerance of modern slavery within their supply chain. The largest supplier of goods is NHS supply chain who have ethical sourcing policies in place. Where any such issues arise within the extended supply chain, the supplier shall act to remove these items from entering the Trust's extended supply chain and implement ethical sourcing programmes and supply chain audits to prevent any repetition.

Our effectiveness in combating Modern Slavery and Human Trafficking

Further work is needed to identify how we measure our effectiveness in ensuring that modern slavery and human trafficking is not taking place in any part of our business or in our supply chain.

This statement has been approved by the Board of Directors of the Birmingham and Solihull Mental Health NHS Foundation Trust who will review and update every two years.

This statement is also made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement.

The statement will be reviewed every two years.

Signature: Chair

4 December 2024

Signature: Chief Executive

4 December 2024

Report to the Board of Directors

Agenda item:	22						
Date	4 December 2024						
Title	Committee 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/endorsement**	✓
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:

A term of reference is a key document that supports effective governance and the implementation of Good Governance as it sets out the purpose, objectives, membership, frequency, chairing and quoracy of governance groups as well as their roles, remits, responsibilities and admin support required to enable their smooth operationalisation. The ToR hereby presented for ratification by the Board have been approved and recommended by the relevant Board committee or governance structure to the Board for ratification.

Introduction:

This is an annual review of the Terms of Reference of related governance structures and Board committees with the view to strengthen and improve governance effectiveness and efficacy in robustly performing its delegated functions from the Board of Directors. The ToR thus provide a framework for an annual review of the effectiveness of the committee or governance structure to ascertain how well it is delivering its key mission and delegated functions.

Key changes that have been captured are highlighted in orange. It`s worth noting that the Trust governance structure incorporated in the updated ToR reflects a holding position as it will be replaced once the Trust`s new governance structure has been approved.

Key Issues and Risks:

1. The key issue here is to ensure that these ToR are sufficiently populated to all members of the relevant committee or governance structure once they have been ratified by the Board. This will be done through circulating to members and presenting at relevant meetings for information, awareness and noting.

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 of Directors is requested to:

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE and RATIFY*** *these updated ToR for the different committees and governance structures.*

Enclosures

1. **Appendix 1**: Updated Audit Committee Terms of reference
2. **Appendix 2** – Updated Terms of Reference for the NED-led Nom. & Rem. Committee
3. **Appendix 3**: Updated ToR of the Quality, Patient Experience and Safety Committee (QPES)
4. **Appendix 4**: Updated ToR of the Finance, Performance, and Productivity Committee (FPP)
5. **Appendix 5**: Updated ToR of the People Committee (PC).

Appendix 1: Updated Audit Committee Terms of reference

AUDIT COMMITTEE

TERMS OF REFERENCE

1. VALUES

1.1 The Committee 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. AUTHORITY

2.1 The Audit Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Board. This will include the responsibilities of the Trust in being a provider and commissioner of services.

2.2 The Committee is authorised by the Board to request the attendance of individuals and authorities from within or outside the Trust with relevant experience and expertise if it considers this necessary.

2.3 The Committee is a Non-Executive Committee of the Board of Directors, with no executive powers, other than those specifically delegated in the Terms of Reference.

2.4 The Audit Committee is responsible for oversight of processes and systems for commissioning, and interfaces with the Commissioning Committee ("**CoCo**" – Board in Committee) for this responsibility.

2.5 The Committee is responsible for providing assurance to the Trust Board and the Commissioning Committee on the adequacy of the audit arrangements (internal control) for the Provider and Commissioning arms of the Trust and on the effectiveness of their risk management systems by means of independent and objective review of the financial, corporate governance, and risk management arrangements, including compliance with the law, corporate governance codes, guidance, best practice and regulations governing the NHS.

2.6 The Audit Committee's remit across both provider and commissioner responsibilities.

3. PURPOSE

3.1 The Committee is authorised by Board to carry out any function within its terms of reference.

3.2 The Committee shall request and review reports and positive assurances from directors and managers, on the overall arrangements for governance, risk management and internal control and will provide assurance on these to the Board.

3.3 The Committee is delegated and authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- Recommend the consolidated "group" Annual Accounts and Report (including the Quality Account and Charitable Funds Account) to the Board for approval. These will incorporate the SSL Accounts, and both provider and commissioner Trust Accounts.

3.4 The Committee may also request specific reports from individual functions within the organisation as it may deem appropriate to provide assurance on overall governance arrangements.

3.5 The Committee will review all matters relevant to both the commissioning and provider functions within the overall group.

4. DUTIES

4.1 Governance, Risk Management, and Internal Control

4.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical, and provider and commissioner) that supports the achievement of the organisation's objectives.

4.1.2 The Audit Committee will scrutinise the provider arm's Board Assurance Framework ("**BAF**") to provide the Board with assurance that the BAF is valid and suitable for the Trust's requirements. Specifically, the Audit Committee will:

- Ensure that there is an appropriate spread of strategic risks. This should be done once a year.
- Assure itself that the process undertaken by management to populate the BAF is appropriate. This could be carried out on the Committee's behalf by the Internal Auditors to terms of reference agreed by the Committee.
- Monitor the implementation of action plans that have been drawn up to cover gaps in controls, assurances, and reports to management.
- Consider the audit needs of the organisation in terms of sources of assurance, and that there is a plan for these assurances to be received.
- Review the results of assurances and the implications these have on the achievement of the Trust's strategic objectives.

4.1.3 The Audit Committee will scrutinise the commissioning arm's Board Assurance Framework to provide the CoCo with assurance that the BAF is valid and suitable for the Trust's requirements. The Audit Committee will discharge the same functions as described in 4.1.2 above, but with a particular focus on the Trust's management of strategic risks associated with Lead Provider and partnership activities.

4.1.4 The Committee will review the adequacy of:

- All risks and controls related to disclosure statements (in particular the declarations of compliance with the CQC regulations and requirements for the Annual Report and Accounts and the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to approval by the Board
- The policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the NHSE Counter Fraud Authority.

4.1.5 The Committee will ensure and assure on behalf of the Board that:

- The Trust has an appropriate and up-to-date Risk Policy.
- The Risk Policy is being adhered to, in that risks are being identified, described, scored, managed, and addressed appropriately.
- There is a transparent and effective method for the escalation of risks upwards within the Trust.
- The higher scoring risks as collated into a single Corporate Risk Register, which is visible to the Board.
- The Board Assurance Frameworks are live documents that reflect the controls and assurances needed to ensure and assure management of the risks associated with delivery of the Trust's Strategy and its responsibilities as a Lead Provider.

4.1.6 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions.

4.1.7 The Committee will review the establishment and maintenance of effective systems of governance, risk management and internal control for the Provider and Commissioning arms of the Trust.

4.1.8 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions.

4.1.9 The Committee will have delegated authority from the Board to receive and recommend for approval changes to the Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers ("**Scheme of Delegation**"). It will also consider any breaches of these arrangements.

4.2 Financial Reporting

4.2.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal instructions by the Regulator regarding financial performance.

4.2.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review both as to the completeness, accuracy, and fitness for purpose of the information and with regard to the effectiveness of the Board's consideration of this information.

4.2.3 The Committee will review the consolidated annual reports and accounts of the Trust before their submission to the Board, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted misstatements in the financial statements;
- Significant judgments in preparation of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

4.3 Internal Audit

4.3.1 The Committee shall ensure that there is an effective internal audit function appointed in line with the scheme of delegation and that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation dismissal; as well as agreeing the adequacy of the procurement process.
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation including those identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

4.4 Counter Fraud

4.4.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

4.5 External Audit

4.5.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor in order for a recommendation to go to the Council of Governors, whose role it is to appoint the External Auditors.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all External Audit reports, including receipt of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Consideration of any non-audit work to ensure external audit retain independence.

4.6 Other Assurance Functions

4.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arms-length Bodies or appropriate regulators/inspectors.

4.6.2 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee, and any Risk Management committees that are established, as well as receiving or seeking assurances as appropriate, from the other board sub committees.

4.6.3 In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

5. MEMBERSHIP AND ATTENDANCE

5.1 All members of the Committee will be independent Non-Executive Directors. At least one member will have a formally recognised accountancy qualification.

5.2 The membership of the Committee will be:

- Chair – Non-Executive Director
- Deputy Chair – Non-Executive Director & Chair of FPP.
- The Chair of QPES
- The Chair of the People Committee
- The Chair of the Caring Minds Committee
- Another Non-Executive Director

The membership will comprise representation (Member or Chair) from the Trust committees leading on quality, finance, and people as outlined above. The Chair of the FPP shall act as the Deputy Chair of the Committee.

5.3 The following will be standing attendees of the Committee:

- Executive Director of Finance
- Company Secretary.

5.4 Invitations for attendance of others will be issued by the Chair of the Committee in line with the requirements of the agenda.

5.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. Other Non-Executive Directors who are not members of the Committee may attend with the agreement of the Chair of the Committee. The Chair of the Board will not be a member of the Committee but may be in attendance at the discretion of the Committee Chair.

5.6 All members will have one vote. In the event of votes being equal the Chair of the Committee (or the Deputy Chair if presiding) will have the casting vote.

5.7 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. At least once a year the Committee should meet privately with the External and Internal Auditors.

6. QUORACY

6.1 A quorum shall be at least three Non-Executive Directors of the Committee.

7. DECLARATION OF INTERESTS

7.1 All members and attending officers must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. The Chair will decide if any Member must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may ask the Committee Chair for a meeting if they consider that one is necessary.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 To include as a standing item on every agenda the Committee should review how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 An Action List and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.4 Any issues with the Action List or minutes will be raised within 7 calendar days of issue.

9.5 The Company Secretary will agree a draft agenda with the Committee Chair, and it will be circulated 7 calendar days before the meeting.

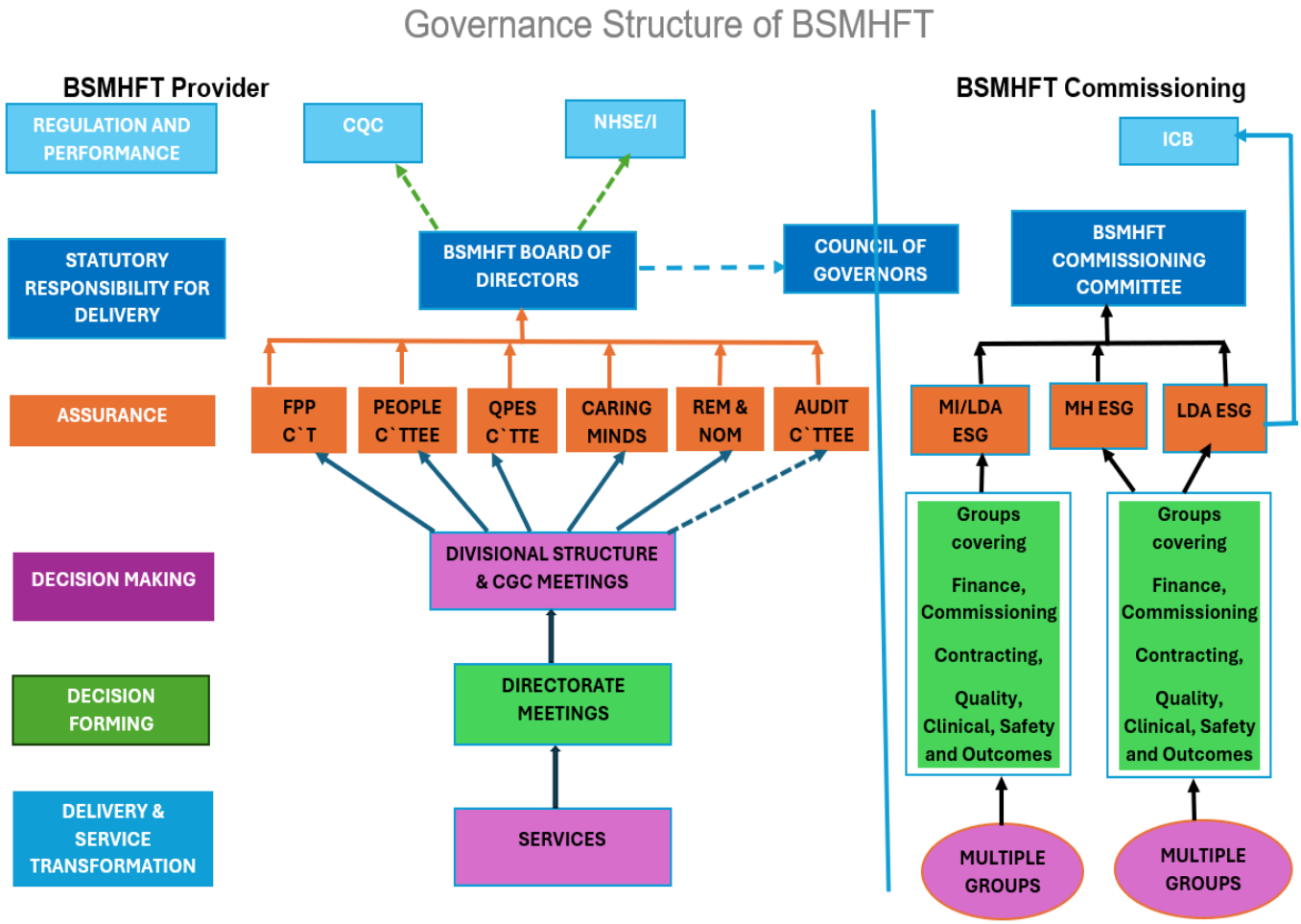
9.6 Any issues with the agenda must be raised with the Committee Chair within 4 working days.

9.7 All final Committee reports must be submitted 7 calendar days before the meeting.

9.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings.

10. Governance Structure

10.1 BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board and the CoCo when required. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

11.2 The Committee will review its effectiveness on an annual basis, reporting the outcome of the review to the Board of Directors.

11.3 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee.

Approved: April 2024

Renewal: April 2025

Amended: April 2024 (to strengthen and provide clarity on membership, quoracy and includes updated BSMHFT governance structure).

Date ratified by the Board of Directors: 4th December 2024

Version: 3.0

Appendix 2: Updated ToR for the NED-led Nom. & Rem. Committee

TERMS OF REFERENCE

BOARD OF DIRECTOR`S NOMINATION AND REMUNERATION COMMITTEE (NED-led)

1. Purpose

- The Board of Directors' Nomination and Remuneration Committee (the Committee) is constituted as a standing committee of the Board of Directors and has been established in accordance with the requirements of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (as amended) ("The Regulations").

- The Committee is directly accountable to the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and once amended must be subjected to the approval of the Board of Directors.

- The Committee is authorised by the Board of Directors to act within its Terms of Reference, ~~as set out below, subject to amendments at future meetings of the Board of Directors.~~ and has delegated authority from the Board of Directors to approve and oversee the arrangements for the appointment, termination and remuneration of the Chief Executive and all Executive Directors. In addition, the Committee will have oversight of and be responsible for agreeing the remuneration for any other posts with remuneration outside the Agenda for Change pay framework.

- The Committee is authorised by the Board of Directors to obtain such information as it considers necessary for, or expedient to, the exercise and fulfilment of its functions. All members of staff of the Trust are directed to co-operate with any request made by the Committee.

- The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its functions.

2. Duties and responsibilities

2.1 Nomination

- To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board of Directors and make recommendations to the Board with regard to any changes.

- To give consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and

opportunities facing the Trust and the skills and expertise needed at the current time and in the future.

3. Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

4. Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

5. Before an appointment is made, to evaluate the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria.

6. To consider any matter relating to the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.

7. To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.

8. To receive assurance reports on behalf of the Board of Directors in relation to compliance with the requirements set out within the Trust's Fit and Proper Persons Requirement (FPPR) Policy as it relates to appointments to the Board of Directors and annual FPPR checking process.

2.2 Remuneration

- To decide upon and review the terms and conditions of office of the Trust's Executive Directors and those individuals on locally-determined pay in accordance with all relevant Trust policies, including:
  - Salary, including any performance-related pay or bonus.
  - Provision for other benefits, including pensions.
  - Allowances
  - Compensation commitments entailed by terms of appointment in the event of early termination with the aim of avoiding rewarding poor performance.

- To monitor and evaluate the performance of individual Executive Directors on an annual basis.

- To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective.

- To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments and agreements. This will also

relate to any matter that requires Treasury approval or any matter that may give rise to public concern.

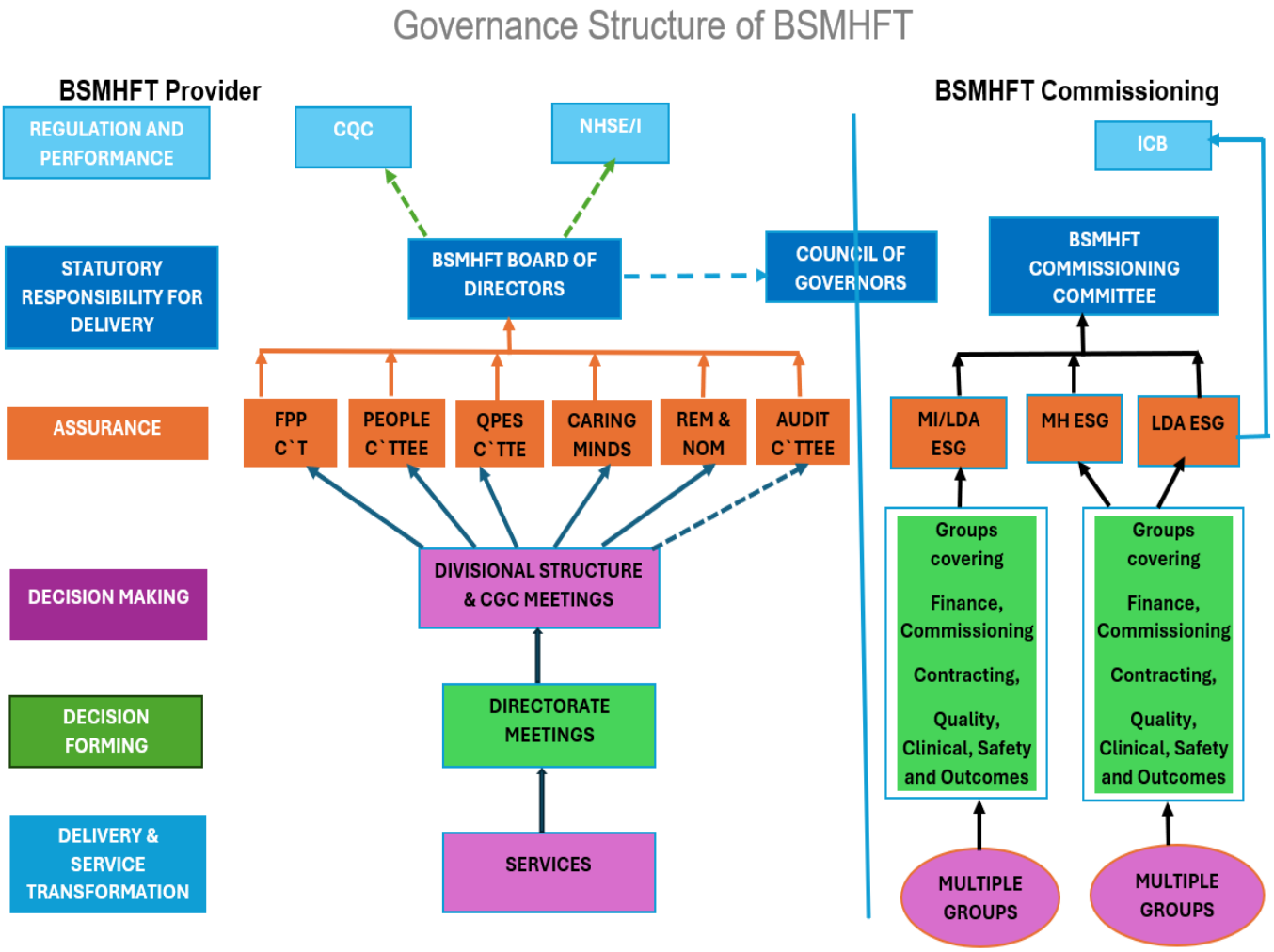
- To determine arrangements for annual salary review for all staff on Trust contracts.

- To ensure, that where remuneration consultants are appointed, a statement is made within the Trust's Annual Report as to whether they have any connection with the Trust.

3. Accountable to

The Committee is accountable to the Board of Directors.

3.1 BSMHFT Governance Structure



4. Reporting

- The minutes of all meetings of the Committee shall be formally recorded and shall be retained by the Associate Director of Corporate Governance or Company Secretary on behalf of the Chair and shall not be shared with the Executive Directors.

- The Committee shall report to the Board of Directors after each meeting of the Committee. In the case of remuneration matters, this report will be restricted to the reporting that decisions have been made by the Committee and that the manner of making them was in accordance with the Committee's terms of reference and delegated powers.

5. Membership and attendance

- The Committee shall comprise of all Trust Board Non-Executive Directors, including the Chair of the Board.

- The Chair of the Board will chair the Committee, and the Vice Chair of the Board will act as Chair of the Committee in the Chair's absence or if the Chair has a conflict of interest. The CEO is also a member but will recuse themselves from discussions on agenda items on which they are conflicted.

In attendance

- At the invitation of the Committee, meetings shall normally be attended by the Chief Executive, Director of Human Resources and Staff Development and the Associate Director of Corporate Governance or Company Secretary.

- Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

- Any non-member, including the Associate Director of Corporate Governance or Company Secretary shall be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Serviced by

- The Committee will be serviced by the Company Secretary who will also act as the Minutes taker.

6. Quorum

- A quorum shall be four members.

- At the discretion of the Chair, business may be transacted through a teleconference or videoconference provided that all Board members present are able to hear all other parties and where an Agenda has been issued in advance. Participation in a meeting via electronic means shall constitute presence in person at the meeting.

7. Meeting frequency

- Meetings to be held as deemed necessary by the Committee.

8. Review

- The terms of reference will be reviewed annually by the Committee and ratified by the Board of Directors.

Date Reviewed: October 2024

Date signed-off by the NED-led Nomination Committee: 29th October 2024

Date Ratified by the Board: 4th December 2024

Date of Next Review: October 2025

Date ratified by the Board of Directors: 4th December 2024

Appendix 3: Updated ToR of the Quality, Patient Experience and Safety Committee (QPES)

Quality, Patient Experience and Safety Committee (QPES)

Terms of Reference

VALUES

The Committee 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.

AUTHORITY

2.1 The Quality, Patient Experience and Safety Committee ("**QPES**") is constituted as a Standing Assurance Committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Board of Directors.

2.2 QPES is authorised by the Board of Directors to govern any activity which falls within its purpose, duties, and responsibilities. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by QPES.

2.3 QPES can request external and internal individuals and/or authorities to attend its meetings to help it make decisions and can escalate any issues within its remit to the Board of Directors for consideration. QPES is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

2.4 The overall aim of QPES is to seek and obtain evidence-based assurance on all aspects of quality and safety of care across the Trust and also to provide scrutiny and oversight of the effectiveness of the Trust`s quality and patient safety arrangements, systems and processes. It shall ensure that both strategic and operational risks aligned to the delivery of the Trust`s Quality and Clinical Services strategic priorities are effectively mitigated and managed.

3. PURPOSE

3.1 QPES is responsible for assuring on behalf of the Board of Directors that the Clinical Services and Quality streams of the Trust's Strategy (~~2020~~ 2024/25) are being delivered:

- Leader in mental health
- Recovery focussed

- Rooted in communities
- Prevention and early intervention
- Clinically effective
- Changing how we work
- Improving service user experience
- Preventing harm
- A Patient Safety culture
- Quality assurance
- Using our time more effectively.

3.2 A key purpose of the Committee is to monitor and receive assurance on the delivery of the Quality Strategy for the Trust.

3.3 The Committee will lead on monitoring of controls and assurances related to the 'Clinical Services' and 'Quality' sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `Quality` and `Clinical Services` priority are effectively mitigated and managed.

3.4 The Committee will ensure and assure, on behalf of the Board of Directors, all matters relating to the administration within the Trust of statutory requirements relating to mental health legislation. These include the Mental Health Act (1983 and 2007 amended) and the Mental Capacity Act (2005).

3.5 The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

4. DUTIES

4.1 Monitor the implementation and progress of the Trust's Quality Strategy against the ~~four~~ five strategic aims to focus on:

- Improving service user experience
- Preventing Harm
- A Patient safety culture
- ~~Happy Teams~~
- Quality Assurance
- Using our time more effectively.
- PEAR
- ~~Value Added Care~~

4.2 Receive the Trust's Quality Account ~~and consider~~ endorse and recommend for approval by the Board of Directors.

4.3 Oversee and receive assurance of statutory and mandatory requirements relating to quality of care.

4.4 Receive assurance on the development and effective governance of the safety culture within the Trust.

4.5 Oversee effective systems for safety within the Trust, with a focus on patient safety, staff safety, and wider health and safety requirements. Undertake detailed scrutiny of the Trust`s Quality and Clinical Services performance information in the Integrated Performance Report (IPR) while linking to any emerging intelligence from the Financial and People strategic priorities.

4.6 Oversee the delivery of a high-quality experience for all service users, with a particular focus on:
a) assessing impact on quality due to financial decision-making involvement
b) engagement for the purposes of learning and making improvement.

4.7 Oversee an effective system for monitoring quality outcomes and effectiveness with focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

4.8 Assure the Trust's maintenance of compliance with the CQC registration through assurance of the systems of control with emphasis on the areas of quality and safety.

4.9 Oversee and assure on external assessments and regulatory bodies' requirements.

4.10 Oversee and assure the Board of Directors on statutory and mandatory requirements relating to quality of care.

4.11 Approve the annual Clinical Audit Plan for the Trust.

4.12 Support and hold to account the committee reporting to QPES in achieving its purpose, responsibilities, and duties.

4.13 Identify its annual objectives, produce an annual work plan in the agreed Trust format, measure performance at the end of the year, and produce an annual report. This will also include an assessment of compliance with its terms of reference.

4.14 Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to QPES and to identify and act upon any areas of significant concern to the Board of Directors.

4.15 Undertake any other responsibilities as delegated by the Board of Directors.

4.16 Discharge the duties that previously rested with the Mental Health Legislation Committee:

- Monitor and scrutinise the Trust's implementation and compliance with current mental health legislation and guidance and consider any proposed changes for the Trust.
- Seek assurance that arrangements for the compulsory detention of service users within the Trust are lawfully managed.
- Monitor and scrutinise trends in the application of the Mental Health Act within the Trust and make recommendations to the Board of Directors for change where necessary.
- Maintain an appropriate number of suitably skilled and experienced Lay Managers in place in the Trust, ensure that they are appropriately supported and trained, and monitor and scrutinise their activities.
- Approve MHL specific policies and procedures for use within the Trust and monitor and scrutinise their application.
- Assess and review risks that may impact on the Trust's ability to meet the requirements of the MHA, review controls and assurance that risks are appropriately managed, and identify and escalate to the Board of Directors as required.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director (Member)
- Executive Director of Quality and Safety (Chief Nurse)
- Executive Medical Director
- Executive Director of Operations

In Attendance

5.2 The following will be standing attendees of the Committee:

- Associate Director of Clinical Governance
- Head of Mental Health Legislation
- Medical Lead for MHA and MCA
- Deputy Director of Nursing
- 1 x Associate Director of Nursing
- Director of Quality and Improvement
- Director of Urgent Care Transformation.
- Company Secretary

5.3 Other Directors will attend if they have an agenda item but only for that item.
Other officers will attend but only for specific agenda items, e.g., Trust Solicitor, Lay Managers, Associate Director of Corporate Governance etc.

5.4 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.5 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.6 Other members of the Board can attend meetings if they indicate to the Chair of QPES, in advance, of their intention to do so.

5.7 Where members are unable to be present, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.8 Members are expected to make every effort to be present at all meetings of the Committee. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings for the year.

5.9 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.9 Meeting attendance will be reviewed by the QPES Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with ~~3~~ 4 Committee members, including ~~one~~ two Non-Executive Directors and one Executive Director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All members must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. ~~Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur~~.
However, if a member is conflicted with an item on the agenda, the Chair ~~will~~ shall adopt a sensible and pragmatic approach in managing conflict during the meeting as they may permit the conflicted member to participate and contribute to the debate and discussions on the item (so as to inform better decision-making) but abstain or recuse themselves from any related voting. (Check section 3.12 – Managing conflict of interests during meetings in the Trust`s Declaration of Interest Policy for more details).

8. MEETINGS

8.1 Meetings will be held 10 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary~~iat~~ will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 ~~The Executive Director of Quality and Safety will agree a draft agenda with the Committee Chair, and it will be circulated 5 working days before the meeting~~. Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the QPES annual calendar of meetings, this will bring together the Chair and Executive Director of Quality and Safety (Chief Nurse) to establish and agree the draft agenda which will be timely circulated for papers to be crafted.

9.4 Any issues with the agenda must be raised with the Committee Chair for advice prior to the final papers and bundle being circulated. ~~within 2 working days.~~

9.5 All reports, papers and the bundle including the agenda, action log and minutes must be ~~submitted~~ circulated at least 5 working days before the meeting.

~~9.6 The agenda, minutes and reports will be circulated 5 working days before the meeting.~~

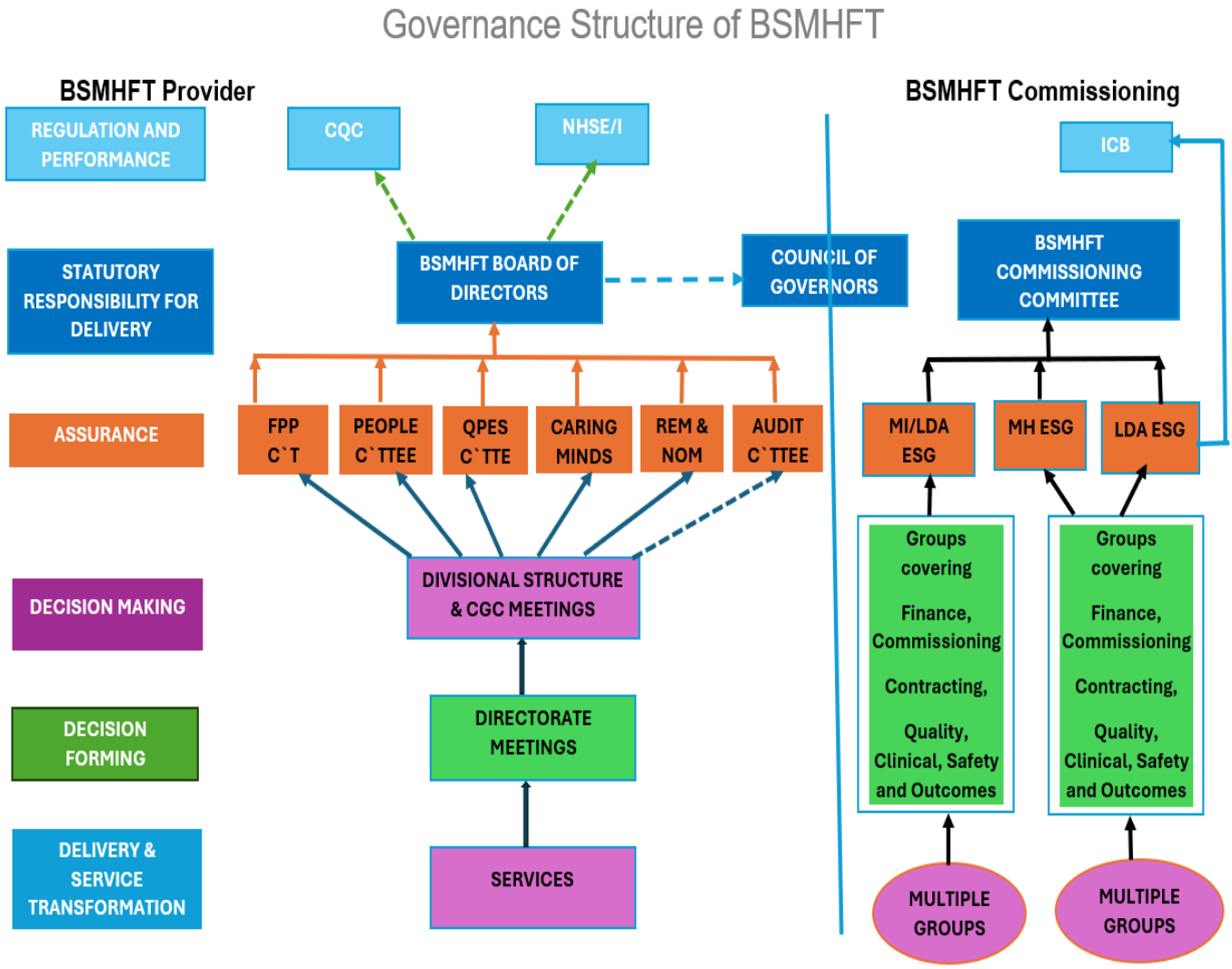
9.7 An action ~~list~~ log and minutes will be compiled during the meeting and circulated within 5 working days of the end of the meeting.

9.8 Any issues about the action ~~list~~ log or minutes must be raised within 5 working days of issue.

9.9 The Company Secretary~~iat~~ will be responsible for updating the forward plan with input from the Director of Quality and Safety (Chief Nurse) and Associate Director of Clinical Governance, for agreement with the QPES Chair.

10. Governance Structure

10.1 BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND LINKS TO OTHER COMMITTEES

11.1 The Committee Chair will provide a `Triple A` Assurance Report at every Board meeting which will reflect the things the Committee is Alerting, Assuring and Advising the Board on.

11.2 The Committee will receive regular reports from the sub-committees and groups reporting into it – the formal timing of these will be outlined on the ~~QSC~~ QPES forward plan and in addition to this

exception reports will be provided as required. The Committee will receive regular Chair`s Assurance Reports from the Trust Clinical Governance Sub-committee (TCGC) at each of its meetings.

11.3 The Committee will provide exception reports to the Audit Committee.

11.4 Any service changes will require sign off in terms of impact on quality by the Medical Director and the Director of Quality and Safety (Chief Nurse).

11.5 Members and Attendees at both QPES and FPP will be expected to have an integrated approach so that impact issues are not lost, and papers to both committees will need to indicate where there is a potential impact on quality. Where necessary, exception reports will be provided between the two committees.

11.6 The Committee will review their effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.7 The Committee Chair will present to the Council of Governors (CoG) annually a report on the work of the Committee. QPES Chair`s Assurance Report(s) will be presented by the Chair to the CoG as per its Forward Plan. ~~next scheduled meeting.~~

REVIEW

12.1 These terms of reference are to be reviewed at least annually.

Date Reviewed: September 2024

Date Approved by QPES: 23rd October 2024

Date Ratified by the Board: 4th December 2024

Date of Next Review: October 2025

Date ratified by the Board of Directors: 4th December 2024

Version: 1.4

Appendix 4: Updated ToR of the Finance, Performance, and Productivity Committee (FPP)

Terms of Reference

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1. VALUES

The Committee 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. AUTHORITY

2.1 The Finance, Performance and Productivity Committee ("**FPP**") is constituted as a Standing Assurance Committee of the Board. Any amendments to its constitution and terms of reference as set out below, must be subject to ~~amendment~~ approval by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from within and outside the Trust with relevant experience and expertise as it considers necessary.

2.3 The Committee is authorised to carry out any function within its terms of reference. FPP is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

3. PURPOSE

3.1 The primary purpose of the Committee is to provide assurance on finance, performance and productivity systems and processes and to approve any business cases in line with the SFI's and scheme of delegation.

3.2 To seek any and all explanations and information it requires from any employee or contractor of the Trust to achieve the Committee's purpose.

3.3 To ensure and assure on behalf of the Board that the Sustainability stream of the Trust's Strategy (~~2020~~ 2024/25) is being delivered:

- Balancing the books
- Transforming with digital
- Caring for the environment
- Good governance
- Changing through partnerships.

3.4 To lead on monitoring of controls and assurance related to the "Sustainability" sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `Sustainability` priority are effectively mitigated and managed.

4. DUTIES

4.1 To receive assurance regarding the Trust's medium- and long-term financial strategy and financial health, including consideration and endorsement of financial plans and budgets for approval by the Board.

4.2 To approve business cases in line with authority limits defined by the scheme of delegation or to make a recommendation to the Board for matters reserved to Board. The Committee will expect assurance that there has been full and proper consideration of the quality implications of any business case coming to the Committee for approval or review.

4.3 To consider savings targets and plans and endorse them for approval by the Board, including assurance of progress against the cost improvement programme.

4.4 To consider the Trust's approach to tax and promote financial sustainability, innovation and transformation while ensuring that the Trust`s purpose and strategy are being pursued in a cost-effective manner and achieving value for money.

4.5 Undertake detailed scrutiny of Trust`s financial and performance information, including performance against the cost improvement programme and the capital investment programme and through detailed review of the Integrated Performance Report (IPR).

4.6 To approve and keep under review the Trust's investment strategy and policy.

4.7 To receive regular reports and insights regarding organisational performance in a form determined by the Committee, including external benchmark information as an aid to improving overall performance and productivity of the Trust.

4.8 ~~To review relevant high-level risks and escalate to QPES and Audit Committees as appropriate to ensure these are properly reflected in the Board Assurance Framework~~. To review and approve `Significant Transactions` within its delegated limits from the Board and review, scrutinise, advise on and recommend `Significant Transactions` above its delegated limits to the Board.

4.9 To scrutinise and challenge financial information and service redesign plans and ensure that any potential impact on quality is fed back to QPES.

4.10 To seek assurance regarding the strategic direction and operational delivery of the digital agenda, its impact on users and plans for sustaining it.

4.11 Where there are any concerns regarding finance, planning, performance and productivity, the committee is authorised to seek assurance that the concerns have been investigated, corrective action taken, and lessons learnt.

4.12 To review and advise on the Trust's strategic business development and planning approach, including strategic intentions. This includes consideration of any relevant, significant business development proposals.

4.13 To approve policies appropriate to the work of the Committee, as defined by the Policy for Management of Policies.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Executive Director of Finance
- Deputy CEO & Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In Attendance

5.2 The following will be standing attendees of the Committee:

- Deputy Director of Finance
- Company Secretariat/Company Secretary

5.3 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.4 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.5 Other members of the Board can attend meetings if they indicate to the Chair of FPP, in advance, of their intention to do so.

5.6 Where members are unable to be present, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.7 Members are expected to make every effort to be present at all Committee Meetings. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings.

5.8 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.9 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with ~~3~~ 4 Committee members, including ~~one~~ two non-executive director and one executive director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. However, if a member is conflicted with an item on the agenda, the Chair ~~will~~ shall adopt a sensible and pragmatic approach in managing conflict during the meeting as they may permit the conflicted member to participate and contribute to the debate and discussions on the item (so as to inform better decision-making) but abstain or recuse themselves from any related voting. (Check section 3.12 – Managing conflict of interests during meetings in the Trust`s Declaration of Interest Policy for more details).

8. MEETINGS

8.1 Meetings will be held ~~8~~ 10 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary~~iat~~ will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 The Associate Director of Corporate Governance/Company Secretary ~~Executive Director of Finance~~ will be responsible for updating the Committee's cycle of business, with input from the Executive Director of Finance and Executive Director of Operations, for agreement with the Chair of the Committee.

9.4 ~~The Executive Director of Finance will agree a draft agenda with the Committee Chair, and it will be circulated 5 working days before the meeting~~. Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the FPP annual calendar of meetings, this will bring together the Chair and Executive Director of Finance to establish and agree the draft agenda which will be timely circulated for papers to be crafted.

9.5 Any issues with the agenda must be raised with the Committee chair for advice prior to the final papers and bundle being circulated. ~~within 2 working days.~~

9.6 All reports, papers and the bundle including the agenda, action log and minutes must be ~~submitted~~ circulated at least 5 working days before the meeting.

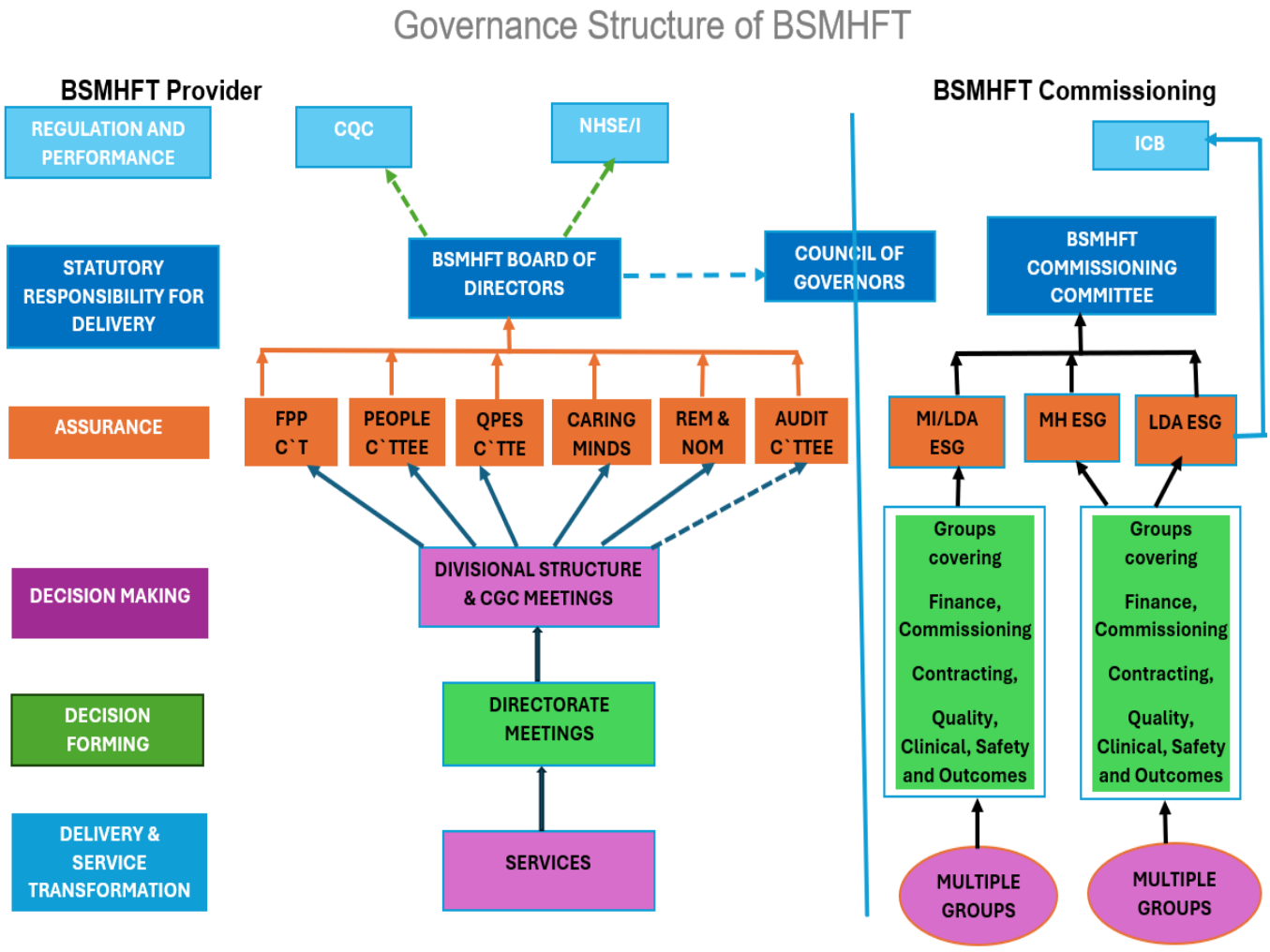
9.7 ~~The agenda, minutes and papers will be issued 5 working days before the meetings.~~

9.8 An action ~~list~~ log and minutes will be compiled during the meeting and circulated within 5 working days of the end of the meeting.

9.9 Any issues with the action ~~list~~ log or minutes will be raised within 5 working days of issue.

10. Governance Structure

10.1 BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report (Triple `A` Report) for the next meeting of the Board. This will seek to amongst others `Alert`, `Assure` and `Advise` the Board as well as describe ~~the~~ any major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

11.2 The Committee will provide exception reports to the Audit Committee as the lead committee for governance and risk.

11.3 The Committee where applicable, will receive exception reports from QPES on concerns which have been raised about potential impact on quality of financial plans. Conversely, and where applicable, exception reports will be reported to QPES on issues the committee needs to draw to its attention about the impact on quality from issues emerging from discussions.

11.4 Overlap between QPES, PC and FPP business will be provided through an attendee at QPES meetings providing a verbal update to FPP. Attendees at QPES, PC and FPP will ensure the need for an integrated approach so that impact issues are not lost, and papers to committees will need to indicate.

11.5 The Committee will review their effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.6 The Committee Chair will present to the Council of Governors (CoG) annually a report on the work of the Committee. FPP Chair`s Assurance Report(s) will be presented by the Chair to the CoG as per its Forward Plan. ~~next scheduled meeting.~~

12. REVIEW

12.1 These terms of reference are to be reviewed at least annually.

Date Reviewed: September 2024

Date Approved by the FPP: 23rd October 2024

Date Ratified by the Board: 4th December 2024

Date of Next Review: October 2025

Date ratified by the Board of Directors: 4th December 2024

Version: 2.7

Appendix 5: Updated ToR of the People Committee

People Committee (PC)

Terms of Reference

Values

The Committee 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. AUTHORITY

2.1 The People Committee is constituted as a Standing Assurance Committee of the Board and is authorised by the Board to investigate any activity within its Term of Reference. It is authorised to seek any information it requires from any employee and contractors as directed to co-operate with any request made by the Committee or the Board of Directors. Any amendments to its constitution and terms of reference as set out below, must be subject to approval by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to instruct professional advisors and require the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee is authorised to obtain internal information as is necessary and expedient to the fulfilment of its functions.

People is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

3. PURPOSE

3.1 To ensure and provide assurance on behalf of the Board of Directors that the People Strategic Priority of the Trust's Strategy (~~2020~~ 2024/25) and people related issues of the Strategic Priorities of the Trust strategy (~~2020~~ 2024/25) are being delivered to all staff groups in line with the Trust values.

3.2 The Committee will take responsibility and delivery of aims set out within the People Strategic Priority as below:

- Shaping Our Future Workforce including
  - Attract and Retain Diverse Talent
  - High-Performing Workforce
  - Flexible &Transformative Workforce Models
- Transforming Our Culture including
  - Inclusion, Equality, and diversity
  - Safety to Speak Up and Share Learning
  - Compassion and Wellbeing
- Modernising Our People Practice including
  - Integrated People Practice
  - Evidence-Based People Practice
  - Digitally Enabled Workforce.

3.3 ~~The Committee will be supported by two sub-groups to provide reports to the People Committee to this effect.~~

3.4 The following sub-committees will be chaired by professional leads outside of the People function:

- Shaping the Future Workforce Sub Committee.
- Transforming Our Culture and Staff Experience Sub Committee.
- Safer Staffing Report from Safer Staffing Sub Committee to include updates on (Recruitment & Retention).

3.5 To assure focus and delivery of wellbeing and inclusion where staff are the top priority to support a happy workforce.

3.6 The People Strategy, structures, systems, and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care.

3.7 Processes are, and the right culture is, in place to support optimum employee performance to enable the delivery of the People Strategy and business plans aligned with the Trust's values.

3.8 To assure The Trust is meeting its legal and regulatory duties in relation to staff, volunteers, and peers by experience.

3.9 To review and advise any human resource risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way.

3.10 To lead on monitoring of controls and assurance related to the 'People' sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `People` priority are effectively mitigated and managed.

4. RESPONSIBILITIES AND DUTIES

4.1 Developing and advising the Board of Directors on the People Strategic Priorities including any leadership and organisational development interventions, actions to improve inclusion, equality, and diversity necessary to deliver the Trust's strategy, incorporating external best practice and professional advice.

4.2 Overseeing delivery of the People Strategic Priorities on behalf of the Board of Directors against agreed plans, a range of workforce metrics, indicators, and targets.

4.3 Undertake detailed scrutiny of the Trust`s People performance information in the Integrated Performance Report (IPR) while linking to any emerging intelligence from Sustainability, Quality and Clinical Services strategic priorities.

4.4 Providing appropriate reports to the Board of Directors on the above indicating assurances received, decisions made, and matters escalated that require consideration by the Board of Directors.

4.5 Monitoring the development of the future workforce, through an effective workforce plan that includes workforce supply, new roles, learning and organisational development.

4.6 Ensure that there is sufficient leadership and management capacity and capability within the Trust to deliver the Trust's strategy.

4.7 Ensuring that the voice of staff and volunteers is heard, via staff networks, staff surveys and other appropriate mechanisms, and that this is acted upon in line with the strategic vision and values and to ensure compliance with requirements relating to Freedom to Speak Up and Whistleblowing.

4.8 Maintain oversight and assure the Trust's equality, diversity, and inclusion agenda is being delivered.

4.9 Ensure the Trust has a suitable policy framework and leadership development framework to deliver the People Strategic Priorities, ensuring alignment with the NHS People Plan and relevant regulatory requirements such as NHS Improvement workforce standards and CQC.

4.10 Oversee the development and implementation of initiatives to maintain the organisation as an undergraduate and postgraduate learning provider.

4.11 Oversee and influence key relationships with educational partners to maximise benefit of these relationships to the Trust.

4.12 Review national and local strategies and reports from external bodies such as CQC, NHSE HEE & NHS Employers, identifying the implications for, and actions required by the Trust.

4.13 Ensure there are ongoing arrangements for reviewing the regulatory requirements relating to staff, such as NHSE and CQC standards such as Well-Led. Ensure that appropriate strategies and plans are developed, implemented, and sustained to meet these requirements.

4.14 Maintain oversight of its associated sub-groups through receipt of regular update reports and metrics.

4.15 The Committee will receive, for information, the minutes from the Joint Negotiation and Consultative Committee and the Joint Local Negotiation and Consultative Committee.

4.16 Receive the People Risk Register and relevant risks from the BAF to review assurance on risk mitigation and controls including any gaps in control.

4.17 Assess any risks within the workforce portfolio brought to the attention of the Committee and identify those that are significant for escalating to the Board of Directors as appropriate.

4.18 Maintain oversight of Remuneration and Reward, ensuring and assuring alignment to relevant Employee and Worker legislation.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Executive Director of Quality & Safety (Chief Nurse)
- Executive Medical Director
- Deputy CEO & Executive Director of Strategy, People & Partnerships
- Executive Director of Operations.

In Attendance

5.2 The following will be standing attendees of the Committee:

- Deputy Director of Nursing
- Deputy Director of Finance
- Deputy Medical Director
- Associate Director for Allied Health Professions and Recovery.
- ~~Chief Psychologist~~ Chief Psychological Professions Officer.
- Associate Director of People, Learning and Development.
- Chair of the Shaping the Future Workforce Sub Committee.
- Chair of the Transforming Our Culture and Staff Experience Sub Committee.
- Company Secretariat/Company Secretary.

5.3 Other members of the Board of Directors can attend meetings if they indicate to the Chair of the People Committee, in advance, of their intention to do so.

5.4 Other members of staff may attend to present papers or to contribute to the staff story.

5.5 Other parties may be invited to present papers from time to time.

5.6 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.7 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.8 Members should make every effort to be present at all Committee meetings. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings.

5.9 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.10 Meeting attendance will be reviewed by the People Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with ~~3~~ 4 Committee members, ~~one~~ two of which must be ~~a~~ Non-Executive Directors and ~~one~~ two must be ~~an~~ Executive Directors. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. ~~Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur~~
However, if a member is conflicted with an item on the agenda, the Chair ~~will~~ shall adopt a sensible and pragmatic approach in managing conflict during the meeting as they may permit the conflicted member to participate and contribute to the debate and discussions on the item (so as to inform better decision-making) but abstain or recuse themselves from any related voting. (Check section 3.12 – Managing conflict of interests during meetings in the Trust`s Declaration of Interest Policy for more details).

8. MEETINGS

8.1 The meeting will be closed and not open to the public.

8.2 ~~Meetings will be held monthly~~. Meetings will be held 10 times per year. Members will agree the meeting dates annually in advance.

8.3 The agenda of every Committee meeting will include as standing items a review of how effectively it has discharged its business and how effective the Committee has role modelled the values of the Trust through its decision making.

9. ADMINISTRATION

9.1 The Company Secretary~~iat~~ will ensure there is appropriate secretarial and administrative support to the Committee.

9.2 The Committee shall report to the Board of Directors on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

9.3 The Committee will provide an annual report to the Board of Directors setting out how it has discharged its responsibilities as set out in these terms of reference.

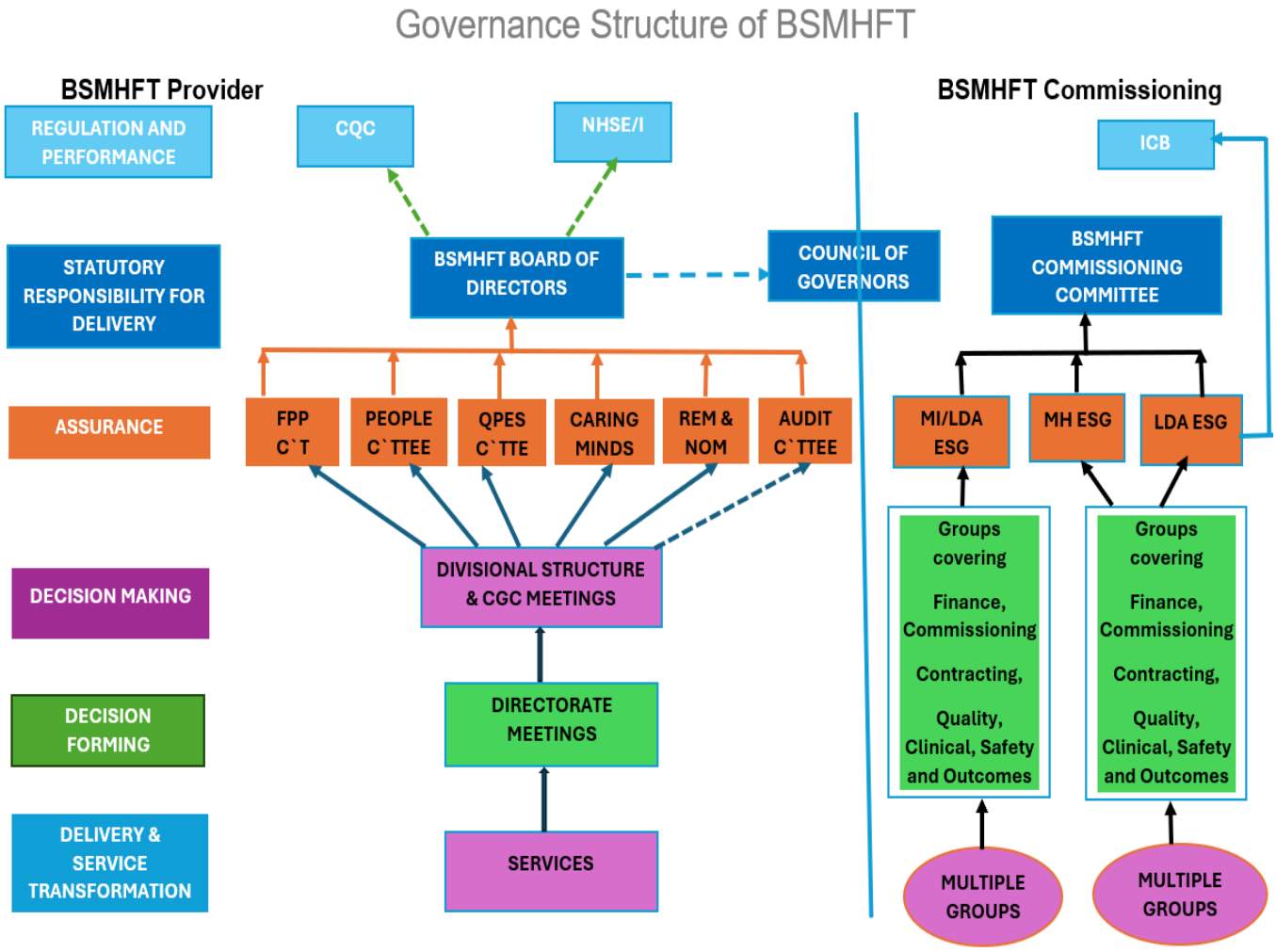
- 9.4 ~~The agenda for each meeting will be agreed by the Executive Director of Strategy, People & Partnerships, and the People Committee Chair~~. Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the People Committee annual calendar of meetings, this will bring together the Chair and Deputy CEO & Executive Director of Strategy, People & Partnerships to establish and agree the draft agenda which will be timely circulated for papers to be crafted. The agenda, minutes and papers will be ~~issued~~ circulated 5 working days before the meetings and any issues with the agenda must be raised with the People Committee Chair within 4 working days.

9.5 An action list log and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.6 Any issues with the action list or minutes will be raised within 5 working days of issue.

10. Governance Structure

10.1. BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND LINKS TO OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report (Triple `A` Report) for the next meeting of the Board of Directors. This will seek to amongst others `Alert`, `Assure` and `Advise` the Board as well as describe ~~the~~ any major issues that were discussed by the Committee, and the level of assurance was received through papers and oral testimony.

11.2 The Committee will report to QPES on matters that are likely to affect workforce resourcing, education, and learning to enable triangulation with clinical outcome and patient care indicators.

11.3 The Committee will ~~report~~ bring to the attention of the Finance Productivity and Performance Committee ("**FPP**") ~~on~~ any matters that are likely to affect expenditure on the Workforce and quarterly on the work of the Workforce Intelligence and Systems as they relate to pay.

11.4 The Committee will provide exception reports to the Audit Committee.

11.5 The Committee will provide reports as requested to the remaining committees.

11.6 Operational delivery of the Committee's work plan will be overseen by the Director of Strategy, People & Partnerships via day-to-day oversight of the HR, OD, and Learning and Development functions.

11.7 The Committee will review its effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.8 The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors ~~at the next~~ as per its schedule of meetings.

11.9 The Committee will foster dialogue and relationships with Trade Union colleagues via biannual conversations and updates from them on their activities, challenges, and suggestions on promoting and enhancing the working conditions of our staff.

12. REVIEW

12.1 Terms of Reference are to be reviewed at least annually.

Date Reviewed: September 2024

Date Approved by the People Committee: 20th November 2024 & via email.

Date Ratified by the Board: 4th December 2024

Date of Next Review: November 2025

Date ratified by the Board of Directors: 4th December 2024

Version: 2.8

Report to the Board of Directors							
Agenda item:	**23a**						
Date	4 December 2024						
Title	Risk Management Policy						
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 highlights the changes that have been incorporated into the enclosed updated Risk Management Policy. The updated Policy was presented at the Trust Policy Development & Management Group (PDMG) on 14th August and the Risk Management Group (RMG) on 22nd August 2024 where it was well received and largely endorsed. The changes captured in this updated Risk Management Policy have had the endorsement of the Chair of the Audit Committee via Chair`s Action while these will also be presented at the Audit Committee on 23rd January 2025 for information and minuting. Effective risk management could offer the opportunity for the Trust to tap into and harness the dividends of a positive risk aware culture, in enhancing decision-making, and driving innovation and improvements in patient-centred outcomes.

Introduction:

BSMHFT`s risk management policy provides a structured and comprehensive framework and guidance for systematically identifying, assessing, mitigating and managing risks that could impact on the achievement of the Trust`s strategic and operational objectives. The new Trust risk appetite framework will be reflected in this updated Risk Management Policy once both documents have been ratified by the Board today.

The Trust`s Risk Management Policy thus defines the principles, processes, responsibilities, and standards guiding the timely, dynamic and proportionate, effective mitigation and management of risks across its corporate functions, services, directorates and divisions.

This updated Risk Management Policy incorporates the following key changes: -

- Widening its applicability to the MHPC, Reach-out and other Trust subsidiaries.
- Clarification and strengthening of the role of the Risk Management Group in moderating risks, providing constructive challenge, advice and overseeing the operationalisation of risk management across the Trust.
- A diagram to reflect the different sources of risks.
- A section devoted to the management of EPRR risks as this is a requirement of the annual Core Standards.
- Clarification of the difference between `Inherent`, `Current` and `Target` risk scores.

- Re-framing and clarification of individual and committee roles and responsibilities for risk management.

Key Issues and Risks:

1. Potential lack of engagement with the Risk Management Policy, however, this would be mitigated by populating the updated policy via the Weekly Bulletin, existing meetings e.g. Directorate CGCs etc.

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 changes that have been made to the Trust`s Risk Management Policy.*
2. ***REVIEW, SCRUTINISE and RATIFY*** *the attached updated Risk Management Policy.*

Enclosures

1. Updated Risk Management Policy.

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	**RS 01**	**Risk & Safety**
VERSION NO & DATE	**17**	**September 2024**
RATIFYING COMMITTEE	**Board of Directors**	
DATE RATIFIED	**4th December 2024**	
NEXT REVIEW DATE	**2 years after ratification**	
EXECUTIVE DIRECTOR	**Executive Director of Finance**	
POLICY LEAD	**Associate Director of Corporate Governance**	
POLICY AUTHOR *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Previously Reviewed:	**June 2023**	**Sept 2024**							
Changes Made: Yes/No:	**Yes**	**Yes**							

POLICY REQUIREMENT

The Policy applies to all staff - including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, agency staff, TSS/Bank staff, trainees, contractors, Trade Union colleagues, students and persons engaged in doing business or providing services on behalf of the Trust. This Policy will be reviewed every two years; however, it could be reviewed earlier if significant changes occur within the Trust risk management landscape.

- All staff members are responsible for:
  - ensuring that risks are identified, assessed and managed.
  - highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role/responsibilities.
- All operational service areas and Executive Directors should systematically review risks on their risk registers, in a timely, dynamic and proportional way, those scored 15 or more, on a monthly basis as a minimum while those scored 12 or less quarterly as a minimum, identify controls for mitigation and evaluate their effectiveness.
- The Risk Management Group (RMG) will ensure effective working arrangements and controls are in place to proactively manage the escalation of risks. Risk moderation will take place at the RMG to determine appropriateness of risk scores, approve risks for escalation and ensure operational risks do not compromise the delivery of the Trust's operational objectives and business plan.
- All risks which could significantly compromise the Trust's ability to deliver its operational and strategic objectives will be reviewed on a monthly basis as a minimum via the Corporate Risk Register and Board Assurance Framework respectively, by the Quality, Patient Experience and Safety Committee, People Committee, and the Finance, Performance and Productivity Committee, as a tool for driving their agendas, discussions and debates.
- The Audit Committee will review the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management and make recommendations to the Board as appropriate regarding the Trust`s risk management arrangements.

Contents

1 Introduction

1.1 Rationale

The development and implementation of this Policy will be underpinned by the Trust`s values of compassionate, inclusive and committed.

Risk is the chance that something may happen which may have an adverse impact on the achievement of the Trust`s aims and objectives. It is measured by multiplying the likelihood (frequency or probability of the risk occurring) by the severity/consequence (impact or magnitude of the effect of the risk occurring)

(Adapted from ISO 31000:2018)

Risks will always be present in the things that we do. The aim of this policy is to ensure that all staff actively understand risk, recognise risk, and know how to identify, assess, report, review, and manage risks to support the overall aims of the organisation. This means that we look at risk at all levels ranging from the risks to delivery of our strategic priorities/aims, through to the day-to-day delivery of team-based objectives which in turn contribute to the bigger picture.

This is demonstrated in the pictorial diagram below: -

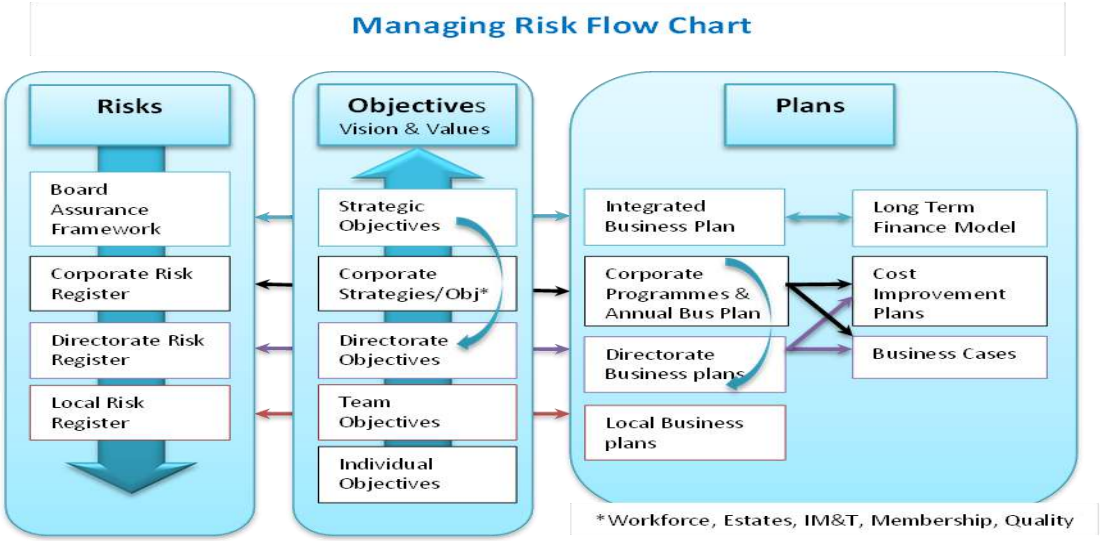


Figure 1 – Managing risks flow chart.

Good risk management is at the heart of everything we do in the Trust. We need to be open, honest, and aware of the risks we are facing on a day-to-day level as well as strategically. BSMHFT is committed to implementing an agile, dynamic, integrated and Trust-wide proactive approach to risk management – i.e. to identifying, assessing and managing potential risks/threats to the delivery of its operational objectives and strategic priorities.

In large complex organisations, managing risk could seem a daunting task. Risks are, however, inherent in everything that we do as the provision of healthcare

entails some uncertainty, hence, that uncertainty brings new opportunities and risks. How we manage existing and emerging risks is important in helping us meet our objectives, improve service delivery, achieve value for money and reduce unwarranted variations, fire-fighting and unwelcome surprises.

This Risk Management Policy provides a framework for the effective, proactive and timely management of risks. Sound recording and escalation mechanisms are described for departmental risks, wider locality service area risks and Trust wide risks. This policy also sets out the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks.

1.2 Scope

The Policy applies to all staff, including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, Agency, TSS/Bank staff, agency staff, trainees, contractors, Trade Union colleagues, and students and persons engaged in doing business or providing services on behalf of the Trust.

The Trust works in partnership with Birmingham Community Healthcare and other partners within the system to ensure individuals with learning disabilities have full and equal access to the full range of mental health services. Therefore, all aspects of this policy will equally apply to service provision within related learning disabilities.

1.3 Principles

The Trust's approach recognises:

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The implementation of the risk management arrangements must be proportionate, timely, dynamic, aligned to the delivery of the Trust`s goals, comprehensive and embedded into business as usual as well as responsive to changes within the Trust`s business environment.
- The need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create and seize opportunities in a managed way e.g. by considering alternative actions to those originally intended. Some risks will always exist and will never be eliminated; all staff must understand the nature of risk and accept responsibility for the management of risks associated with their area of authority.
- The Trust explores an integrated approach to risk management that combines a top-down strategic view with a complementary bottom-up operational process.

2 Policy

All staff members are responsible for ensuring that risks are identified, assessed and managed.

All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.

The consequence and likelihood of risk occurrence will be assessed against the Trust wide risk scoring matrix (see appendix 1 for details). Risks will be recorded on risk registers via the Eclipse electronic risk management system.

All local service areas, managers and Executive Directors should systematically review risks on their risk registers or within their portfolio on a monthly basis as a minimum, for those scored 15 or more and on a quarterly basis as a minimum, for those scored 12 or less as well as provide assurance that the risks are being managed thoroughly and through their local governance arrangements. Local service areas, Directorates and corporate support teams are expected to escalate any risks with a score of 15 or more that have been approved at their local governance meeting, signed off at the Directorate level and by the relevant Executive Director. Such risks will then be presented at the RMG for consideration and approval for inclusion onto the CRR, please see section 5 for more details on risk escalation.

Risks which could significantly compromise the delivery of the Trust's corporate objectives/business plan, once approved by the RMG, will be added onto the Corporate Risk Register (CRR). Relevant extracts of the Corporate Risk Register will be presented to the Quality Patient Experience and Safety Committee, People Committee and Finance, Productivity and Performance each time the BAF is received to ensure both the CRR and BAF complement and inform each other.

Whilst management is responsible for operationalising risk management across the Trust, Board Committees, the Board and related governance arrangements are responsible for providing scrutiny, constructive challenge and oversight. The entire CRR will be presented to the Audit Committee and Board each time they receive the BAF.

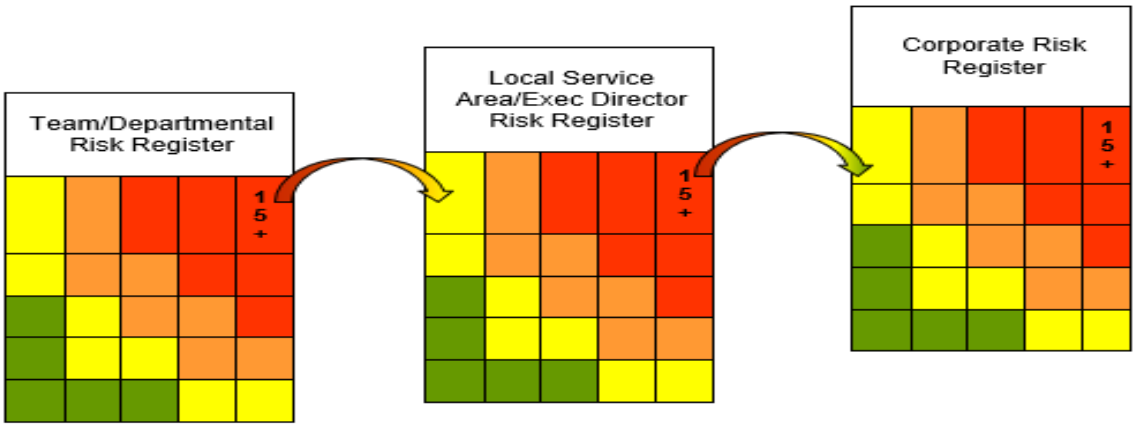


Figure 2 - Escalation in the Risk Register Hierarchy

BSMHFT`s Risk Management Policy provides a comprehensive framework to underpin how staff in all Services and Directorates across the Trust should timely and proactively identify, assess, manage and mitigate any potential risks that

could compromise the achievement of their local operational objectives/goals. It thus seeks to foster standardisation, engagement, consistency and galvanise leadership in fostering effective risk management and risk escalation from `Ward to Board`.

3 Procedure

3.1. The Trust's overall approach to risk management is underpinned by the following 5 key distinct but interrelated and complementary steps: -

- Establish the Context
- Risk Identification
- Risk Analysis
- Risk Evaluation
- Risk Control/Treatment

} Risk assessment

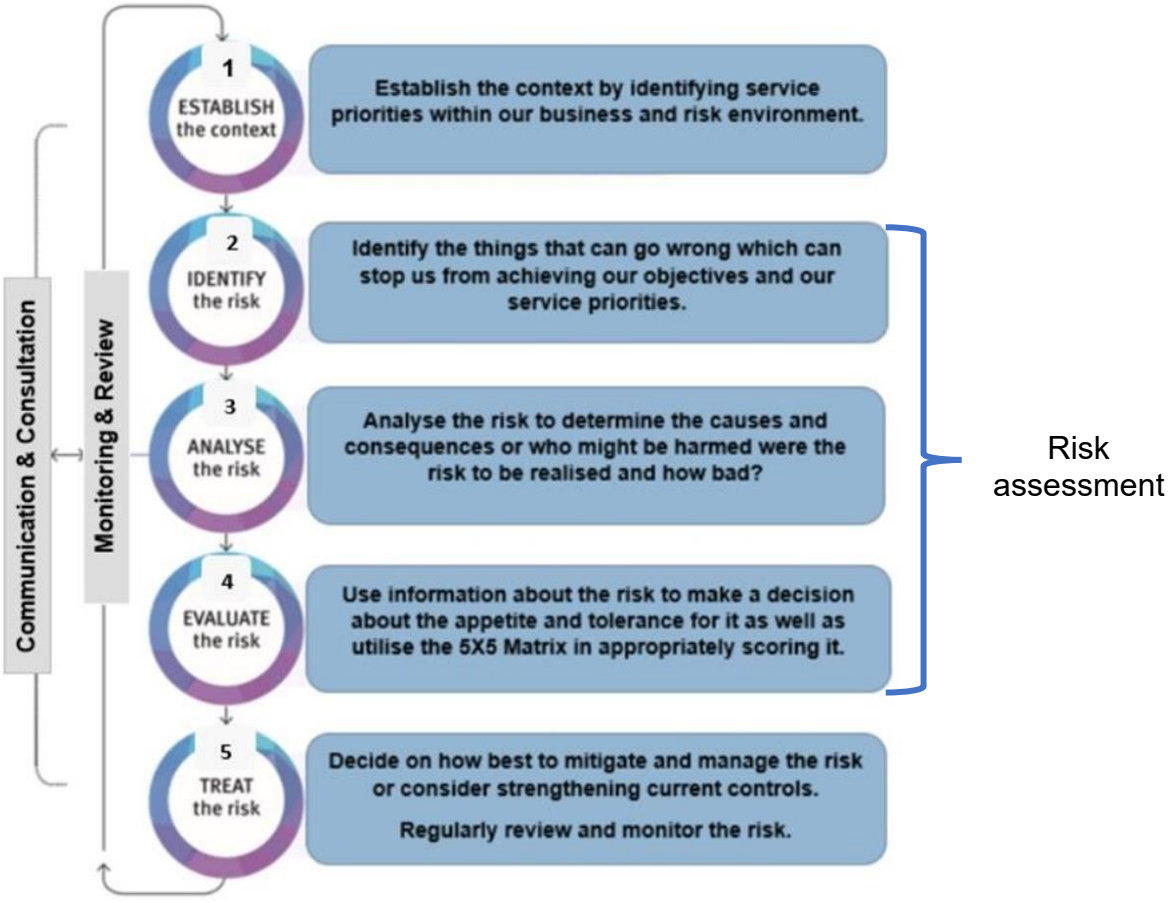


Figure 3: BSMHFT`s approach to risk management - Five steps

3.1.1. Step 1: Establish the context

As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priorities in order to clearly identify risks and opportunities which may impact on their achievement. It is also important to consider the internal and external contexts.

3.1.2. Step 2: Risk identification

The identification of risk needs to be dynamic process, which involves all staff and ensures that action is taken before incidents/actual loss or harm have occurred. Risks may be clinical or non-clinical, including financial and reputational and may be identified from many sources, such as but not limited to:

Figure 4 - Sources of Risk Identification

Any managed change generated within the Trust should be risk assessed before, during and after the change occurs. Significant projects are managed through the Project Management Office where risk & issue logs and Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams.

For risks which arise in the Trust`s Emergency Preparedness, Resilience and Response (EPRR) space, BSMHFT`s Emergency Preparedness & Business Continuity (BC) Management Policy clearly sets out a strategic framework for the effective management of EPRR-related risks, including the emergency planning and business continuity for the Trust as this applies to all staff (both temporary and permanent). The Emergency Preparedness and Major Incident plans, as well as a range of other associated documents, are designed to ensure the resilience of the Trust in a range of scenarios that would limit its operating capacity.

Major Incident plans should be tested on a regular basis, and risks identified from any learning are communicated back to the relevant groups to ensure processes are refined. All risks relating to EPRR and BC are captured on the Trust risk management information system (Eclipse), reviewed monthly as a minimum for those scored 15 or more and quarterly as a minimum for those scored 12 or less, as well as reported to the Business Continuity & Emergency Preparedness

Committee which has responsibility for scrutinising, communicating and escalating such risks through the relevant Trust governance channels.

Staff should adhere to the Trust`s structured approach for describing risks also referred to `Cause and Effect Analysis` or the `Bow-tie` model. This model clearly identifies the event, the cause and the effect. It is helpful to frame the description of a risk into three parts by starting with these phrases:

- **There is a risk of/that/if…**(this relates to not achieving an objective as intended).
- **This may be caused by…**
- T**his may lead to an impact/effect on …**

Risk description must be clear and use concise appropriate language e.g.

- *"There is a risk that patients may not be discharged promptly from the Community Hospital.*

  This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Hence the description of a risk must clearly outline the event or objective that relates to or might not be achieved if the risk were to crystallise, what could be the cause(s) and what could be some potential impacts and/or opportunities.

3.1.3. Step 3: Risk analysis

Determine the cause and effect and analyse what could happen, where, when, why and decide who might be harmed and how. Also determine the existing controls, the likelihood and consequences as well as estimate the level of risk. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

3.1.4. Step 4: Risk Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and if the risk were to be realised (likelihood). The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix (see appendix 3 for details) in assessing and scoring the risk. Decide on the most appropriate risk response option. The following three risk scores will have to be identified during a risk assessment process: -

- **Inherent** – this refers to the uncontrolled level of risk i.e. the initial or gross risk before any controls and actions are put into place.
- **Current** – this is the residual risk after controls and action have been put into place.
- **Target** – this is the threshold at which the risk would be sufficiently mitigated such that it could be tolerated or accepted as actions have been completed and controls internalised into BAU. The target risk score is linked to the Risk Appetite Framework (see appendix 6 for details).

3.1.5. Step 5: Risk Treatment & Prioritisation

Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to reduce the risk and then identify further actions, which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan or risk treatment plan and decide on how best to manage it.

Hence, a decision should be made as to whether the Trust should avoid, reduce, eliminate, accept/retain or transfer the risk.

- **Avoid**: Whether a particular task can be undertaken a different way so that the risk does not occur.
- **Reduce**: Whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure.
- **Eliminate**: Whether definitive action can be taken to eliminate the risk exposure.
- **Accept/Retain**: Whether the level of risk is acceptable as no further mitigating actions can be taken, or the extent of actions to be taken outweighs the consequence of the risk occurring. Risks that are accepted will continue to form part of our review and reporting processes.
- **Transfer**: Whether the risk can be transferred to another organisation

Where further actions are required to avoid, eliminate or reduce the risk, these actions must be entered onto the risk register along with the date by which the action will be implemented and the individual responsible for assuring delivery of the action.

3.2. Risk Review and Monitoring

Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales: -

- Risks scored 15 or more should be reviewed monthly as a minimum.
- Risks scored 12 or less should be reviewed at least quarterly as a minimum.

The resources deplored to mitigate and manage a risk must be proportionate to the perceived potential impact of the risk were it to crystallise. All risks must be captured on, mitigated and managed via Eclipse - the Trust`s electronic risk management information system as managing risks on papers/spreadsheets is highly discouraged by the Trust.

3.3. Types of control: Risk control techniques

Controls are measures or interventions that are implemented in order to reduce either the likelihood and/or impact of a risk were it to materialise. The following types of control are frequently used in mitigating and reducing risks: -

a. **Preventive controls** - these controls are designed to limit the possibility of a risk crystallising e.g. regular maintenance of electrical equipment.

b. **Corrective or Response controls** – These controls are designed to correct or in response to undesirable outcomes which have already been realised e.g. contingency planning.

c. **Detective controls** – these controls are designed to detect a risk before it occurs e.g. Medication reconciliation to identify potential risk of medication error or accounts reconciliation to identify potential fraud.

d. **Directive controls** – these are controls that we implement because we are directed by guidelines, regulation or legislation e.g. Requiring new staff to shadow before being allowed to work alone.

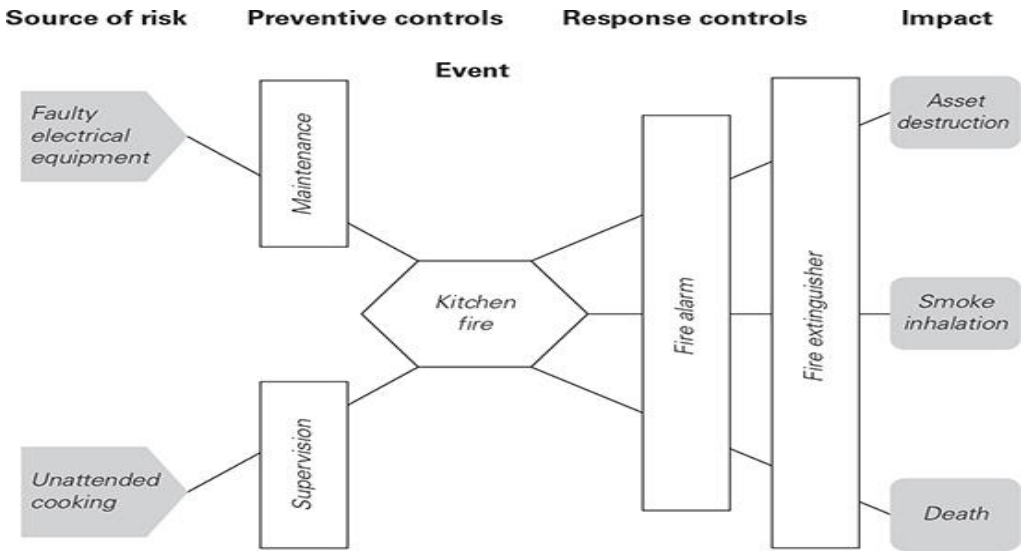


Figure 5. Types of control

3.4. Criteria for escalating risks onto the Corporate Risk Register (CRR):

- The risk must be scored 15 or more and must be approved for escalation by the Service, Departmental or local governance meeting and/or management team, supported by the Directorate Governance meeting and/or senior management team and the relevant Exec Director.
- The risk must be appropriately assessed, and all fields completed prior to presentation for escalation.
- Once a risk has been approved for escalation by the Directorate Governance meeting and/or management team, the risk Manager should be notified so they could liaise with the Service and/or Directorate to ensure the risk is appropriately captured on the CRR template and included onto the agenda for the RMG. Please see appendix 2b for details of the Trust`s risk escalation flow chart.

3.5. Risk Escalation:

- Timely and dynamic escalation of risks is important for effectively risk management; hence this policy identifies two pathways through which risk could be escalated to the RMG: -

- **Via Governance route**: through appropriate governance meetings as described above.
- **Via management route:** This implies expedited escalation, hence, in the case where the local governance meeting isn`t due to be held for a few weeks or months. Once management at the local service/Directorate/ Corporate Service have reviewed the risk and are satisfied that it has been appropriately described and scored, it should be presented to the Clinical Director (CD) (or the appropriate Senior Manager/Professional Lead in the case of Corporate Services) for support and then shared with the relevant Executive Director for signed-off and either: -
    a. Presentation and approval at the RMG.
    b. Direct inclusion on the CRR, in the case where the RMG isn`t due to hold soon. This is to ensure timely and dynamic escalation of risks; however, such a risk will need to be presented at the earliest RMG for review, scrutiny, noting, learning and minuting.
- If in doubt, services and Directorates are encouraged to contact the Risk Manager for support and clarifications.

Managers from the Service/Directorate escalating the risk and the CD supporting the escalation may be invited to attend the RMG to present the risk. However, if a risk isn`t approved at the RMG following escalation, the RMG will provide advice through the colleague who presented the risk and request for it to be de-escalated to the relevant service for appropriate mitigation and management or for review, amendments, and re-escalation if that is deemed appropriate.

3.6. Board Assurance Framework (BAF)

- The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Trust and co-ordinating them to best effect.
- The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Trust`s strategic goals have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance.
- It thus provides a structure and process through which the Trust could focus on those principal risks which may undermine the achievement of its strategic goals as defined in the Level 1 priorities in its updated Strategy.
- Executive Directors and their ADs are responsible for ensuring that risks within their portfolio captured on the CRR and BAF are timely and regularly updated prior to presentation at the relevant Board Committees.

3.7. Linking the CRR to the BAF

- BSMHFT`s BAF and CRR are maintained distinctively separate, however, both toolkits complement each other and are symbiotically linked; inform, shape and feed-off each other. Both documents are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks to the delivery of the Trust`s priorities are managed in accordance with this Risk Management Policy.

3.8. Collaborative and shared Risk Management

- BSMHFT recognises that there will be instances where the effective management of a risk will require inputs from other colleagues and stakeholders who may not necessarily be part of the service/Directorate in which the risk has been identified. For example, a service may identify a risk, which requires inputs from subject experts from say Informatics, Finance, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively mitigate and manage it. However, responsibility for owning, mitigating and managing the risk lies with the local service where it has been identified.
- In such a situation, Services/Directorates should ensure that all key stakeholders who could contribute to the effective management of risks are involved in the discussions on how best to reduce and manage the risks in question. In other instances, such stakeholders for example, the Local Authority may be external; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately mitigating and managing such risks.

3.9. Risk Management Training:

- BSMHFT recognises that developing staff capacity and capability in risk management is critical for fostering engagement and embedding its risk management culture.
- The Risk Manager with the support of the relevant AD, Senior Professional Lead or Exec will design and deliver bespoke risk management training that will be available to all staff and managers as well as to contractors delivering services on behalf of BSMHFT. Staff will be regularly signposted to log onto the learning zone to book onto the Trust`s risk management training programme.

3.10 Risk Management Annual Improvement Plan:

- BSMHFT is committed to continuously learning and improving its risk management arrangements, hence, it has adopted a QI approach to

improving its risk management landscape through the implementation of a risk management annual improvement plan.

- The plan will be monitored at the RMG on a quarterly basis and assurance provided to ET.

4. Responsibilities

Staff/Groups	Responsibilities	Ref
All Staff	All staff should be aware of risk assessment findings and risk management measures, which could affect their practice and professional needs. They must inform their line managers of risks deemed to be unacceptable and/or outside of their ability to manage. In addition, all staff (permanent and temporary) must • Report incidents/accidents and near misses in a timely manner and in accordance with incident reporting policies via Eclipse. • Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business. • Comply with all Trust policies and procedures and any other instructions/guidelines to protect the health, safety, and welfare of anyone affected by the Trust's business. • All staff including Trade Unions colleagues, contractors and partners who provide services for and on behalf of BSMHFT are responsible for effectively mitigating and managing risks to the delivery of the Trust`s operational and strategic objectives/priorities. In short, risk management is everyone`s responsibility.	
Executive Directors & Trust Board	The Chief Executive maintains overall accountability for risk management within the Trust but will delegate responsibility to nominated Executive Directors of the Trust Board. The Director of Finance (on behalf of the Chief Executive) is the Executive Director responsible for risk management and for co-ordinating the implementation and operationalisation of the Risk Management Policy across the Trust. The Director of Finance shall ensure the provision of effective risk management including risk governance	

	structures and robust systems which assure implementation of the Trust's risk and risk governance objectives through the proactive identification and prioritisation of key organisational and risks from service areas, through to Directorates and ultimately the Board. The Director of Finance shall ensure the development of systems, control process and risk management arrangements that comply with internal and external risk governance and best practice requirements and ensure continuous improvement of the quality of risk information, particularly in the areas of key controls. The Director of Finance shall be responsible for designing, developing, coordinating and reporting on the Corporate Risk Register to the rust Clinical Governance Committee, Board and Board Committees as well as for the implementation of the Annual Risk Management Improvement Plan and the Annual RMG Self-assessment while ensuring there are effective risk management systems and processes in place. They are also responsible for ensuring that there is a bespoke risk management training programme in place to support developing staff capacity and capability and organisational resilience in risk management. The Director of Finance has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and for the effective management of risks within their portfolios. The Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning. The Director of Strategy, People and Partnerships has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships.	

Clinical Directors	Clinical Directors are responsible for ensuring that there are robust systems and processes in their Directorates to support the effective identification, assessment, mitigation, monitoring and management of risks. They are responsible for ensuring that risk management and especially high-level operational risks in their directorates are periodically reviewed and scrutinised at their Directorate Clinical Governance Meetings. Clinical Directors will be responsible for timely reviewing and approving high operational risks scoring 15 and above from their directorates being put forward for escalation to the RMG prior to their presentation at the RMG.	
Associate Director for Clinical Governance/ Associate Director of Corporate Governance	The Associate Director for Clinical Governance will be responsible for ensuring all clinical and patient safety related risk are appropriately added onto the Trust risk management information system. They will liaise with the Risk Manager in ensuring Services and Directorates escalating risks to the RMG for consideration, approval and inclusion onto the corporate risk register are appropriately supported. The Associate Director of Corporate Governance has overall responsibility for the designing and regularly refreshing Risk Management Policy and through the Company Secretary for the management of the Board Assurance Framework. They shall also work closely with ADs, Non-Executive Directors, Executive Directorates and the Company Secretary in designing, regularly refreshing and implementing the BAF. The AD of Corporate Governance shall with the support of the Company Secretary be responsible for presenting the BAF twice a year at the TCGC, quarterly at the RMG, monthly at Board Committees and twice yearly at the Board.	

Associate Directors / Corporate Senior Professional Leads	All Associate Directors and Corporate Senior Professional Leads have delegated responsibility for the effective management of risks within their portfolios and for ensuring that significant risks to the achievement of their local operational objectives are escalated in line with this Policy. ADs and Corporate Senior Professional Leads are responsible on behalf of their Executive Directors, for BAF and CRR risks that are assigned to their portfolio, ensuring these are regularly reviewed and updated as well as all related actions appropriately implemented and evidenced.	
Senior Leaders and Managers (including Senior Directorate Teams).	• Implementing Trust policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility. • Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. • Overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register. • It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.	
Risk Manager	• They are responsible for ensuring the Trust has effective risk management arrangements in place, populating the Trust`s risk management	

	policy, raising the profile, visibility and supporting Services and Directorates across the Trust to embed risk management into business as usual. • Creating space for a risk aware-culture to flourish across the Trust and the provision of risk management-related assurance to the Board and its sub-committees. • Act as an adviser to the Trust on all aspects of risk management and lead on the development of a dynamic, comprehensive, proactive, agile, sustainable Trust-wide risk management infrastructure. • Support local services and Directorates in reviewing and keeping their local risk registers up-to-date and in pulling risk registers for local governance meetings if requested including servicing the RMG. • Designing and delivering the Trust`s risk management training. • Provide admin support to the RMG including, servicing, minuting and ensuring all reports and papers are collated and timely circulated.	
Trust Board	Responsible for: - • overall risk oversight, scrutiny, gaining assurance, setting the tone and culture that underpins the Trust`s risk management approach. • ratifying the Trust's Risk Management Policy including the Risk Appetite Statement. • reviewing the Board Assurance Framework and the Corporate Risk Register.	
Audit Committee	Responsible for: - • reviewing the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management. • making recommendations to the Board as appropriate regarding its risk management arrangements.	
Quality, Patient Experience and Safety Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect quality, safety, and patient experience risks and that there are effective	

	controls, assurance and mitigation to manage these.	
Finance, Performance and Productivity Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect performance, sustainability, financial and governance risks and that there are effective controls, assurance, and mitigation to manage these.	
People Committee	Responsible for • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect workforce related risks and that there are effective controls, assurance, and mitigation to manage these.	
Risk Management Group	Responsible for: - • seeking assurance on the effectiveness of the Trust's risk management systems. • developing and overseeing the implementation of the Risk Management Policy. • reviewing and approving risks escalated to it and ensuring that those rated 15 or above are properly recorded in the Corporate Risk Register. • Considering evidence and approving the closure of risks on the Corporate Risk Register. • Supporting the Board with the development and maintenance of the Risk Appetite Statement and the CRR. • Receive, review the BAF twice a year and offer advice and recommendations to the Board via relevant Board Committees.	
Strategy and Transformation Board / Sustainability Board	Responsible for: - • Strategy and Transformation Board for providing scrutiny, assurance, governance and oversight, of all risks and impact assessments relating to change programmes and projects. • Sustainability Board for providing scrutiny, assurance, governance and oversight of finance-related risks.	

Local management and assurance groups	Responsible for: - • maintaining risk registers relating to their area of responsibility. • systematically reviewing relevant risks, seeking and providing assurance that they are being managed through their local governance arrangements. • escalating risks with a score of 15 or above through their Directorate meetings to the Risk Management Group.	

5. Development and consultation process

Consultation summary	
Date policy issued for consultation	July 2024
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Staff and reps from Services/ Directorates - Workshops	July/August 2024
Policy Development Management Group (PDMG – for noting)	14th August 2024
Local Governance Committees	July/August 2024
ET	August 2024
Risk Management Group	22nd August 2024
Audit Committee	26th July 2024 & 24th October 2024.
Board	4th Sept 2024 & 2nd October 2024

6. Reference documents

Australian/New Zealand Standard AS/NZS 4360:

7. Bibliography

None

8. Glossary

None

9. Audit, assurance & monitoring implementation.

The policies, systems, framework and processes covered by the Risk Management Policy and Strategy and the Board Assurance Framework will be regularly, systematically and independently audited as required by the Audit Committee.

Monitoring implementation of this Risk Management Policy

- BSMHFT will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs – please see appendix 2a for details) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 10 risks randomly selected from each Directorate risk registers and 5-10 from the Corporate Risk Register in measuring the following KPIs as set out on the table below: -

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
1. Compliance	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.
2. Maturity	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.
3. Data Quality	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.

10. Appendices

1 Equality Impact Assessment
2a. Definitions of KPIs for monitoring implementation of this Risk Management Policy
2b. Risk Management Flow Chart
3. Risk Scoring
4. Risk Thresholds/Risk Level Monitoring
5. Key definitions
6. Risk Appetite Framework

Appendix 1: Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Risk Management Policy		
Person Completing this proposal	David Tita	**Role or title**	AD Corporate Governance
Directorate	Finance	**Service Area**	Corporate Governance Team
Date Started	July 2024	**Date completed**	July 2024
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Quality, Sustainability, People and Clinical Services			
Who will benefit from the proposal?			
The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The Policy may directly affect service users as its effective implementation may have positive impacts the Trust`s safety culture and enhance the delivery of high-quality patient-centred safe care.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
N/A			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			

N/A				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
N/A				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimal Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	✓			It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their age.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			It is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of any disclosed disability. The Trust have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. This is dependent if the individual

				feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues. The current WDES is showing the Trust is ranked in the top 10% nationally in Recruitment and Reporting of harassment, bullying and abuse.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	✓			It is anticipated that gender will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. Currently gender is collated and there is a disparity around gender pay gap overall with an increase from 6.99% to 11.17%. The Trust has now set up a Women's Network and Men's Network who meet on a monthly basis.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	✓			It is anticipated that marriage or civil partnership will not have an impact in terms of discrimination as this policy ensures that the staff group who affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	✓			It is anticipated that pregnancy and maternity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide

				necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. This is dependent on staff feeling comfortable about being open about their or their partners pregnancy, including miscarriage. We also have started the Women's Network where these matters can be discussed and shared there.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	✓			The Trust is working towards a Anti Racist organisation and will be launching the Anti Racist Framework. It is anticipated that Race or Ethnicity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. We also have the Race Equity Network and Anti Racist Campaign to support those who are facing racial discrimination.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. The Trust will provide necessary support and reasonable adjustment for employees, and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their religion or belief.
Including humanists and non-believers				

Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. We currently have LGBTQ Staff Network who meet regularly where information is shared. It is anticipated that sexual orientation will not have a negative impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. The Trust has also launched the LGBTQ+ campaign to support staff and training.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	✓			Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment. The Trust is currently offering Trans Awareness training to support staff.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	✓			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010.

				This policy applies to all, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust

Affecting someone's right to Life, Dignity and Respect?
Caring for other people or protecting them from danger?
The detention of an individual inadvertently or placing someone in a humiliating situation or position?

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	~~Yes~~	No		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				✓

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

Discussions took place with colleagues in the development of this policy.
EDI Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns.

How will any impact or planned actions be monitored and reviewed?

Via the Directorate CGCs, RMG, Board and Board Committees. Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
This is not relevant. The policy is applicable to all members of the Trust regardless of their personal protected characteristics.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Directorate or Service planning and monitored on a regular basis.

Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive impact in highlighting risks to equality and support specific approaches to close the gaps where these are identified.

Appendix 2a: Definitions of KPIs for monitoring implementation of this Risk Management Policy

- **Compliance:** This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components: -

  % of risks which are in date and/or out of date;

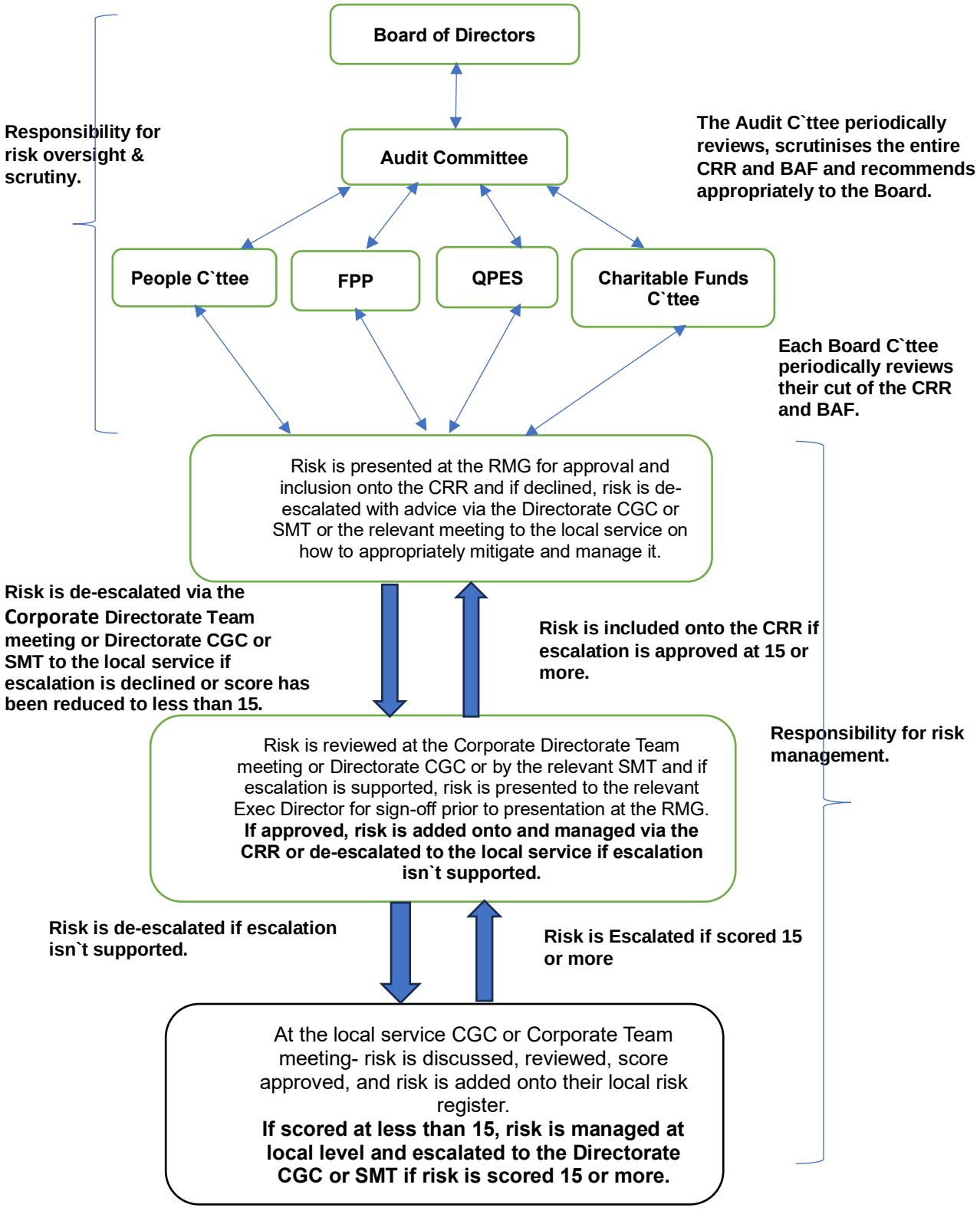
  Evidence that services escalating risks in line with this Risk Management Policy.

- **Maturity:** This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: -
  % of risks appropriately completed.

- **Data Quality:** This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -
  % of risks which have been appropriately described.

Appendix 2b: Risk Management Flow Chart

BSMHFT Risk Management flow chart - Escalation and de-escalation of risks.



NB: Responsibility for mitigating and managing risks on the CRR lies with the local service which owns the risk as escalation doesn`t exonerate them from this responsibility.

Appendix 3: Risk Scoring

RISK SCORING

The prioritisation and allocation of risk

To ensure that meaningful decisions on the prioritisation and treatment of risks can be made, the Trust will grade all risks using the same tool.

- **The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) will be used to assign risk priority.**

  It is essential to have one system for prioritising and rating risks, and this will be used to prioritise risks on the Assurance Framework and Risk Registers, and for rating incidents, complaints, and claims. Risk analysis uses descriptive scales to describe the magnitude of potential consequences and the likelihood that those consequences occur.

Measures of likelihood – likelihood scores (non-financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur **at least annually.**	Expected to occur **at least monthly.**	Expected to occur **at least weekly.**	Expected to occur **at least daily.**

Measures of Likelihood – likelihood scores (financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur in the current or next year	Unlikely to occur during the current or next year.	Could easily occur during the current or next year.	Will probably occur during the current or next year.	Definitely will occur during the current or next year.

Measures of Consequence – Domains, consequence and examples of score descriptors

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention. Requiring time off work <3days. Increase in length of hospital stay by 1-2days.	Moderate injury requiring professional intervention. Requiring time off work 4-14 days RIDDOR/agency reportable incident An event that impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work >14days. Increase in length of hospital stay by >15days.	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
				Mismanagement of patient care with long term effects.	
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if not resolved. Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if findings not acted on Inquest / Ombudsman inquiry Gross failure to meet national standards.
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day).	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>1day). Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objectives / service due to lack of staff. Unsafe staffing levels or competence.	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training / key training on an ongoing basis.
Statutory duty / Inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved.	Single breech in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breeches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable.	National media coverage with >3days service well below reasonable public expectation. MP

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		expectation not being met.		public expectation.	concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget. Schedule slippage.	<5-10% over project budget Schedule slippage	Non-compliance with national 10-25% over budget project. Schedule slippage. Key objectives not met.	Incident leading >25% over project budget Schedule slippage. Key objectives not met.
Finance – including claims	Non delivery/Loss of budget to value of <£10K	Non delivery/Loss of budget between £10K and £100K.	Non-delivery/Loss of budget between £100K and £500K.	Non delivery/Loss of budget between £500K and £2M.	Non-delivery/Loss of Budget of more than £2M.
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Measures of Consequence – Additional guidance and examples relating to risks impacting on the safety of patients, staff or public.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling – no time off work required	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information / communication on transfer of care Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation, fracture, blow to the head Loss of limb Post-traumatic stress disorder	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis Incident leading to long-term mental health problem Rape / serious sexual assault

5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)

	Almost Certain	5 Yellow	10 Yellow	15 Red	20 Red	25 Red
	Likely	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	Possible	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	Unlikely	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	Rare	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

Appendix 4: Risk Thresholds/Risk Level Monitoring

RISK THRESHOLDS / RISK LEVEL MONITORING

Level of Risk	Risk Scores	Determination of Level, monitoring of Action Plans and acceptability of risk to the Trust	Monitoring Process
Red	All risks rated ≥15 (post moderation) Unacceptable level of risk exposure which requires immediate corrective action to be taken. Risk should be considered for escalation.	Unacceptable risk Approved by the RMG if escalated. Risk treatment plan approved by relevant Executive Director and RMG.	Oversight by Risk Management Group QPES, FPP and People Committee if risk has been escalated onto the CRR. QPES, FPP and People Committee to advise Board on ways of managing high risks that cannot be addressed within existing resources.
Amber	All risks rated 12. Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	Unacceptable risk Risk scores approved by local Service and Directorate clinical governance Committees. Level determined by **Executive Director.** Risk treatment plan managed by senior managers. Progress updates via Directorate Leads.	Included on the Risk Register and reported to local Service and Directorate Clinical Governance Committee. Risk treatment plan monitored by Executive Director.
Yellow	All risks rated 4- 10	Level determined by the **Service Manager.** Risk treatment plan managed locally by named managers on behalf of the Director.	• Risk treatment plan monitored by Directors Management team.
Green	All risks rated 1 - 4		

Appendix 5: Key definitions

KEY DEFINITIONS

Risk Description		There are 3 main components will need to be considered when articulating the risk description (cause, event and effect):
		- There is a risk of…if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Rating	Inherent	This is the score of a risk without taking into consideration any controls which may be in place to mitigate it. This is also referred to as gross risk, initial risk, uncontrolled risk or absolute risk.
	Current	This is the score of the risk taking into consideration the controls and mitigation measures in place. This is also referred to as net risk, residual risk, current risk, or managed level of risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is `rare` which denotes it will probably never happen, with a 5 being `almost certain` which indicates that it will undoubtedly or possibly happen.
Risk Score		Risk score is derived by multiplying the Impact by Likelihood.
Risk Appetite	Definition	Is defined as the amount and level of risk that the Trust is willing to pursue or accept in order to achieve its priorities.
Controls or risk mitigations	Definition	These are measures/interventions implemented by the Trust to reduce either the likelihood of a risk and/or the impact were it to be realised. Controls could include strategies, policies, procedures, systems, SOPs, Checklists etc being implemented to reduce either the likelihood and/or impact of the risk were it to crystallise. A control is also a measure that maintains and/or modifies risk (ISO 31000:2018(en).
Three Lines of Defence Model	1st Line of Defence	The first Line of defence refers to the service or function that owns, mitigates and manages the risk on a day-to-day basis.
	2nd Line of Defence	This refers to other functions in the in the Trust which oversee compliance or risk management e.g. HR, Risk Management team etc.
	3rd Line of Defence	This refers to functions in the trust which provide objective and independent assurance and may include Internal Audits, External Audits etc.

Appendix 6: Risk Appetite Statement

RISK APPETITE STATEMENT

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement
- Focusing on priority areas within an organisation
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

NB: Please note that this Risk Appetite Framework will change once the Board ratifies the final version at its business meeting on 4th December 2024. The new Risk Appetite Framework will thus be inserted here to replace the version below!

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range
Quality & Safety	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.	Cautious	6 - 8
Reputational	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Minimal	2 - 4
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Eager	12
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	9 – 10
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	6 - 8
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open	9 – 10

Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**
Data and Information Management	Accept need for operational effectiveness in distribution and information sharing.	**Open**	**9 - 10**
Governance & Legal	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.	**Minimal**	**2 - 4**
Digitalisation/ Technology	Systems / technology developments considered to enable improved delivery. Agile principles may be followed.	**Open**	**9 – 10**
Transformation/ Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	**Open**	**9 – 10**
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	**Minimal**	**2 - 4**
Property & Environment	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	**Open**	**9 – 10**
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**
Partnerships & Provider Collaboratives	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.	**Open**	**9 – 10**

Report to the Board of Directors							
Agenda item:	**23b**						
Date	4 December 2024						
Title	Draft Trust Risk Appetite 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**	

Purpose:

This report highlights the outcome of the risk appetite SurveyMonkey which members of the Board completed. All 13 members of the Board completed the survey thus scoring 100%. A risk appetite is set by the Board and provides a framework in underpinning the amount and type of risk the Board is willing or prepared to accept (or not to accept) in pursuit of the organisation's objectives. A risk appetite framework is key to achieving effective risk management, shaping organisational risk culture, enhancing the quality of decision-making, representing a balance between the potential benefits of innovation, wise risk taking and the threats that change might bring.

Introduction:

At an operational level, the Trust`s risk appetite framework defines the type and level of risk the Board is willing to accept as operational teams seek to deliver high quality patient-centred care and achieve the Trust`s operational and strategic objectives. This risk appetite framework therefore provides a structured, agile and comprehensive mechanism against which operational teams are expected to set the target score for each risk on their operational risk registers, hence risk management across the Trust must be aligned to this risk appetite framework. When skilfully used and adhered to, the Trust`s risk appetite framework could deliver the following added value: -

- Enable staff to become more informed and confident in driving appropriate and wise risk taking in achieving Trust objectives, better decision-making and seizing opportunities in fostering improvements and innovation in services.
- Foster an informed risk-based approach in the efficient use of scarce resources.
- Provide a common yardstick in driving consistency and transparent risk-rewarding trade-offs.

Whilst the preferred risk appetite category for each type of risk was clearly reflected in the survey result, members were unable to make a clear risk appetite preference with regards the risk type, `**Property & Environment`.** 4 (33.33%) respondents chose `**Open**`, 4 (33.33%) said they prefer `**Eager**` while 3 (25%) chose `**Cautious**` and 1 (8.33%) selected `**Minimal**`. One member skipped this question. The Board needs to discuss and agree on its

preferred risk appetite category for `**Property & Environment`,** *(please see below for details),* bearing in mind the state, availability, suitability and sustainability of our current Trust estates.

Choose your preferred Risk Appetite category

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board`s preferred risk appetite
Property & Environment	Application of dynamic environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements.	Eager 33.33% (4)	12	
	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Open 33.33% (4)	9 - 10	
	Requirement to adopt arrange of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Cautious 25% (3)	6-8	
	Recommendation to follow strict environmental policies or policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Minimal 8.33% (1)	2 -4	

Key Issues and Risks:

1. The main issue here is the need to robustly and effectively communicate the Trust`s risk appetite framework trust-wide and embed it into business as usual and in the operationalisation of its Risk Management Policy. This will be achieved through training, `check and challenge` at the Risk Management Group and Board Committees and through other meetings where risks are presented and discussed.

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. ***CONFIRM*** *its preferred risk appetite category for the risk type* ` **Property & Environment`.**
3. ***REVIEW, SCRUTINISE and RATIFY*** *the Trust`s Risk Appetite Framework here enclosed (Please see appendix 1 for details).*

Enclosures

1. *Appendix 1: Trust Risk Appetite Framework*

Appendix 1: Trust Risk Appetite Framework

BSMHFT Risk Appetite Framework

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board`s preferred risk appetite
Quality & Safety	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.	Cautious 69.23% (9)	6 - 8	Cautious
Reputational	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Open 61.54% (8)	9-10	Open
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Open 61.54% (8)	9 – 10	Open
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open 69.23% (9)	9 – 10	Open
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious 46.15% (6)	6 – 8	Cautious
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open 75% (9)	9 - 10	Open
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Open 53.85% (7)	9 – 10	Open
Data and Information Management	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Cautious 50% (6)	6 - 8	Cautious
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls	Cautious 53.85% (7)	6 – 8	Cautious

	maximise fraud prevention, detection and deterrence through robust controls and sanctions.			
Digital Improvement	New technologies viewed as a key enabler of operational delivery. Maximisation of patient care andavoidance of harm. Agile principles are embraced.	**Eager** **66.67%** **(8)**	**12**	**Eager**
Cyber Security	Systems / technology developments considered to enable improved delivery, enhanced cyber security and greater awareness of cyber threats. Agile principles may be followed.	**Open** **41.67%** **(5)**	**6 - 8**	**Open**
Transformation / Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	**Open** **53.85%** **(7)**	**9 – 10**	**Open**
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	**Minimal** **41.67%** **(5)**	**2 - 4**	**Minimal**
Property & Environment	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	**Open** **33.33%** **(4)**	**9 - 10**	
	Application of dynamic environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements.	**Eager** **33.33%** **(4)**	**12**	
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	**Open** **61.54%** **(8)**	**9 – 10**	**Open**
Partnerships & Provider Collaboratives	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.	**Open** **46.15%** **(6)**	**12**	**Open**

N.B: BSMHFT's Risk Appetite Framework is aligned to target risk scores