Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Board of Directors Public Meeting

09.00, Wednesday 5 February 2025

Uffculme Centre

AGENDA

Ref	Item	Purpose	Report type	Time
	Staff Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 4 December 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 4 December 2024**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Director of Operations*	Assurance	Enc	09.55
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	10.15
9	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	10.25
	Quality and Clinical Services			
10	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.40
	People			
11	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.50
12	**Freedom to Speak Up Guardian Report** *Emma Randle, Freedom to Speak Up Guardian*	Assurance	Enc	11.00
	Sustainability			
13	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.15
14	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.25
15	**Summerhill Services Ltd (SSL) Overview Report** *Shane Bray, SSL Managing Director*	Assurance	Enc	11.35
16	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.50
	Reflections			
17	**Living the Trust Values**		Verbal	12.00
18	**Board Assurance Framework reflections**		Verbal	12.10
19	**Any other business**		Verbal	12.20
20	**Questions from Governors and members of the public**			

Close by 12.30

Date and Time of Next Meeting: Wednesday 2 April 2025, 09.00-12.30

IRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 4 December 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
	Thomas Kearney	TK	Non-Executive Director
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnerships
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Katherine Allen	KA	Recovery, Service User, Carer and Family Experience Lead (item 1 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
	Katy Wilmont	KW	Patient Experience Lead (item 1 only)
Observers	Two governors and four members of staff/the public observed the meeting in person.		

Ref	Item
1	**Service User Story** The Board welcomed KA and KW to the meeting to share the twelve-month update following a presentation received at the Board of Directors in December 2023 on the development of the Patient Council. The Board reflected that in December 2023 they had been advised that the Patient Council had been co-produced and developed as a safe, supportive space across the 16 acute wards for bi-monthly hybrid meetings where service users could voice their concerns and needs in an open forum. KW confirmed that the Patient Council was now a well -stablished bi-monthly meeting that had been embedded across acute wards since November 2023 with positive regular attendance from across 12 to 13 wards. The Patient Council was attended by both staff and service users with regular speakers in attendance for specific enquires, including food provisions and the smokefree policy, with relevant updates provided for assurance. KW highlighted the positive feedback received from service users in attendance and advised that discharged service users supported the Council as Experts by Experience. With the inclusion of Experts by Experience, service users in attendance had fed back that this continued to provide them with hope and allowed them to relate to their peers. The Patient Council had implemented a number of positive recommendations and requests, including Recovery College on wards which was currently being rolled out across a number of acute wards and had been positively received by service users. Other improvements included the scheduling of morning meetings to allow service users to be engaged and assured for the plans for their day, food provision in North Birmingham where fresh fruit was now delivered and available on a daily basis, and group psychology sessions which had been well received by both staff and service users.

	KW was pleased to confirm that Dementia and Frailty and Steps to Recovery services were developing Patient Councils to support service users through an inclusive and co-produced approach. The Board was apprised of two main ongoing challenges. The first related to inpatient wards activities and some inconsistency highlighted by service users, as sometimes activity workers were absent, or posts remained vacant for extended periods. The Council were supporting the development of timetables and schedules and had recommended training with support from occupational therapists for Health Care Assistants to engage and support in delivering activities. KW highlighted the second main challenge raised and identified by the Patient Council as communication with service users. The Board was advised that service user feedback highlighted a lack of clarified communication and engagement including bank staff and introductions on admission. KW noted the importance of getting the basics right and the positive impact this can have on de-escalating anxieties and reducing the use of restrictive practice. DT highlighted feedback from recent visits where activity rooms are not being utilised and queried how staff could be supported to deliver activities. KW confirmed that staffing levels continued to be the key driver impacting on the ability to deliver activities, and confirmed that the Council would support training for Health Care Assistants to be able to support activity workers and deliver activities in the absence of available staff to ensure service users were able to receive and take part in sessions. The Board acknowledged the importance of activities as a critical aid to recovery. BC challenged the Board to reflect on how the Trust invested in temporary and agency staff and how they were inducted to the Trust and held to account for engagement and behaviours. RFW confirmed the Trust have seen a significant reduction in the use of agency staff and confirmed feedback had previously been shared with employment agencies if there were any concerns in relation to the conduct of agency staff and where they had been asked not to return. RFW confirmed the Trust temporary staffing service was managed in-house and the Board had recently agreed to reinstate the pastoral care role for temporary staff to ensure they were fully supported through induction where accountability would be clarified. LC highlighted the importance of improving ward inductions and reflections on how staff could introduce a 'meet and greet' process for service users on admission to wards. PG thanked both KA and KW for the update which highlighted the positive improvements implemented, ongoing challenges and areas for improvement. The Board reflected on the positive co-production and engagement with both staff and service users and thanked KW and the Patient Council members for their continued dedication and determination to drive improvements.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting. PG introduced Nicholas Moor who was observing the meeting and would formally join the Board as Associate Non-Executive Director in January 2025.
3	**Apologies for absence** Monica Shafaq, Non-Executive Director
4	**Declarations of interest** No new interests were declared.
5	**Minutes of meeting held on 2 October 2024** The minutes were agreed as a true and accurate record.
6	**Matters arising from meeting held on 2 October 2024** All matters arising were updated.

7	**Chair's Report** The Board received the report for information, noting the following key points: • Nicholas Moor had been appointed as Associate Non-Executive Director, formally joining the Board in the new year. • Committee Chairs had been asked to reflect on the NHSE Insightful Provider Board report. • A Midlands Leadership engagement workshop had been held, focusing on the development of the NHS ten-year plan. KC advised the Board that the next Board Strategy Session in January would focus on the Insightful Provider Board report.
8	**Service and Site Visits Annual Report** The Board received the report for information, noting the increased Board visibility throughout the year. PG advised that evening and nighttime visits would be incorporated into the schedule for 2025/26. KC acknowledged and thanked the team for the dedicated and focused work that had been put in place to strengthen and improve the visiting schedule during the year.
9	**Staff and Service User Stories Annual Report** The Board received the report for information.
10	**Chief Executive and Director of Operations Report** The Board received the report and noted the following key points: • The Trust's Learning and Development team had been identified as the lead for the implementation of a coaching and mentoring framework across BSOL ICS. • The Trust had supported celebrations for National Psychological Professions week in November. • Allied Health Professionals Day had also been celebrated in November. • Following the Trust's signing of the Sexual Safety Charter in April, the People team was leading on the adoption of NHSE's Sexual Safety Policy and how this would be implemented across the organisation. • There was positive working within the system on the financial position. • Two CQC reports had been published into Reaside Forensic Services and Community Mental Health Teams. • The Trust had 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. • RFW advised the Board that the Children and Young People's transformation programme continued, with the development of an all-age model that would be led by BSMHFT. • The Trust had attended an engagement workshop on the NHS 10 Year Plan. • There continued to be significant productivity focus for the organisation, including the establishment of the performance delivery group. • The Right Care Right Person programme launch of phase 3 and 4 commenced in November. • RFW commended the number of celebrations, awards, and recognition of so many of the Trust's teams and staff over the last two months. The Board recorded congratulations to the Art Psychotherapy team. BC asked how much emphasis was being given to prevention within the NHS 10 Year Plan. RFW commented that there were three very specific programmes within the plan, one of which related to the move from treating illness to prevention. PG asked about health and social care packages to support Clinically Ready for Discharge patients. VD advised of the processes in place to support service users, including utilisation of Care Match data and assessment by organisations who then advise of cost which can take some time. RFW advised of continued meetings with the ICS Board, and the Health and Wellbeing Board to discuss impact.

	PG asked about Right Care Right Person and what intelligence was being received on progress. VD commented that there were regular touch point meetings with partners where data was considered. The number of Section 136 detainments had reduced. Concerns and issues were recorded on the Eclipse system to enable reports to be compiled and discussed.
11	**Board Assurance Framework** The Board ratified the decision to close and archive the old Board Assurance Framework. The new Board Assurance Framework had been established and would be implemented. The Board approved the new BAF. DTi noted that SR7 required further discussion and development which would be reviewed by Finance, Performance and Productivity Committee in the new year. DT added that SR6 and SR7 would be further developed to reflect the experience of care programme.
12	**Integrated Performance Report** The Board received the report for information, noting dashboard reports on service levels as well as divisional levels. The Board noted overall performance against Talking Therapies, waiting times, and out of area. VD felt that the deep dives were working well, both to showcase the work that was taking place within the organisation and also to constructively and collectively discuss concerns. PN noted that People Committee reviewed data by profession and division, but not individual teams. The team would review how escalations could be reported.
13	**Quality, Patient Experience and Safety Committee Report** The Board received reports for October and November meetings. LC highlighted the key points as follows: • Site visits for the Committee were underway and more were planned for the rest of the year. • Nurse staffing capacity was discussed, and the Committee was mindful of the inexperienced workforce that required training and development. • The Committee had noted the Section 64 notice that had been issued for the Zinnia Centre, and that key issues related to staff competencies. • Acuity and risk in inpatient settings was raised as a concern, with increase in harm noted. A deep dive had been planned for January. • The Committee continued to monitor progress on Right Care Right Person. • The Committee was encouraged by the proactive work undertaken through the Patient Safety Incident Response Framework, which had highlighted inappropriate admissions and restraints issues.
14	**Safeguarding Annual Report** The Board received the report for information. LSG commented on the hard work and visibility of the safeguarding team, and advised the Board of the intense context the team was operating under.
15	**Medical Directorate Annual Report** The report was formally **approved** by the Board. FA advised the Board that a peer review would be undertaken to ensure standards remained robust. RFW suggested that the celebratory nature of the work undertaken be drawn out in future reports.
16	**People Committee Report** The Board received the report from November's meeting. SB highlighted the following key points: • Concern was raised around the nursing skills gap at Band 6 and above, particularly in relation to development of Band 5 staff into Band 6. This was being monitored by the Safer Staffing Group.

	• The Committee had highlighted concern about bank staff use not being reduced at pace, and further assurance had been sought around the trajectory. • Overall sickness had reduced, however concern remained around wellbeing of staff particularly as the top reported reason for absence was recorded as stress/anxiety/depression. The People team was reviewing the implementation of HR clinics as part of return-to-work conversations. WW observed that both People and Quality, Patient Experience and Safety Committees had referenced staff wellbeing. PN advised that the staff wellbeing steering group would review this, but that it could also be the subject of one of People Committee's strategy and development sessions. PG highlighted the need to reflect health inequalities throughout all Committees and how the Trust was making a difference.
17	**Guardian of Safe Working Hours Q2 2024/25 Report** The Board received the report for information, noting the following key points: • No immediate safety concerns had been raised during the quarter. • Exception report rates had increased, with 22 out of 32 reports related to overtime. • Two fines had been levied during the reporting period. • The number of reports taken forward during the quarter had decreased. • The majority of gaps were due to vacancies. BC suggested that a piece around engagement with the process could be included in the next quarter's report in order to support constructive conversation around how the Board could support.
18	**Finance, Performance and Productivity Committee Report** The Board received reports from October and November meetings. BC highlighted the following key points: • The Committee received assurance that the planned year-end surplus of £2m would be achieved. • Out of area spend remained a key challenge. • The Committee had raised concern about bank spend not reducing at pace, despite substantive vacancies being filled. • Agency spend had significantly reduced, and the Committee had commended the great work undertaken by the Trust. • The Committee had not been assured on plans to achieve cost savings into the next financial year, with the key concern around the lack of opportunity of recurrent savings. • Good assurance had been received on the performance metrics that underpin the winter plan. • The new Cyber Assurance Framework had been received. • Significant amount of work continued to improve the Integrated Performance Report. PG asked whether the Committee had the opportunity to discuss AI and the opportunities for the Trust. BC confirmed that the Committee had taken part in a deep dive on Digital and the potential uses, and how the refreshed Trust strategy would embrace digital opportunities. PG asked about Cost Improvement Plans and whether areas had been identified. DT advised that this was being discussed on a service-by-service basis. BC commented that the Committee would consider the new services that would be taken on and how this would impact the overall position of the Trust. VD commented on the work being undertaken around Clinically Ready for Discharge, noting that a significant increase in reporting had been seen following implementation of criteria. A patient flow programme meeting had been established to review Clinically Ready for Discharge, with work taking place in localities. A productivity plan would be reviewed at Finance, Performance and Productivity Committee. **Action**
19	**Finance Report** The Board received the report for information, noting the following key points:

	• The month seven consolidated Group position was a reported £624k surplus. This was £857k adverse to plan, and was driven by non-Trust beds expenditure, slippage on savings delivery, and significant agency spend reduction and a favourable interest receivable position. • There had been significant improvement in agency spend, however bank spend remained a concern and was not reducing at pace. Nursing was a key area of concern in relation to bank spend. • Non-Trust beds overspend was a concern, with year-to-date expenditure at £13m against a plan of £14m. The current full-year forecast was £23m. • All corporate and operational teams had been asked to identify a 2% savings plan for 2025/26. • The consolidated pay award uplifts for all staff groups had been paid in month seven. • The BSOL system financial position was a reported £77m deficit at month seven. WW noted concern about the underlying savings position, particularly as the savings plan had not been fully identified and there was a 2% target for 2025/26. WW also highlighted the impact of any future industrial action and noted that national insurance was increasing. The Board noted the challenging position for 2025/26, and acknowledged the ongoing plans to work with system partners and ensure the Trust was in the best possible position for the next financial year.
20	**Trust Strategy Update Report** The Board received the report for information, noting particularly the high-level plan for the new Trust strategy. PN advised the Board that work on the new strategy would begin in 2025 and would link with the systemwide mental health strategy. Engagement conversations would begin in January. SB asked if the Trust strategy refresh would also link to the NHS ten-year plan, and PN confirmed that it would.
21	**Audit Committee Report** The Board received the report from October's meeting. WW advised on the key points: • The Committee had received assurance on the development and oversight of the Mental Health Provider Collaborative risk register. Some key points would be raised at Commissioning Committee. • The process for the appointment of the external auditor was currently underway.
22	**Modern Slavery Statement** The Board **approved** the statement for publication.
23	**Committee Terms of Reference** The Board **ratified** the terms of reference for the following Committees: • Audit Committee • Quality, Patient Experience and Safety Committee • Finance, Performance and Productivity Committee • People Committee • Nominations and Remuneration Committee (non-executive director led)
24	**Risk Management Policy and Risk Appetite Framework** The Board **approved** the Risk Management Policy. DTi presented the draft risk appetite framework and advised that there was no clearly defined agreement for the area of risk related to Property and Environment. The Board asked that the risks for Property and Environment were separated so that a consensus could be determined on each. **Action**
25	**Living the Trust Values** FA reflected on the overall very positive feedback that she had received from staff, service users and families during site visits.

26	**Board Assurance Framework reflections** The Trust would consider partnership working and it was reflected in the BAF. The link to the developing Corporate Risk Register would also be made.
27	**Any other business** None.
28	**Questions from Governors and members of the public** The following questions were posed to the Board: • LT noted that the Trust's Deputy Lead Governor wished to pass on his regards, and advised the Board that he was keen to continue the 15-step initiative. • JT commented that sickness absence had been discussed at November's Council of Governors pre-meet, and was encouraged that it had been discussed by the Board. The Council of Governors may wish to dedicate some time to this particular issue.
Close	

Actions/Decisions

Item	Action	Lead/ Due Date	Update
Board Assurance Framework	The Board ratified the decision to close and archive the old Board Assurance Framework.		
	The Board formally adopted the new Board Assurance Framework.		
Medical Directorate Annual Report	The Board approved the report for signature.		
Modern Slavery Statement	The Board approved the statement for publication.		
Committee Terms of Reference	The Board ratified the Committee terms of reference.		
Risk Management Policy and Risk Appetite Framework	The Board approved the Risk Management Policy.		
	Property and Environment risk areas to be separated for the Board to agree appropriate risk appetite.	DTi March 25	In progress
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	Scheduled
Finance, Performance and Productivity Committee Report	A productivity plan would be received at FPP.	KC/VD Jan 25	

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**6**						
Date	5 February 2025						
Title	Chair's Report						
Author/Presenter	Phil Gayle, Chair						
Executive Director	Phil Gayle, Chair	**Approved**	**Y**	✓	**N**		

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

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

Purpose

The report, for information and accountability, with overview and key events, is presented to the Board, highlighting areas of involvement during the month and to report on key local and system wide issues.

Recommendation
The Board is asked to note the contents of the report.
Enclosures
N/A

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. Since the last meeting of the Board of Directors held in public in December 2024 the Trust has continued to respond during a challenging winter period and the use of out of area beds rising slightly but being managed and focused work taking place to reduce these. I would like to place on record my thanks responding to at times challenging pressures whilst still maintaining patient and service user safety and care.

2. GOVERNANCE MATTERS

Our Committees continue to provide oversight and assurance on matters of quality and safety, patient experience, of finance, productivity and performance, of people and culture, as well as audit and internal controls.

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

3. SERVICE VISITS

3.1 Visits to our Trust services are ongoing and both the NEDs and Governors are joining us on these visits over the coming months.

The visits schedule will focus on ensuring ward visits are scheduled and planned to ensure increased Board visibility. The schedule for 2025/26 will incorporate night visits to ensure we are speaking to staff and service users during the later hours. This is a really important element of our role as NEDs, as we are keen to see and listen to staff, patients, and service users about our services both positive aspects and areas of improvements.

LISTENING TO STAFF

3.2 My visits to the different services continue.

3.3 I was pleased to visit the Homeless Health Exchange service with our Lead Governor on 31st January at their new location. The visit was insightful and engaging, ensuring staff and service users are settling into their new environment. This was a positive visit and a great location and facilities, and I will re-visit them again during the year. I have recently undertaken visits to Rookery Gardens and Reservoir Court, inpatient units based in Erdington, providing services to include a Rehab Unit, Older People's Inpatient unit, day centre and CMHT base.

3.4 I look forward to visiting other services and sites this 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.

4. PARTNER AND SYSTEM DEVELOPMENT / STAKEHOLDERS

4.1 I regularly attend meetings to ensure involvement and relationship building and maintaining with Partner's and Stakeholders regionally. I have attended meetings in recent months such as the NHS Confed Chairs Group, the NHSE Operating Model Workshop and the BSOL Integrated Care Partnership and close working with Birmingham and Solihull Integrated Care System (ICS)

continues. Our NEDs were encouraged to attend a system-wide NED engagement meeting on 4 December arranged by the ICB and governors are also invited to attend similar governor events. Our committee chairs are liaising with their ICB counterparts.

4.2 I continue to attend the BSOL Chairs meeting every month.

5. MENTAL HEALTH PROVIDER COLLABORATIVE

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

The MHPC has received over 200 responses to the Call for Comments on the Children and Young People's proposed model of care including feedback from the Birmingham Health and Adult Social Care Committee and the Solihull Children and Young Peoples Education and Services Scrutiny Committee. A detailed report setting out the key findings and recommendations will help shape the development of a new model of care across Birmingham and Solihull which provides an integrated and graduated approach to meeting the care and support needs of children and young people.

Views are currently being sought from stakeholders and partners on the high-level blueprint for the Mental Health Strategy. This blueprint has been developed based on work that was undertaken to gather insight on the population health needs and experiences of communities regarding mental health services. Community events are being scheduled in Birmingham and Solihull to set the vision and review the key priorities proposed in the blueprint.

The MHPC have launched a tender for the provision of adult inpatient acute and PICU beds. This tender is open until the 23 February 2025 and seeks bids from suitably qualified providers who can meet the needs of BSOL patients in appropriate and local settings.

Funding to support the Voluntary, Community, Faith & Social Enterprise (VCFSE) Panel including the backfill of panel members time and a partnership role have been agreed by the collaborative.

The Collaborative has developed a new inpatient cohort management framework for BSOL to help avoid admissions and to support timely discharge for those who are in hospital.

Key developments moving forward:

- The MHPC will continue to have oversight and focus on the delivery of the Intensive and Assertive Community Action Plan.
- A working group is being established to develop a strategic approach to shaping the market for those individuals with severe mental illness requiring support with independent living.
- A governance review will be undertaken across the collaborative to understand whether the current architecture needs to be changed or improved because of organisational or system needs. This will include how we embed co-production and the voice of our communities into the governance of the collaborative.
- The MHPC will continue to seek assurance and have oversight of the transition of the Forward-Thinking Birmingham Service into BSMHT during 2025 ensuring the appropriate due diligence and impact assessments are undertaken and reported into Board.
- Community Engagement Events are being scheduled for 2025 with a focus on Health Inequalities and how we can improve outcomes in identified areas of need.

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 will shortly be meeting again with the local Police and Crime Commissioner, Simon Foster, with regards to Right Care, Right Person. We will discuss positive feedback and also discuss any risks and challenges. RCRP has been designed to end the inappropriate and avoidable involvement of Police in responding to incidents involving people with Mental Health needs.

6.3 I have meetings with the West Midlands Mayor and some local MPs scheduled this spring.

6.4 I maintain my regular monthly meetings with Shane Bray from SSL which are informative and valuable. I continue to meet bi-monthly with Andy Cave and Richard Burden from Healthwatch Birmingham.

6.5 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 chair the Board Strategy sessions where important discussions are held, and information shared. Progress is discussed with a collective focus to enable and ensure continuous progress Trust-wide. The first Strategy session of the year focused on the Insightful Provider Board framework from NHSE, and financial planning for 2025/26.

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 Governor's to maintain regular communication and working relationships and to discuss ongoing developments.

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

7.5 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.

7.6 We are now in the planning stages for the Values Awards and the judging of different categories will take place in February. The values awards are an integral celebration for our People where we hope to show them how much both them and their hard work is valued and appreciated.

PHIL GAYLE
CHAIR

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**7**					
Date	5 February 2025					
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 contents of the report.

Enclosures

N/A

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

Operational Team

Continuing efforts are being made in respect of formal employee relation cases. Between September 2024 and January 2025, a total of 39 cases have been concluded for staff members (from a 12-month peak of 91 cases to a 12-month low of 52 cases.) This area will continue to be a key focus area for the People team and key stakeholders to improve the wellbeing and experience of staff in formal processes. This is in addition to increasing informal resolution where appropriate and reducing overall timescales.

Our new Occupational Health provider – Optima will commence from the 1st April, a multidisciplinary team between the Trust and Optima meet every week to ensure a smooth transition from our current provider. We know from multiple sources that, stress, anxiety and depression remain the leading cause of colleague absence, with the new Occupational Health provision and the Trust Health and Wellbeing steering group the People team will continue to identify and create new support offers for staff.

Following a period of turnover within the People Operations Team, successful recruitment and development activities have supported an increase in capacity. Work will continue to strengthen relationships with and support to the Divisional teams.

Workforce, Recruitment and Temporary Staffing Service

Our vacancy rate continues to drop with a rate of 11.8% in November which is ahead of our workforce plan target. Progress on recruiting to and therefore reducing vacancy rates in nursing posts at band 5 level is of note in particular (now at 9% from 9.9% twelve months ago). Our key area of focus now is on filling nursing roles at band 6. Our turnover rate has remained stable at circa 8.3%.

We joined other Birmingham and Solihull (BSoL) Trusts to present to NHS England on our progress with People Promise work. We received very positive feedback and have been asked to showcase this work nationally. Following workshops planned for February we will refresh our People Promise priorities for 2025/26.

Bank and agency usage continues to be monitored. In November, our agency usage dropped to 1.7% of our total pay bill which is well below target, and we are below our workforce plan target for both bank and agency usage.

Learning & Development

Work continues on the BSol wide coaching and mentoring framework, of which the Trust is lead for. This offer will feed into the wider Talent management agenda across the Trust, further communications on how to access this offer will be launching soon. The ICS consortium coaching and mentoring Framework became available in December to all organisations within the system.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

The recently recruited DIALOG+ training lead is now in place to support the ongoing roll-out of DIALOG+ across teams, with a focus; on embedding DIALOG+ with individual teams, supporting the medical workforce with the uptake of the tool and offering a space for best practice and reflection.

The joint MDT referral meetings being piloted across localities are demonstrating the impact of having professionals across pathways in one meeting space. Early evaluation is highlighting a reduction in allocation to CMHT caseloads, timely allocation to partners like Talking Therapies and the multi-disciplinary benefits of having Occupational Therapy and Psychology present to support decision making.

Peer Support Worker roles are now coming into post from initial waves of recruitment, longer term these roles will be embedded across the Community Mental Health and Wellbeing Service, to focus on areas such as support whilst waiting and transitions, alongside this supporting specific local needs identified through ongoing health inequalities work. The Peer Support workforce will also be supporting Recovery College with the delivery of group interventions cross ICCR.

Community Mental Health Teams (CMHTS)

Teams are continuing to work on seeing individuals who have waited longest for first and second appointments, this is monitored weekly with fortnightly oversight from Clinical Service Managers, Associate Director and Heads of Service. There has been an overall reduction on waits for first appointment of 11% between June December 24, (to just over 1000 people now waiting) the reduction of waits continues to be a key priority area.

Homeless CMHT, Homeless Health Exchange, and Rough Sleeper Mental Health Team.

The Homeless Health Exchange has now moved to Attwood Green Health Centre, the move took place on 2nd December 2024 following the announcement of the closure of the Salvation Army at the William Booth Centre. The team and service users are settling in well into the new premises. Although both the Salvation Army and Washington Court closed their doors is December 2024 the teams are still working together with partners to support the homeless population in BSol.

COMPASS Dual Diagnosis Team - COMPASS

Having successfully embedded new ways of working across Acute care and CMHT settings COMPASS have moved focus and are working with Steps 2 Recovery, focusing on upskilling, supervision, training and consultation. Level 2 Dual Diagnosis training is also being reviewed following the successful launch in Dec 24 of the updated level 1 Dual Diagnosis E-Learning. This mandatory course for all patient facing clinicians, is now required annually, providing a universal level of dual diagnosis understanding benefitting all patients across BSMHFT.

ICCR Psychological Services

Several teams are now at full capacity after successful recruitment, we are experiencing less recruitment challenges at this time through a variety of creative strategies including split posts e.g. enhanced team for personality disorder and CMHTs; skill mix, recruit to train and ‘grow our own’ training through HEE funded courses. All of this has had an impact on reducing our waiting lists with greater access to a more stepped care approach.

Secure Care & Offender Health (SCOH)

Staffing has significantly improved across the division with more qualified nurses taking up positions. In the women's service there has been a reduction in self-harm, violence and aggression incidents over the last few months. Development of the outreach provision within the women service remains positive with good connections now established. Low Secure Child and 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 the 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 summer. Ther 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. 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. Charitable funds 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 hatches. We continue to work closely with our Birmingham Community Healthcare Trust (BCHC), and we are pleased to note their staff recruitment 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 three new band 7 psychologists and three band 8b psychologists 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 has significantly improved on 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) and our Deputy Director of Operations and Associate Director for the Division (Coumar Marimouttou) has been awarded an MBE in the New Year Kings Honors.

Acute and Urgent Care

Patient Flow Improvement Programme continues to make progress in addressing the challenges of reducing non-NHS bed use. The disproportionate impact of high-cost acute and urgent care demand underlines the importance of collaborative locality working, starting with upstream interventions in the community and continuing across the patient pathway. The next phase involves a sustained focus on clinical oversight, quality improvement, progress on the Productivity Plan will be feedback in the follow up deep dive January FPP Committee.

The Acute and Urgent Care Financial Recovery Plan is being developed to address ongoing financial challenges, particularly those arising from high-cost bed pressures, and high use of bank. The plan, to be presented at the Sustainability Board in January and outlines measures to restore financial balance while maintaining service quality and improving patient care.

Key workforce developments include the appointment of a psychologist at Oleaster after a prolonged gap in MDT representation, with further posts out to advert. Mitigation measures are in place, including signposting patients to community DBT and psychotherapy services and increasing recruitment for Occupational Therapists and activity workers. Staffing sickness has improved, and a Discharge Manager has been recruited for the South Locality. Long-term sickness among substantive RCs is being mitigated through interim cover by Dr Joji George. To support staff well-being, work is underway on Meadowcroft PICU with the Equality, Diversity, and Inclusion team to improve support for staff who have experienced verbal, racial, or misogynistic abuse from service users.

Improvements linked to the CQC action plan for the Zinnia Centre are ongoing, with significant progress made in addressing concerns. Both teams on Lavender and Saffron are now fully staffed, and local training on ligature risk and physical health, delivered by the Health and Safety Team and clinical educators, has been well-received. Door implementation programme is also underway, with bedroom doors on Saffron being installed and works on Lavender commencing in February. Clinical supervision figures across wards have risen above 73% in Central, supported by reflective practice, Professional Nurse Advocate sessions, and one-to-one clinical supervision. Group supervision, led by Dr Jed Jerwood, will begin on 22nd January to further improve uptake in the North. In Urgent Care clinical supervision uptake and ILS/ELS figures remain low, with both areas highlighted on the risk register and plans in place to ensure improvements. In South East and South West Home Treatment Teams, leadership capacity has been strengthened with the successful recruitment of two new managers. Plans have been developed to address poor performance in RMS, clinical supervision, and Annual Development Reviews across the directorate, through action plans and targeted staff

training.

Admission process audits, previously conducted by the ICB, are now embedded across all Psychiatric Liaison Teams, with clinical leads submitting monthly results. Initial audits have identified barriers and delays, with compliance improving from 54.6% to 68.3% following the launch of the Front Door Project at QE. A staffing review for Liaison Psychiatry is also underway to evaluate the skill mix and identify any specialist roles needed to optimise the service. High referral volumes to PLT teams, coupled with staffing shortages, remain a challenge, and work continues to address these pressures.

Primary Care, Dementia Services & Specialties

The Dementia and Frailty Community Services have been focusing on a local implementation plan to address health inequalities across the 'at risk' population and people with dementia and their carers to improve their overall care and experience. The service has focused on seeking opportunities to work in partnership with two key VCSFE partners: the Alzheimer's society and Age Concern, this forms part of the overall memory assessment and service improvement plan. Another key focus has been redesigning a co-produced post diagnosis group, this will be delivered in partnership with the Recovery College and Alzheimer's Society following the success of 'Waiting Well' sessions aimed at people waiting for a memory assessment.

Dementia and Frailty Inpatients have had a busy period with some very unwell frail service users requiring enhanced periods of observations for support across the wards, as well as flu and covid outbreaks. The service had a recent unannounced Mental Health Act visit from the CQC and received positive verbal feedback from our CQC colleagues. They praised the multi-disciplinary teams care plans calling them patient centered and functional. Feedback from carers was all very positive one of the quotes from service user carer was that the team are 'miracle workers'. CQC stated that there are great activities on the ward and that all team members are 'very kind and caring'.

In October 24 Birmingham Healthy Minds began new contracting payment arrangements of cost per case. There have been confirm and challenge meetings re trajectories and performance activities and there is a robust recovery plan in place. High Intensity Psychological Therapist vacancies are filled, and recently recruited staff are undergoing recruitment checks. Vacant posts at low intensity step 2 Psychological Wellbeing Practitioners were also recruited with 6 staff presently going through recruitment checks. A further interview round is scheduled for February and the team are optimistic that the last 6.0 remaining vacancies will be filled. Recent feedback from a service user stated that they had received *'Clear and timely correspondence and excellent treatment by specialist experts'.*

The community perinatal service is pleased to report that, for the first time since its inception in 2017, our local data indicates that we are meeting our access rate trajectory. The service is commissioned to see 1953 women in any rolling 12-month period, and December's data indicates we saw 1957 women. On behalf of the senior leadership team in perinatal, we have thanked staff for their continued hard work in reaching and engaging with women and families. The data is a good indication of the extent of the reach of the service and the achievements in extending this offer to women who previously didn't receive the service. Significant co-produced, third sector and system work with maternity services has been done over the past 5 years to address health inequalities. This has focused on the increase in both access and referral rates, especially in areas of high social and ethnic diversity, indicate that awareness of perinatal mental health is increasing and stigma around accessing support is reducing. In December 2024 the Solihull Perinatal team formally opened its new team base at Maple Leaf Centre, celebrating this with an opening ceremony attended by Patrick Nyarumbu and colleagues from perinatal and other mental health services in Solihull. The service

continues to have challenges around its team base in South the south of the city and looking to access support from Trust wide estates planning in 2025 to address this.

Our Bipolar service has just completed training another fellow NHS Trust in the Mood on Track intervention, widening access to psychological interventions for those with a diagnosis of bipolar disorder. This is the 3rd organisation we have worked with, with a 4th to follow in Spring. Our Lead psychologist Dr Elizabeth Newton and other members of the team have also contributed to the "Handbook of Psychological Therapies for Bipolar Disorder"

The Deaf Service recently had an unannounced CQC Mental Health Act Visit. Positive feedback was received regarding the quality of risk assessments and care planning. The team will now continue to work on patient participation and feedback in line with the transformation project and following the successful recruitment of psychology and occupational therapy team members.

BSoL Mental Health, Learning Disability & Autism Provider Collaborative

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

The MHPC has received over 200 responses to the Call for Comments on the Children & Young People's proposed model of care including feedback from the Birmingham Health & Adult Social Care Committee and the Solihull Children & Young Peoples Education & Services Scrutiny Committee. A detailed report setting out the key findings and recommendations will help shape the development of a new model of care across Birmingham and Solihull which provides an integrated and graduated approach to meeting the care and support needs of children and young people.

Views are currently being sought from stakeholders and partners on the high-level blueprint for the Mental Health Strategy. This blueprint has been developed based on work that was undertaken to gather insight on the population health needs and experiences of communities regarding mental health services. Community events are being scheduled in Birmingham and Solihull to set the vision and review the key priorities proposed in the blueprint.

The MHPC have launched a tender for the provision of adult inpatient acute and PICU beds. This tender is open until the 23 February 2025 and seeks bids from suitably qualified providers who can meet the needs of BSOL patients in appropriate and local settings.

Funding to support the Voluntary, Community, Faith & Social Enterprise (VCFSE) Panel including the backfill of panel members time and a partnership role have been agreed by the collaborative.

The Collaborative have developed a new inpatient cohort management framework for BSOL to help avoid admissions and to support timely discharge for those who are in hospital.

Key developments moving forward:

- The MHPC will continue to have oversight and focus on the delivery of the Intensive & Assertive Community Action Plan.
- A working group is being established to develop a strategic approach to shaping the market for those individuals with severe mental illness requiring support with independent living.
- A governance review will be undertaken across the collaborative to understand whether the current architecture needs to be changed or improved because of organisational or system

needs. This will include how we embed co-production and the voice of our communities into the governance of the collaborative.

- The MHPC will continue to seek assurance and have oversight of the transition of the Forward-Thinking Birmingham Service into BSMHT during 2025 ensuring the appropriate due diligence and impact assessments are undertaken and reported into Board.
- Community Engagement Events are being scheduled for 2025 with a focus on Health Inequalities and how we can improve outcomes in identified areas of need.

SUSTAINABILITY

Funding and Finances

At the time of writing, we are still awaiting the details of the annual Planning Guidance which sets out the key priorities that the NHS needs to plan for in the coming year. Alongside this document will be the assumptions for the financial allocations and other detailed information around savings and activity plans. Once these documents are available our teams will need to produce the detailed financial, workforce and activity plans and we will be able to understand the level of financial savings required for the new year. Early indications are that this will be an extremely challenging year ahead financially and we will have to work closely with system partners to ensure that the mental health investment requirements are protected.

BSoL COMMUNITY CARE COLLABORATIVE

The draft operating model has now been completed:

In line with the Community Care Collaborative (CCC) Implementation Plan, we have developed examples of integrated neighbourhood teams and locality hubs. As we prepare for roll out starting in 2025/6, we are aiming to set out our “operating model” for integrated care (and therefore neighbourhood health) in Birmingham and Solihull.

We expect full implementation of the new operating model to be a large-scale, multi-organisation change programme likely to take three years (2025/6 to 2027/8).

The CCC Steering Group endorsed an initial draft operating model at our meeting in December 2024. This document updates that model in the light of discussion at the meeting and subsequent comments.

The operating model is still very much in draft for further development in the light of input from partners. At present the model concentrates on services for adults. As it develops, we aim to extend it to encompass integrated care for children, young people and families in line with the BSol Children & Young People’s Health Partnership vision. This could include further developing integrated community-based service delivery models.

Alongside the operating model we are developing (a) a roll out plan (b) an investment proposal and (c) a benefits realisation approach that will align to the outcome framework in the CCC Implementation Plan. Taken together this set of products can form the basis for the commissioning of and delivery by the CCC from 2025/6.

We are aiming to finalise the operating model at the CCC Steering Group in March 2025. At this stage

it should be "good enough" to guide the first year(s) of roll out. We expect it will continue to evolve as we continue to learn.

BCHC and BHMFT have now had several meetings and smaller group discussions around the Integrated Neighbourhood Teams (INT) roll-out several agreements have been reached.

- There are real opportunities for the organisations to work together and share learning and plug into specific meetings and spaces
- The Additional Roles Reimbursement Scheme (ARRs) workforce remain a critical element to INT rollouts if mental health are part of the MDT staffing mix and GP champions will be critical to support in unlocking this
- In addition to increased uptake of the ARRs workforce, there would ideally need to be a change to the annual service level agreement renewal cycle – to support both organisations in having a stable and clear workforce.
- Escalation and support from ICB around this required.

Embedding INT intervention delivery, triage and meetings will require a change to job plans and expectations for GPs for the ARRs workers currently in post.

QUALITY

Section 29A and Focused Inspections

Following the re-inspection of CMHTs in June 2024, the Section 29s were removed as the CQC found enough evidence that the Trust had taken appropriate actions in the areas of concern. However, we will continue to report on compliance for risk assessment and care plans for those on Care Support as we have noted a downward trend for the last few months of reporting.

Reaside: Ongoing actions underway to address the cultural, environmental and governance concerns flagged in focused inspection and the issuing of a Section 29A.

Zinnia Inpatient Wards: Focused inspection following in-patient death - Section 29 Warning Notices issued for clinical risk assessments, learning culture, and ILS/RMS compliance; workstreams initiated for resolution. Draft report factual accuracy submitted, and changes accepted with an overall rating of requires improvement, with inadequate for safety. Report due for publication on Friday 31st January 2025.

Section 29A – Staffing and Supervision (January 2023) - We continue to see variation in the levels of compliance for both management and clinical supervision, with management supervision very low in some teams. Acute Care appears to be the area with most challenge in this area based on the data. Overall compliance as a trust for clinical supervision has remained stable at 79% and although improving, RMS remains low at 60%. Action plans are in place to address these issues and are monitored via our governance processes.

Preventing Future Death (PFD's) Notices from Inquests

There have been no new PFDs since the last report.

LOCAL NEWS

Innovation fund to boost Inpatient Services

The Birmingham and Solihull MHPC has been in operation since 1 April 2023 and is responsible for commissioning of mental health services. In June 2024, it also took on responsibility for commissioning of learning disability and autism services.

Provider Collaboratives are a key pillar in Integrated Care Systems, aiming to improve patient/service user care by leading greater collaboration across the NHS, local authorities, the voluntary, Community, Faith and Social Enterprise (VCFSE) organisations and other stakeholders, to ensure the most appropriate support through integrated pathways of care.

The Trust is the lead provider organisation for the MHPC, which means that as well as being a major provider of mental health care, it also has delegated budget and responsibilities from the Integrated Care Board to commission all age mental health pathways of care, manage contracts with other providers of mental health care, and undertake some other responsibilities such as managing the s117 aftercare funding process.

Bids for up to £200,000 for a one-year project were opened up to NHS and voluntary, community, faith and social enterprise (VCFSE) partners within the collaborative who could demonstrate innovative solutions to reduce the use of inpatient beds - from admission avoidance and preventing readmission to reducing hospital stays and facilitating quicker discharge.

A total of 26 bids were received and 10 have been awarded funding. The projects, which are closely aligned to the Birmingham and Solihull three-year inpatient bed strategy, include a dementia pathway for older adults, enhanced provision for bed management, an autism key worker project, low intensity psychological interventions, support for young adults with serious mental illness and young people's taking spaces.

The Patient Portal

The Patient Portal is a brand-new online system that gives service users/patients 24-hour access to their personal mental health and community healthcare information.

We now have 561 people signed up to the Patient Portal, but we would like to encourage more service users/patients to use this convenient system where mental health care information is available at the click of a button regarding mental health appointment dates, care plans and key information also available from Birmingham Community Healthcare NHS Foundation Trust (BCHC) who provide core community health services to 1.1 million people across the Midlands.

The Patient Portal is compatible with all smartphones, tablets, laptops and PCs and is currently available to past and present BSMHFT service users who are aged 16 and over, registered with a GP and have an NHS number.

Appointment to four permanent roles in Birmingham City Council's Leadership Team

In January, BCC announced the appointment of four permanent roles to their Corporate Leadership Team, stating "It is important to Birmingham's improvement journey to have a stable senior management team. I am delighted that our recruitment process has brought the best to Birmingham

to work alongside the existing senior team who have already made substantial progress on our improvement journey."

The new appointments include:
Rishi Shori - Deputy Chief Executive
Carol Culley - Executive Director of Finance and S151 Officer
Stuart Lackenby - Executive Director of Adult Social Care and Health
Richard Lawrence - Executive Director of Place, Prosperity and Sustainability

NATIONAL NEWS

MPs to examine the state of community mental health services
A new inquiry has been launched by the Health & Social Care Committee, to examine the provision of Community Mental Health services for adults with severe Mental Health needs.

The inquiry will focus on the experience of patients receiving mental health care in the community, with MPs examining what high quality care looks like from the point of view of adults with severe mental illness (SMI).

The Committee will investigate the current state of access to community mental health services for adults with SMI, considering how access could be improved across the country.

Issues over access to mental health services were highlighted in Lord Darzi's report into the state of the NHS in England, which found that for people needing to access mental health services, "long waits have become normalised". Darzi found that there were around 1 million people waiting to access mental health services by April 2024, including 345,000 referrals where people were waiting more than a year for first contact.

As part of their inquiry, the cross-party Committee will also probe how the wider health and social needs of people with SMI can be addressed, including in employment and housing. MPs will explore how community mental health services can work with social care, the third sector and local government to better address the wider determinants of mental health outcomes.

Source: MPs to examine the state of community mental health services in new inquiry - Committees - UK Parliament

Right Care, Right Person (RCRP)
A report has been published by The King's Fund, ***'Exploring health and social care perspectives on the implementation of Right Care, Right Person, under the National Partnership Agreement'*** explaining the policy details around Right Care, Right Person.

RCRP has been designed to end the inappropriate and avoidable involvement of Police in responding to incidents involving people with Mental Health needs.

RCRP doesn't come without its risks and challenges, and some of the key points are highlighted in the report linked above, as well as shining a light on the importance of the step forward in RCRP in identifying and addressing issues in health and care services.

Mental Health Bill

Members of the House of Lords resumed their line by line examination of the individual clauses of the bill in January, with proposed changes and amendments that you can read about here - ***Lords continues detailed check of Mental Health Bill - UK Parliament***

The NHS Federated Data Platform (NHS FDP)

The NHS FDP is software that enables NHS organisations to bring together operational data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment.

By streamlining access for healthcare professionals, this reduces the need for multiple logins, resulting in faster, more coordinated care, increased patient choice, and improved health outcomes.

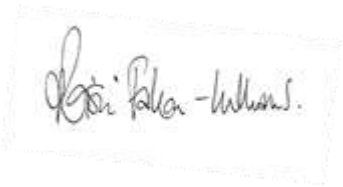
At an individual trust level, the platform provides access to information in one secure place – so that the most up-to-date information about a patient is easily available for teams to review.
The information can be viewed, in near real time, which helps to manage waiting lists, schedule operations and better plan care.

Whilst most of the current examples of development of its use are from Acute Hospital settings (eg Surgery planning, elective waiting list planning) we believe it will have scope to support a system wide approach that supports patients with mental health needs and the staff providing their care.

As a Birmingham and Solihull system we had an engaging and interactive session with representatives of the national team at the last meeting of all our executive teams and further support from the national team leads is being planned to support our BSoL adoption and implementation of the FDP.

Change NHS – 10 Year Plan Consultation

The Government opened this national public consultation in the Autumn, and we have engaged in this and made a submission with views on three key pillars, described as 'shifts' in the consultation. These relate to the clear intent of the 10-year plan to move care from hospitals to communities, to make better use of technology and to focus on preventing sickness not just treating it.



ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Report to Board of Directors							
Agenda item:	**8**						
Date	5 February 2025						
Title	Board Assurance Framework						
Author/Presenter	David Tita, Associate Director of Corporate Governance						
Executive Director	David Tomlinson, Executive Director of Finance	**Approved**	**Y**		**N**	✓	

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

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

Alert		**Advise**		**Assure**	✓

1. **Purpose:**

This report aims to present the Board Assurance Framework (BAF) to the Board of Directors for scrutiny, oversight and assurance following its recommendation by the Audit Committee meeting which held on 23rd January 2025. The BAF is an extension of the Trust`s risk management arrangements and seeks to provide assurance to Board members that strategic risks linked to the delivery of the Trust`s `strategic priorities` as per its strategy are being effectively mitigated and managed in line with the Trust Risk Management Policy and best practice.

2. **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 robustly and efficiently mitigated and managed. Below is a list of the 9 overarching BAF risks which constitute the Trust BAF, however, details of BAF SR7 haven`t been reflected in appendix 3 as these are being finalised (Please check appendixes for details of the full BAF).

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

Key changes to this iteration of the BAF include:

In appendix 1: the People Committee BAF:

- The target BAF risk scores for SR1 & SR2 have been adjusted from **(4x3=12)** to **(3x3=9)** to align with the new risk appetite category of `Open` assigned to both risks which equates to 9-10.

In appendixes 2 & 4: the QPES BAF:

- Target BAF risk scores for SR8 & SR9 have been adjusted from **(4x2=8)** to **(3x3=9)** to align with the new risk appetite category of `Open` assigned to both risks which equates to 9-10.
- Requests for extension of the due dates of some actions have been presented with reasons captured herein and highlighted in orange.
- Completed actions have been RAG rated `Green` and will be removed from the next iterations of the BAF once approved by the Risk Management Group which will hold on 20th February, 2025.
- Additional entries that have been captured on the assurance section of SR3 are highlighted in `orange`.

In appendix 3: the FPP BAF:

- The target BAF risk score for SR6 has been adjusted from (3x3=9) to (4x3=12) to align with the new risk appetite category of `Eager` assigned to this BAF risk which equates to 12.

3. Key issues and risks:

There are two key issues worth noting here: -

a. The need to sufficiently populate and embed the BAF across the Trust.
b. And the need to ensure that the BAF is regularly reviewed and updated.

This BAF will be populated through existing governance and management meetings for greater awareness and visibility. Key changes to the BAF which were recommended by Board committees at their last meetings in January 2025, haven`t been reflected in this iteration as such changes will need to go through the RMG for endorsement prior to their inclusion.

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 asked to:

1. **NOTE** the content of this report.
2. **REVIEW, SCRUTINISE** and **GAIN ASSURANCE** that BAF risks linked to the delivery of the Trust`s `strategic priorities` are appropriately mitigated and managed in line with the Trust Risk Management Policy and best practice.

Enclosures

Table 1: Summary of the Board Assurance Framework.
Table 2: Heat Map of the BAF.
Appendix 1: Details of the People Committee Board Assurance Framework
Appendix 2: Details of the QPES Board Assurance Framework.
Appendix 3: Details of the FPP Board Assurance Framework.
Appendix 4: Details of the QPES Board Assurance Framework – continuation

Table 1: Summary of the Board Assurance Framework (BAF)

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	**3x3 = 9**	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	**3x3= 9**	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	**3 x 3 = 9**	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	**3 x 3 = 9**	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	**3x 3 = 9**	N/A	**4 x 4 = 16**

Table 2: Board Assurance Framework - Heat Map

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					

***Appendix 1: Details of the People Committee Board Assurance Framework*.**

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
Open - 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 9-10.***			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 3 x Likelihood 3= 9**	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
Open - 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 9-10.***			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 3 x Likelihood 3 = 9**	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	31/12/2024	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	30/11/2024	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	31/12/2024	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 • Flexibility with the targeted use of Bank incentives and Trust-wide reward.	• Diversity gaps in senior positions • Gender pay gap • Significant workforce gaps • Cost of living increases with AfC pay-scales not as	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention. • Complaints • Bank and agency • Disciplinary Process	

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

Appendix 2: Details of the QPES Board Assurance Framework

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	**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 / Risk score: 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	• 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

• 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	• 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 Request extension of action due date to 28th Feb 2025 to enable finalisation of LCGC ToR. Please see progress for more details.	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 continuous improvement in quality through an embedded safety culture	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.
Development of process to meet requirements of statutory reporting and required reporting	IDCN	30 November 2024 completed	Process in draft shared with external stakeholders for comment

Alignment of policy and audit processes and reporting schedule through CEAG	IDCN	31st December 2024 Request extension of action due date to 31st March 2025 as meetings to review and improve current processes have been delayed due to leave and competing priorities.	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). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation • Zinnia draft CQC report.	• 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. • Submission made to the CQC in response to the Sections by the required deadline in December 2024, showing improvement in the areas that were highlighted.	• 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.**	
14/01/2025 Local CGC (LCGC) Review completed. TOR adjusted and standardised across all directorates. LCGC Agenda also updated, refreshed, and used similar TCGC style template for agendas (3 as per theme months). Consultation exercise undertaken with executive colleagues. Consultation exercise undertaken with Directorate SLT – concluded 6th of January. Final amendments to be made and new LCGC process rolled out. New LCGC process has been augmented with improved, bespoke reporting on quality, safety and experience, with learning from death reporting due to be rolled out in the coming months. Final Review of Audit Recommendations against works completed to be undertaken by 31/01/25.	

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** - Accept need for operational effectiveness with risk mitigated through careful management limiting distribution. ***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 Request for extension of action due date to 31st March 2025 to enable meetings to be setup as it has been difficult to get diary time to discuss how to take this forward.	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 Completed.	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	• 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.

		escalated 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.**			

Appendix 3: Details of the FPP Board Assurance Framework.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 5	**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
SR 6	**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				**INHERENT RISK SCORE**	Impact	Likelihood	Risk score

	Eager - Application of dynamic environment-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements. ***Target risk score range 12.***		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 4 x Likelihood 3 = 12**	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	Ongoing	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	Ongoing	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.

Appendix 4: Details of the QPES Board Assurance Framework – continuation

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	• 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	QPES	Executive Medical Director	**SR3** **SR4** **SR9**

			• 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.	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.			
RISK APPETITE		**Open** - 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**.** ***Target risk score range 9-10.***		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Risk 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 3x 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**			

• SI oversight Group • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • Clinical service structures, 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	• 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. • 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.

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 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	• 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.	• 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.

improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. • Participation Experience and Recovery (PEAR) Group. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.		• Out of Area Steering • 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 feed to Inequalities board.	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. • 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
SR 9	**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. • The difficult financial landscape.	• 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

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.**		INHERENT RISK SCORE	Impact	Likelihood	Total 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 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
• 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.

Report to Board of Directors					
Agenda item:	**9**				
Date	5 February 2025				
Title	Integrated Performance Report				
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information				
Executive Director	Dave Tomlinson, 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 points raised for consideration by the Committees on which they need to provide assurance to the Board are as follows:

- Dashboard now contains links to relevant measures for each Division and services
- Both Talking Therapies waiting times targets are being sustainably achieved
- Use of non-Trust Beds and Out of Area placements remain key priority areas for improvement. A separate Productivity Plan update was discussed at FPPC
- Clinically ready for discharge is a major contributor to additional bed usage this and is proving difficult to tackle. System level escalations being undertaken
- CPA 3 day follow up largely being met, improvements in late data entry required, this is being followed up with service managers to improve timeliness of recording contacts on RIO
- Formal review of patients within last 12 months is now reliably upper 90%s
- Referrals over 3 months with no contact remains high, but mitigations are in place to avoid risks
- Vacancies have reduced to 9.4% (475 FTE), but vary considerably across departments
- Physical restraints reduced from 266 to 230, 143 in AUC
- Reported incidents reduced from 2632 to 2252 – large reduction in Secure CAMHS from 273 to 120
- Incidents of Self Harm have decreased from 192 to 114
- Report is starting to become extremely long because of the detail added
- Moving on with deep dives, they will all include benchmarking and waiting times where appropriate
- Deep Dives are being supplemented by review of leadership team approach and culture

Following the recent January 2025 Board Strategy Session on the Insightful Provider Board, feedback will be utilised to

review the Integrated Performance Report, working with lead Executives and teams where appropriate to take forward.

The Board is asked to note the improvements made to the Trust's Performance Management Framework, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement through the service area deep dives and more recently the introduction of divisional leadership review meetings.
- Bringing all performance management matters (People, Quality, Performance, Finance) through a single set of forums via the Performance Delivery Group (PDG) to support.

The Board is asked to note that the service area deep dive framework has been in place since March 2024 and supports the implementation of a more granular level service specific approach focusing on the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance, alongside strategy and partnerships. A service line RAG rating assessment covering each of the domain areas is also agreed with the service area senior leadership team at each meeting.

In addition, and building on the service line review meetings, from November 2024 Divisional Leadership review meetings have been introduced. These will take place with the Executive Team on a quarterly basis. The discussions will focus on jointly reviewing and discussing team working, management and delivery of the Trust's finance, people, quality and performance priorities, understanding dependencies across the team and fostering multi-disciplinary leadership.

Since the last FPPC meeting in December 2024, there has been no Performance Delivery Group and one Deep Dive meeting held on 20th December covering the Men's secure service. Updates are provided in the report.

Members are reminded that at the request of FPPC, there is a continued focus on selected metrics. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the relevant service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is either a deteriorating trend or requires improvement.

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				
Inappropriate out of area Number of placements			Improvement last month but remains above trajectory	2-3, 10-12
National Waiting times – Long waits – Adult CMHTs			Improvement in performance in last month. Ahead of 104 week waits trajectory	3
National Waiting Times – Long waits - CYP			78-week trajectory decline in last month. 104 weeks on track	3
People				
Vacancies			Improved position in December, 9.4%	4

Sickness			Improved position in December to 6.3%.	4, 19-20
Appraisals			Improvement in month at 80.2% but remains below the 90% standard	4, 21-22
Sustainability				
Monthly Agency costs			Significantly better/lower than NHSE target	4

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving trend in last 3 months (49.7%) below 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last 2 months (45.45%) below target of 48%	3, 17-18
Talking Therapies Reliable improvement rate			Deteriorating trend in last month (61.09%) below target of 67%	3, 15-16
Clinically Ready for Discharge: percentage of bed days			Deteriorating trend in last month. Dec at 14.13%	3, 13-14
Clinically Ready for Discharge: Number of delayed days			Deteriorating trend in last month. Dec at 2300 bed days.	3, 13-14

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 2 months (94.32%). Remains below target of 95%	4, 23-24

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incidents resulting in self harm			Reducing trend in last 2 months. Reviewed via QPES.	3,25-26
Incident resulting in harm (patients)			Decreasing trend in month. Reviewed via QPES.	3, 27-28
Reported incidents			Reduction in month from 2632 to 2252	3, 29-30
Staff assaults			Increased in last 2 months to 126 (from 123)	3, 31-32

Recommendation

The Committee is asked to note the latest performance position, update on areas identified for improvement and feedback following the service area deep dive meeting held for Men's Secure Services.

Enclosures

Integrated Performance Report and Dashboard

Appendix I FPPC January 2025 FPPC Performance Improvement Metrics

Appendix II FPPC January 2025 Performance Framework update

Details on Deep Dive meetings are available on request.

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 2024 and committee chairs were asked to consider how 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 required improvement.

- Active Inappropriate Adult Mental Health Out of Area Placements (Previously Inappropriate Out of Area Bed Days)
- 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.

Since the last FPPC there has been no Performance Delivery Group meeting and there has been one service area deep dive meeting focusing on the Men's Secure Services on 20th December 2024.

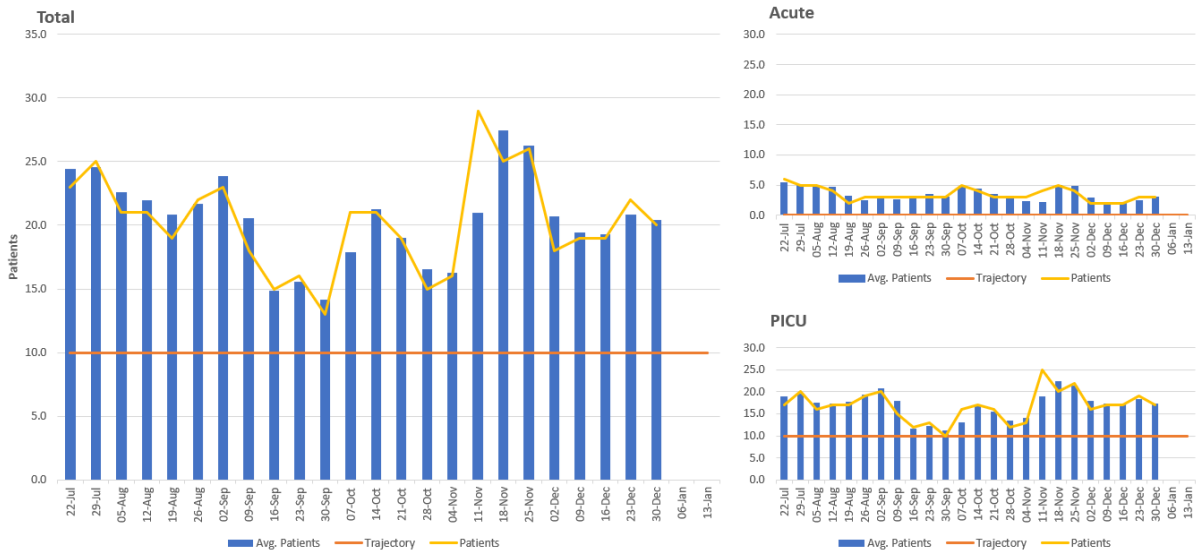
Performance in December 2024

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 decreased for PICU beds leading to a decreased use of inappropriate placements, however performance remains above trajectory for December 2024. The granular level weekly data is outlined below. As at the end of December 2024, there were 3 acute (target 0) inappropriate placements and 18 PICU (target 10) patients. This is 6 lower than the previous month.



A separate update on the productivity plan and actions will be provided to January 2025 FPPC by the Acute and Urgent Care Associate Director. A summary of the areas for continuing focus include:

- **Locality model implementation**
- **Clinically Ready For Discharge –** daily and weekly partnership based meetings, escalation to senior system wide discussions, with a specific focus on Social Worker support requirements. Birmingham City Council progressing recruitment of social workers to allocate to older adult and adult services.
- **Crisis House Tender –** progress being achieved with MIND being successful bidder. Implementation plan in progress.
- **Contract procurement** - extended Priory capacity to include an additional 20 beds for BSOL system.
- **Demand Management/Gatekeeping/Reducing LOS - Clinical Oversight Team** renewed action to progress.

Talking Therapies Recovery rates

The 2024/25 NHS planning guidance 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 but show an improving trend this month. The service leads are discussing these metrics with teams and new starters to enable an understanding about what is required and utilising data to identify service users who require additional appointments to improve the position.

National Community Waiting Times – Both Adult and Older Adult CMHTs have made progress against their improvement plans which have focussed on reducing long waits. Challenges in both services remain in particular around managing high caseload levels and pressures arising from staffing levels.

In line with the national 2024/25 operational planning guidance, trajectories were submitted to NHSE via the ICB to improve and reduce long waits in adult and CYP services. The initial focus is to review all long waiters over 104 weeks within adults and CYP trajectory also includes reducing long waits over 78 weeks. The detail of these improvement plans have been added to Appendix 1. Adults, performance as at December 2024 is in line with agreed trajectory and CYP is just over the 78 week wait trajectory.

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

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 14.13%. The main drivers for this are the delays in both adult and older adult acute services. CRFD in December 2024 in Adult Acute & Urgent Care was at 18.16% (59 patients) and in Older Adult Services at 35.7% (35 patients). The number of delays in Acute and Urgent Care and Older Adults has increased this month. The main reasons for the delays in adult acute are allocation of a social worker and lack of public funding 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. Barriers have also been escalated to senior system wide level.

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

- Incidents of Self harm have decreased from 192 to 114 this month
- Incidents resulting in harm (patients) has decreased to 24% (from 29.9%) and is back within control limits.
- Reported incidents have reduced from 2632 to 2252 (large reduction in secure CAMHS)
- Staff assaults have increased for the second month to 126 (from 123)

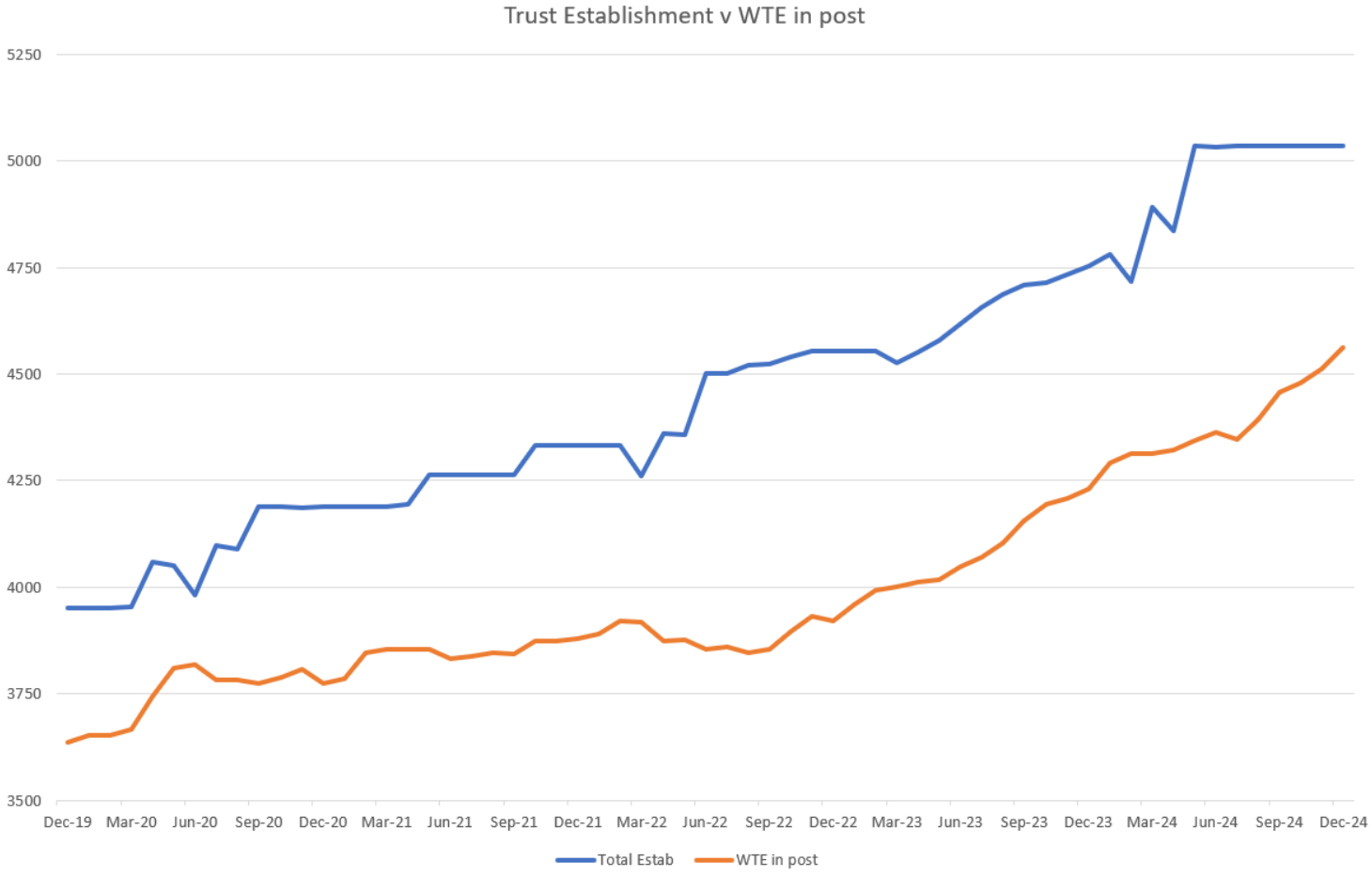
People Workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there is an adverse variance against most of the set performance standards although there have been improving trends in fundamental training and reduction in staff turnover.

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 – While agency expenditure continues to reduce, bank expenditure shows little change. The Director of Nursing is now taking a lead role in this area.
- Staff Appraisals at 80.2% as at December 2024 just below improvement trajectory and below the 90% Trust standard.

- Paper developed for the Strategy & Transformation Board to provide update on project.
- L&D continuing to provide support interventions to staff and hot spot areas

- Staff vacancy levels Vacancies reduced from 10.4% to 9.4% in month



- We continue to increase substantive staffing numbers (4,561.6 WTE at end of December, v 4,511.9 in November and 4,229.4 in December 23, although levels of vacancies vary significantly by area:
  - Acute & Urgent Care 8.9% (77.8 WTE in December v 86.1 in November and 113.5 Dec-23)
  - Specialties 2.9% (24.4 WTE in December v 28.8 in November and 149.6 Dec-23)
  - ICCR 13.0% (146.1 WTE in December v 159.1 in November and 101.7 Dec-23)
  - Secure 9.3% (106.7 WTE in December v 115.3 in November and 167.4 Dec-23)

  - Qualified Nursing 15.4% (255.8 WTE in December v 178.6 in November and 282.3 Dec-23). The budgeted establishment increased from 1,565.9 in November to 1,662.6 in December

- Mandatory Training at 94.32%, sustained position this month.

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 £11,394k against plan of £12,618k. Majority of slippage relates to out of area spend and unidentified savings
- YTD agency expenditure now below NHSE ceiling (£3,679k v £7,088k). Level of medical staff expenditure significantly down on 23/24
- Operating Surplus - YTD surplus of £1,208k against plan of £1,795k surplus. Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

December 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	2300 ↓
Clinically Ready for Discharge: Bed Days (%)	14 ↓
CPA 3 Day Follow Up (%)	84
CPA 7 Day Follow Up (%)	91
Eating Disorders: Waiting Time - Routine (%)	100 ↑
First Episode Psychosis: Waiting Time (%)	100 ↑
Out of Area: Inappropriate Placement Bed Days	631
Out of Area: Inappropriate Placements Active	21
People on CPA with a Formal Review in last 12 Months (%)	97 ↑
Referrals over 3 Months with no Contact	3851 ↓
Talking Therapies: Reliable Improvement Rate (%)	61 ↓
Talking Therapies: Moving to Recovery (%)	50
Talking Therapies: Reliable Recovery Rate (%)	45
Talking Therapies: Seen in 18 Weeks (%)	98 ↑
Talking Therapies: Seen in 6 weeks (%)	93 ↑

People

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

Quality

Absconsions from Inpatient Units	3
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	0
Failure to Return	16 ↗
Incidents of Self Harm	114 ↑
Incidents Resulting in Harm: 1 - Patients (%)	24 ↓
Incidents Resulting in Harm: 2 - Other (%)	9 ↑
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	14
Ligature with Anchor Point	1
Patient Assaults	36
Patient Assaults / 1000 OBDs	1.9
Physical Restraints	230
Physical Restraints / 1000 OBDs	12.0 ↑
Prone restraints	42
Prone restraints / 1000 OBDs	2.2 ↑
Reported Incidents	2252 ↓
Staff Assaults	126 ↓
Staff Assaults / 1000 OBDs	6.6 ↓

Sustainability

Agency Staff Spend	£323k ↑
Capital Expenditure	£874k
Cost Improvement Programmes	£1,449k
Group Cash Balance	£91,629k ↑
Info Governance (%)	94
Operating Surplus	£458k

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

Last refreshed 14th Jan 2025

Integrated Performance Dashboard

December 2024

Trust | Acute & Urgent Care | ICCR

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Measure	Latest Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Clinically Ready for Discharge: Bed Days		1689	1603	1933	1909	2117	2300 ↓
Clinically Ready for Discharge: Bed Days (%)		10	10	12	12	13	14 ↓
CPA 3 Day Follow Up (%)	80	86	74	80	85	80	84
CPA 7 Day Follow Up (%)	95	93	89	91	93	88	91
Eating Disorders: Waiting Time - Routine (%)	95	100	100	100	100	88	100 ↑
Eating Disorders: Waiting Time - Urgent (%)	95				100		
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	100	100 ↑
Out of Area: Inappropriate Placement Bed Days	328	775	712	536	560	658	631
Out of Area: Inappropriate Placements Active	10	27	23	14	17	27	21
People on CPA with a Formal Review in last 12 Months (%)	95	97	96	97	97	96	97 ↑
Referrals over 3 Months with no Contact		3646	3821	3758	3671	3707	3851 ↓
Talking Therapies: Reliable Improvement Rate (%)	67	59	61	59	59	63	61 ↓
Talking Therapies: Moving to Recovery (%)	50	48	48	43	45	48	50
Talking Therapies: Reliable Recovery Rate (%)	48	44	45	40	40	44	45
Talking Therapies: Seen in 18 Weeks (%)	95	93	96	96	98	98	98 ↑
Talking Therapies: Seen in 6 weeks (%)	75	83	88	90	90	93	93 ↑

Integrated Performance Dashboard

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

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

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Measure	Latest Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Absconsions from Inpatient Units		1	6	4	8	1	3
Commissioner Reportable Incidents		0	0	0	0	0	0
Community Confirmed Suicides		2	0	0	0	0	0
Community Suspected Suicides		1	2	3	4	1	0
Failure to Return		20	18	22	18	17	16 ↗
Incidents of Self Harm		227	208	218	234	192	114 ↑
Incidents Resulting in Harm: 1 - Patients (%)		28	27	27	26	30	24 ↓
Incidents Resulting in Harm: 2 - Other (%)		8	7	9	8	9	9 ↑
Inpatient Confirmed Suicides		0	0	0	0	0	0
Inpatient Suspected Suicides		0	0	0	0	0	0
Ligature no Anchor Point		36	21	17	25	23	14
Ligature with Anchor Point		3	0	1	1	0	1
Patient Assaults		38	37	43	38	52	36
Patient Assaults / 1000 OBDs		2.0	1.9	2.3	2.0	2.7	1.9
Physical Restraints		312	364	285	343	266	230
Physical Restraints / 1000 OBDs		16.2	18.8	15.2	17.6	14.0	12.0 ↑
Prone restraints		67	35	43	74	49	42
Prone restraints / 1000 OBDs		3.5	1.8	2.3	3.8	2.6	2.2 ↑
Reported Incidents		2725	2535	2319	2678	2632	2252 ↓
Staff Assaults		69	117	97	88	123	126 ↓
Staff Assaults / 1000 OBDs		3.6	6.0	5.2	4.5	6.5	6.6 ↓

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Measure	Latest Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Agency Staff Spend		£404k	£375k	£389k	£337k	£416k	£323k ↑
Capital Expenditure		-£56k	-£2,102k	£1,080k	£397k	£342k	£874k
Cost Improvement Programmes		£1,292k	£947k	£2,826k	£1,306k	£1,201k	£1,449k
Group Cash Balance		£85,539k	£93,790k	£97,993k	£98,784k	£94,821k	£91,629k ↑
Info Governance (%)		95	94	93	96	86	94
Operating Surplus		-£162k	-£432k	£187k	£685k	£127k	£458k
System Oversight Framework (SOF) Rating		3	3	3	3	3	

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

Out of Area: Inappropriate Placements Active

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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. Inappropriate out of area placements has fluctuated since January 2024 with large peaks and troughs. December is showing a decrease in the last month at 21 placements with 3 in acute beds and 18 in PICU beds above the trajectory of 10 for December 2024. These all relate to adult acute/PICU patients. There were 13 inappropriate admissions during December with 4 acute and 9 PICU which is an overall decrease of 13 compared to November. 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 for 2023/24 confirms that BSMHFT has a low number of inpatient beds per 100,000 weighted population indicating the need for additional capacity to meet the needs of the BSOL population. 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 are above the national average due to high levels of acuity requiring a higher number of observations. The number of patients clinically ready for discharge has been increasing over the 12 months with circa 86% delay reasons attributed to community which is not in the Trust's immediate control. CRFD at 2,300 overall in December with adults at 1234 lost bed days which equates to 18%. Adult bed occupancy has decreased in the last month to 95.75% and length of stay has decreased to an average of 108 days in December The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. The combination of these challenges and the 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.

D: What are we doing about it?	3 key workstreams are in place 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, localities are now 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 • The locality model is now in place accross all acute areas and a new bed management function to support the locality model being developed. CRFD Workstream and length of stay • Renewed focus on Clinically Ready for Discharge. 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. Reducing gaps in CRFD recording and plans to increase the usage of ICRT as an alternative to care packages • Social workers have been appointed who will work across adut acure/ older adults and with the homeless team. The first 2 will commence in January 2025 • Strategic level conversations are also being planned with the Local Authority 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

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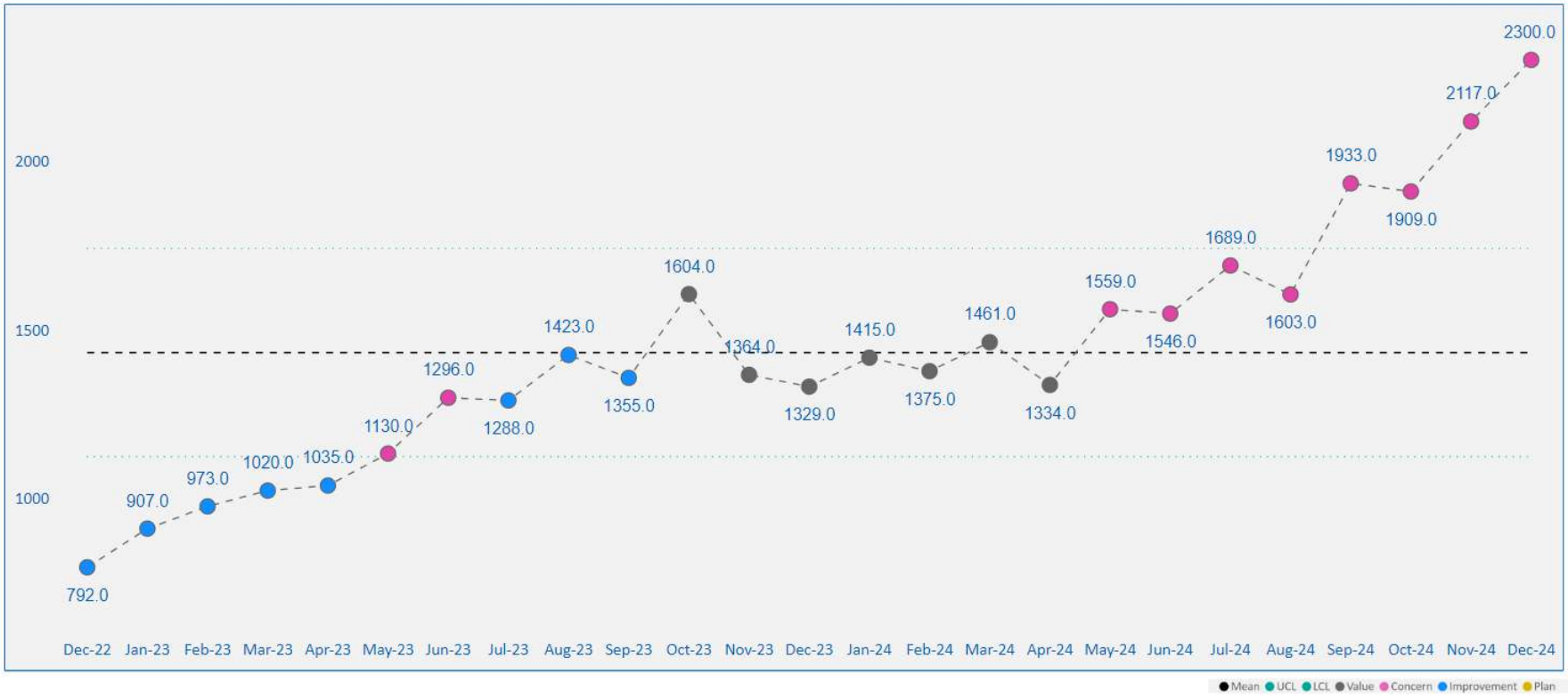

Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days has been on an increasing trend since May 24 and has reached a peak in December to 2300 bed days. Adults moved from 1144 days in November to 1234 days in December, which related to 59 patients, with a main delay reason of Social Worker allocation and awaiting public funding and older adults moved from 614 days in November to 765 in December and related to 35 patients, who were waiting for care home placements with nursing and without nursing.
B: Why has it happened?	The main reasons for the delays across both services include awaiting of a social worker, 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.
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 is in place 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. Weekly meetings with ICS colleagues to review those CRFD. Discussions with 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. 8 Social workers have been appointed by the Local Authority and the first of these will commence in January 2025 There are some gaps in the current CRFD recording which the localities will be working with the discharge managers to address.
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.

Talking Therapies: Reliable Improvement Rate (%)

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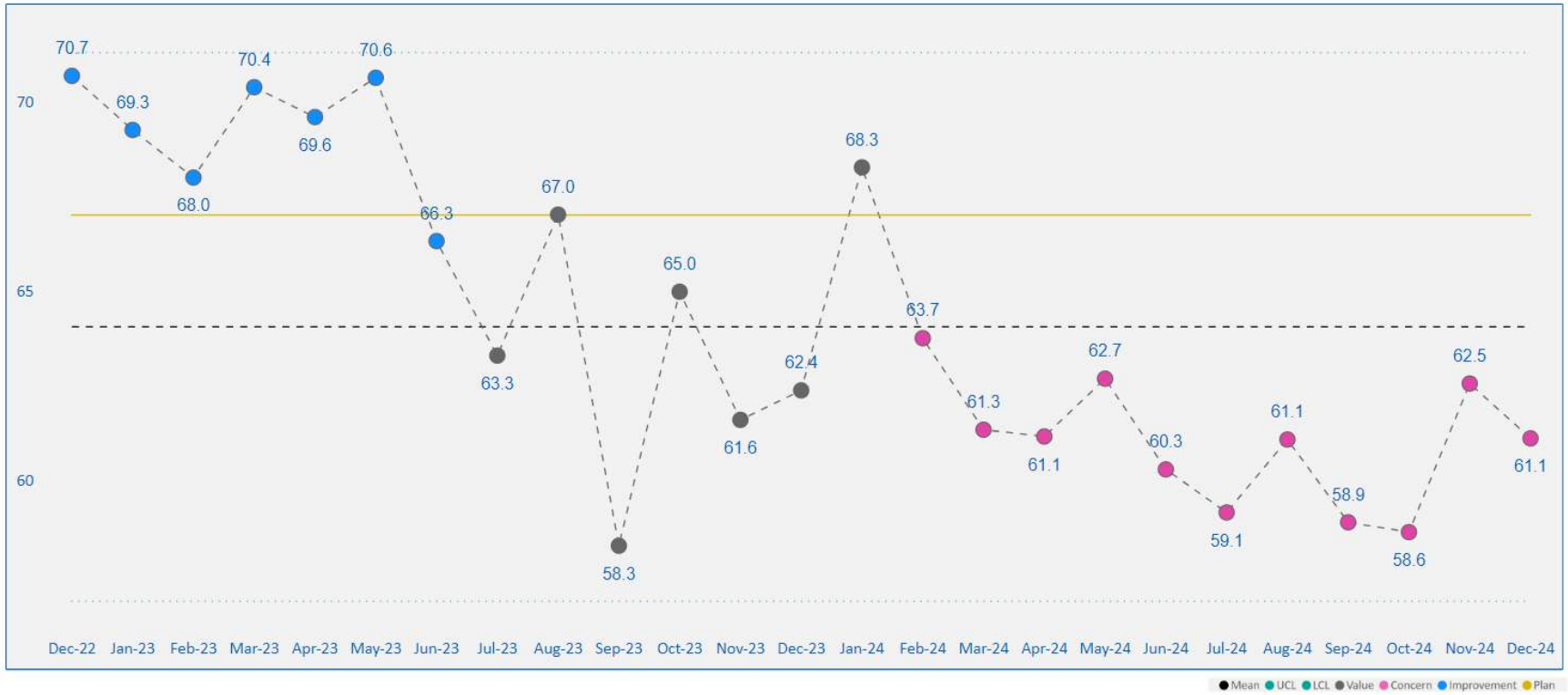

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. December 2024 has shown a decline to 61.09% and remains below the 67% target and below the lower control limit. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.
B: Why has it happened?	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. The improvement in previous month is due to the service providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to.
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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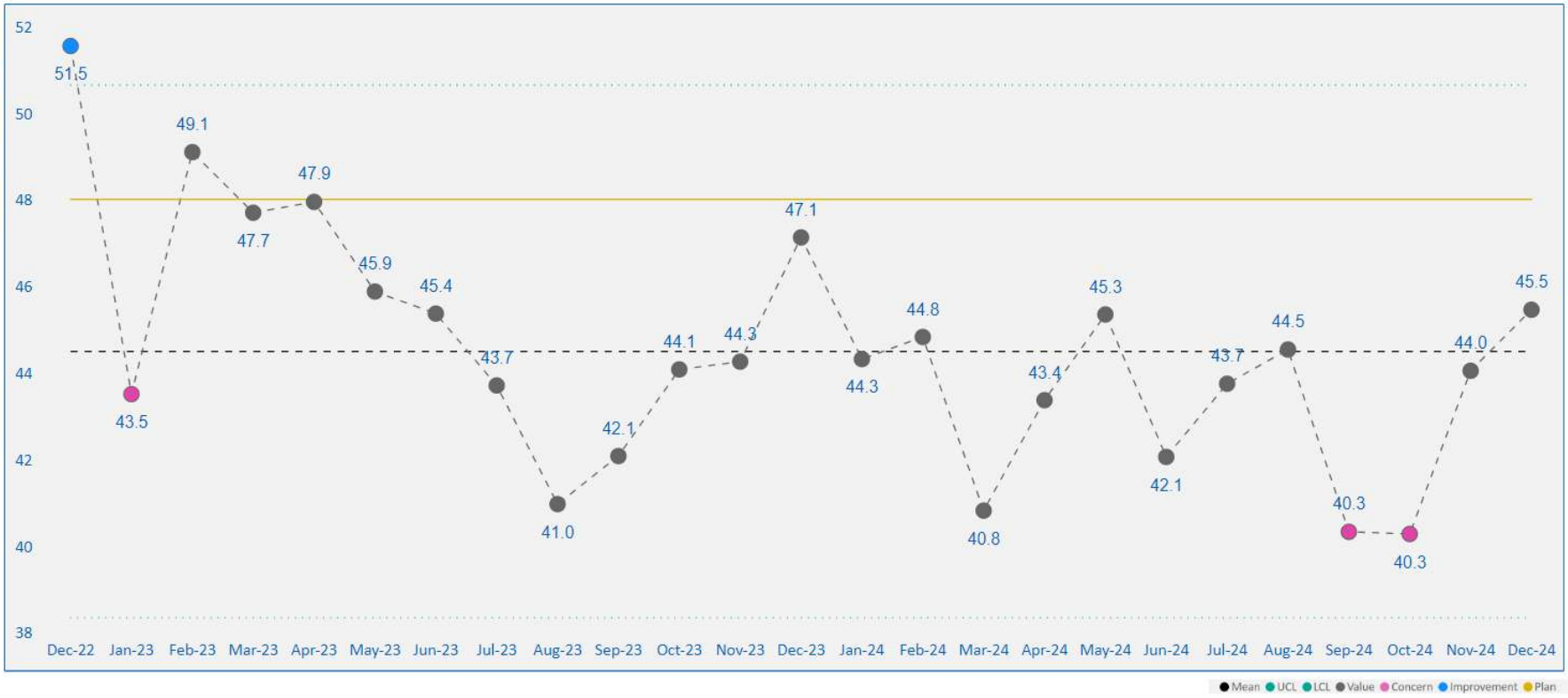

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. December 2024 position has increased to 45.45% but remains below target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment.
B: Why has it happened?	The target for recovery is 48% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria that met caseness at the start of treatment. Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery. The improvement this month is due to the service providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to. These actions have contributed to an increase in the reliable recovery rate this month.
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 (%)

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Question	Answers
A: What has happened?	Trust wide sickness absence rate for December 2024 was 6.3%, against 6.7% in November 2024 and 6.4% in October 2024. Of all absences across the Trust, 2.3% were Short Term and 4% were long-term. Across the divisions, the following services had the highest absence rates: - Secure Services and Offender Health 8.2% (3.3% Short Term and 4.9% Long Term) - PCDS 7.2% (2.1% Short Term and 5.1% Long Term) - Acute and Urgent Care 7.7% (3.3% Short-Term and 4.4% Long-Term) All divisions were showing as having a below target rate of Return to Work Interview completion, standing at 63.3% across the Trust.
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 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.
C: What are the implications and consequences?	1. Operational Inefficiencies: • High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. 2. 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?	Continued Development of HR Clinics and Insight Action is ongoing to refine the structure and underlying data discussed in HR Clinics, so that these insight and action driven conversations can support confident and early manager intervention and support in the event of staff absence. Sucessful HR Clinics will both support manager confidence, enhance people management practices and ensure compassionate, timely support for colleagues (both unwell and their teams). HR Case Management Developments Action is ongoing to refine the management of People Relations cases, supporting prompt action and wellbeing intervention should a colleague become unwell during a formal process. Proposed developments include case operational risk ratings - identifying where discussion and support planning may be needed with critical cases. Renewed People Management Masterclasses A range of new Masterclasses have been introduced for managers and aspiring managers, to support people management competency development and confidence across the Trust. These include Health and Wellbeing Masterclasses, which focus on practical employee support and processes. Delivery routes for these courses are being reviewed to identify whether localised delivery would reach a wider audience and how eLearning tools may provide further reach.
E: What do we expect to happen?	The areas with high levels of sickness absence cases have an impact on service provision as fewer staff are available to provide service and it also ultimately impacts on the health of the 'remaining staff who are well and who continue to provide service. This can result to fatigue for the remaining staff. The sickness absence cycle continue, if we do not deal with the root causes of sickness absence.
F: How will we know when we have addressed issues?	Sickness absence levels will improve; outcomes will be achieved within parameters set by Trust Policies, reduction of high levels of stress and anxiety across the Trust.

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Staff Appraisals (%)

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Question	Answers
A: What has happened?	The trust's Appraisal compliance is 80.2% which is an increase from November which was 80%. 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 68.1%, Exec- Medical 72.4% Exec-Nursing 69.8%, Exec - Resources - 61.7% and New Care Models 46.7%.
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- Working group meeting held alongside regular project group catch-up's to discuss and support the implementation of change ideas. The next QI catch-up is scheduled mid Jan to review progress. The VBA QI paper will be presented on Thursday 9th Jan for Strategy and Transformation Management board to provide an update on the VBA QI project. In addition to the BAU activities, L&D are continuing to provide VBA support interventions to staff/hot spot areas.
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.

Fundamental Training (%)

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Question	Answers
A: What has happened?	The overall Fundamental Training compliance stayed the same as November at 94.3%. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain slightly below of the 95% Trust target for substantive staff. Every area is still below the 95% Trust target except for Exec Director - Medical, Nursing and Resources - Chief Exec - 84.2%, - Exec Ops - 94.4%, - New Care Models - 88.2%, - Strategy, People and Partnerships - 91.5% Temporary Staffing Compliance has decreased from 90.3% in November to 88.9% in December, 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. 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%. On the 1st of December Dual Diagnosis will only be completed once every year instead of once only (grace period in place until the 3rd of June 2025), and Patient Safety Level 1 and Level 2 have also been added to the traffic lights(they have a grace period until the end of May 2025)
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 95% overall compliance 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 of Self Harm

December 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

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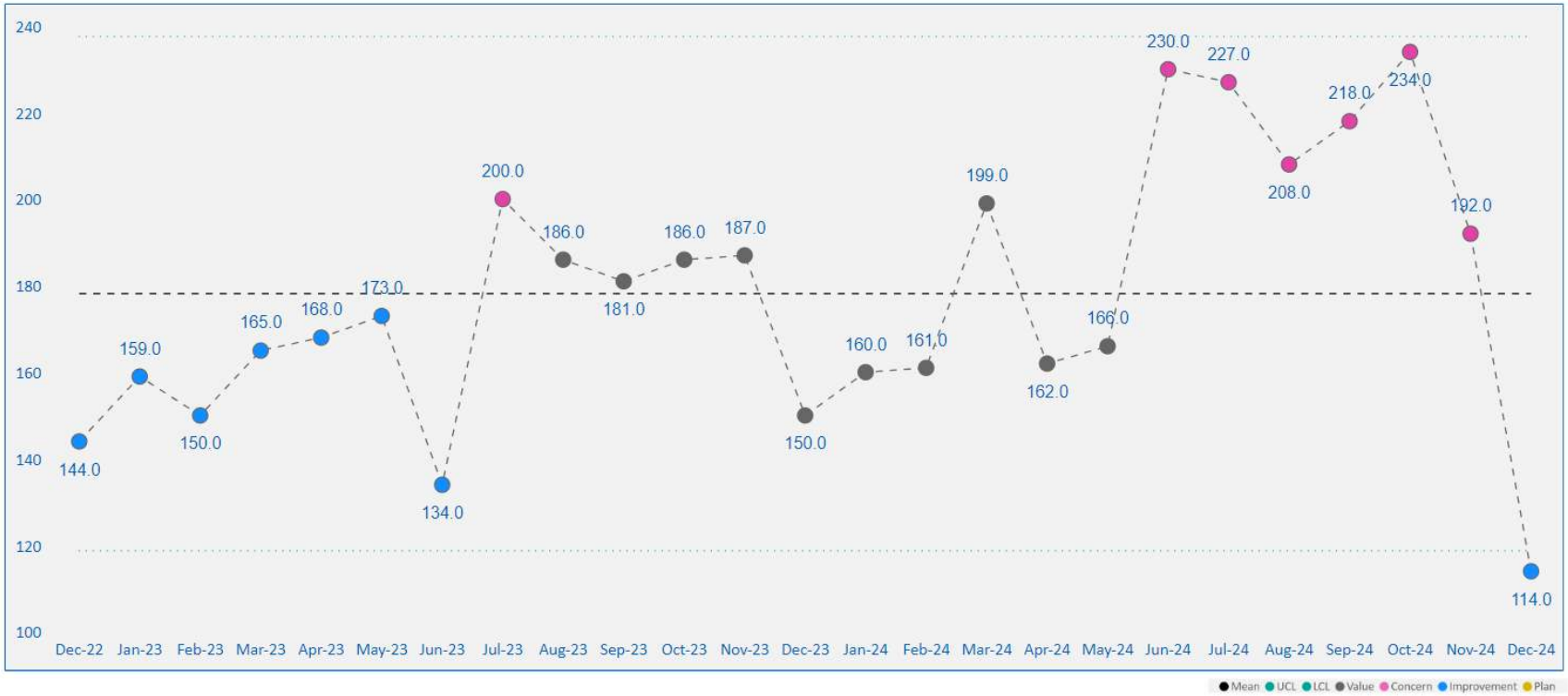
Trust

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 December there were 114 incidents reported which is the first month below the mean of 178 since June 2024. Significant decrease has occurred in Secure Care Services.
B: Why has it happened?	A high number of incidents were attributed to a single service user, who was new to the service. The team have collaborated with the service user to collaborate a personalised plan focused on coping strategies which have been effective.
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

Incidents Resulting in Harm: 1 - Patients (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

December 2024

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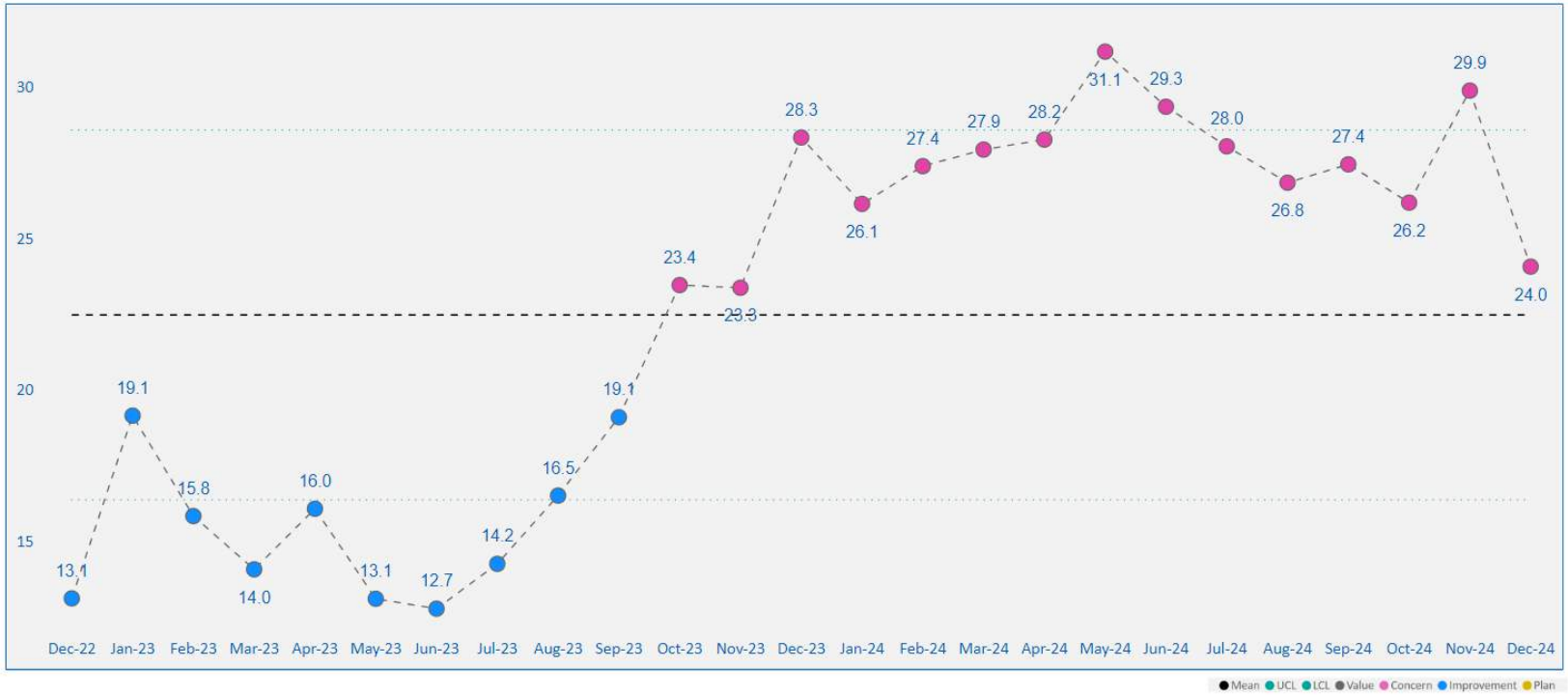

Question	Answers
A: What has happened?	24% of our incidents reported during the month resulted in harm. In cases where the threshold for duty of candour has been met, the appropriate actions and disclosures required by legal standards are enacted. These actions include open and honest communication with 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. From February 2025 we will be reporting psychological harm seperately.
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.

Reported Incidents

December 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

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Commentary

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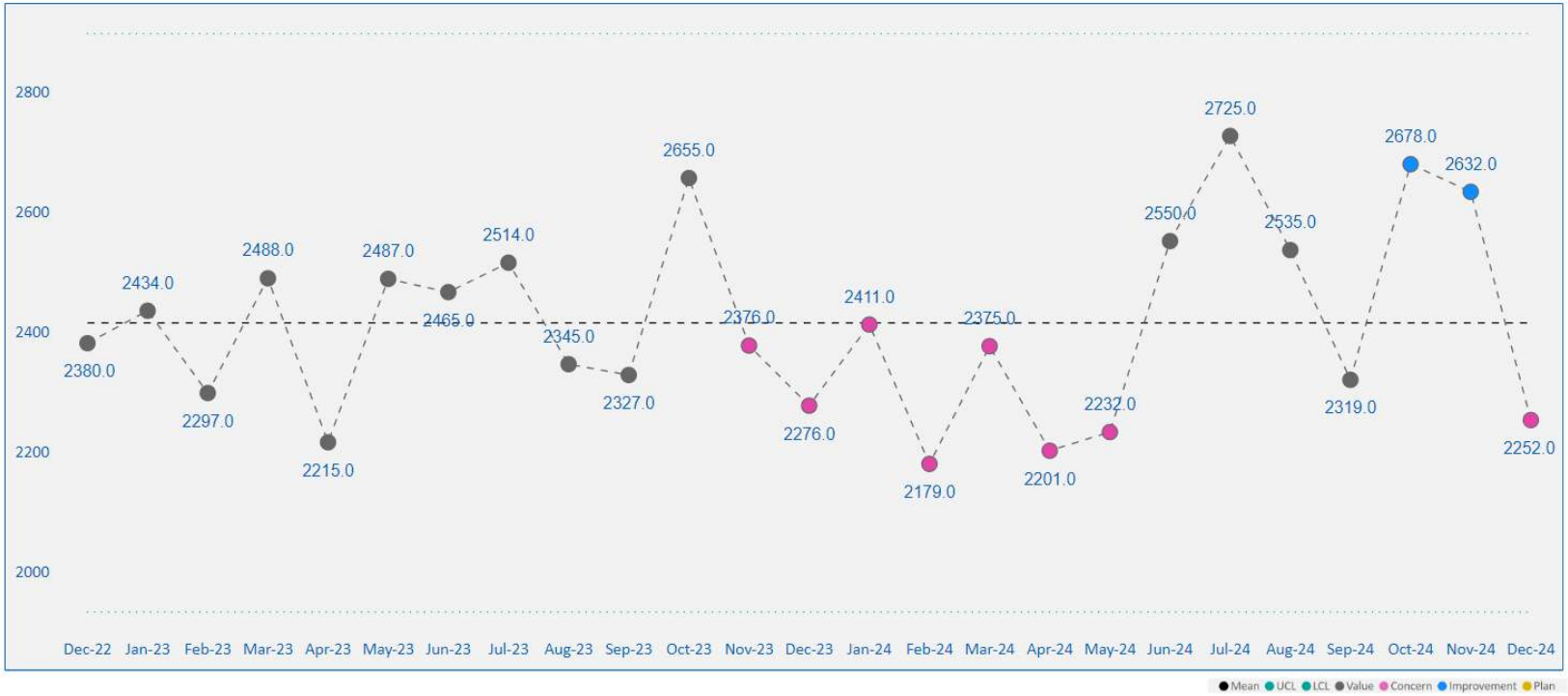

Question	Answers
A: What has happened?	There were 2252 incidents reported during December, which is below the mean of 2413.. Notable reductions occurred in Secure and Offender Health and Specialties
B: Why has it happened?	
C: What are the implications and consequences?	Reporting incidents allows us to be a learning organisation and identify those incidents that require a learning response
D: What are we doing about it?	Local safety panels commission learning responses, which are proportionate to the incident where there is the opportunity for learning
E: What do we expect to happen?	We continue to be a learning organisation which improves the quality of care it provides
F: How will we know when we have addressed issues?	Through the safety culture metrics within staff survey

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Assaults

December 2024

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Trust

Divisions

Services

Commentary

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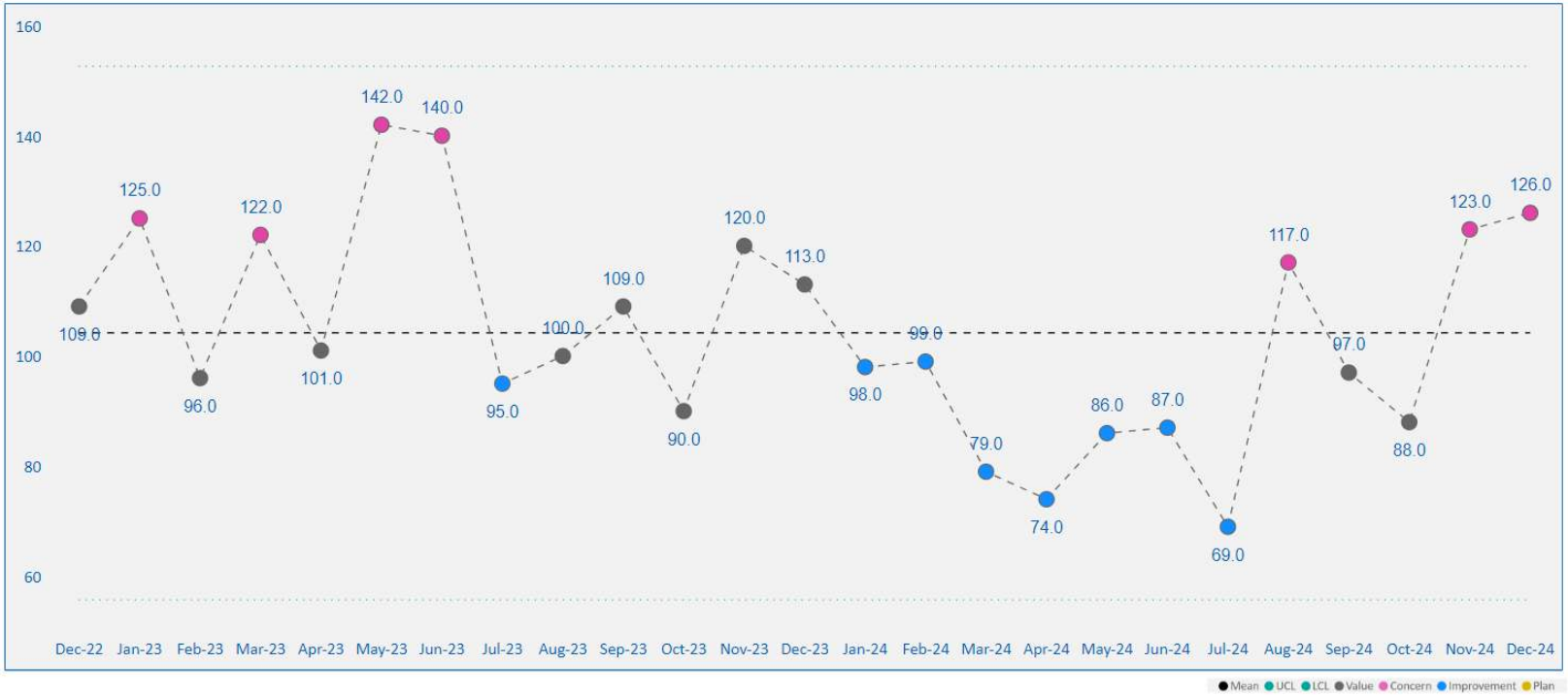


Question	Answers
A: What has happened?	The total number of assaults on staff in December was 126, this is the second sonsecutive montha above the mean of 104. Significant increases in reporting were noted in Acute Care.
B: Why has it happened?	Assaults happen for a number of reasons, however, it is noted that many assaults result from restrictive intervention
C: What are the implications and consequences?	Continued exposure to violence and aggression can lead to a decrease in staff morale; burn out; sickness and RIDDOR reporting; poor staff experience and staff safety and have an impact on recruitment and retention. Poor staff survey score regarding violence. Additionally when patients are exposed to violence it has an impact on their feeling of safety.
D: What are we doing about it?	The RRP has introduced a staff assault work stream, the key themes of work are to fully implement processes of operation stonethwaite, to reduce the risk factors leading to conflict and staff assault and to ensure there is a robust learning system from assaults, leading to improvements. There is also a Review of post incident support to staff is taking place
E: What do we expect to happen?	A reduction in the number of assaults on staff and their harm level, together with an improvement in staff morale and feeling of safety and support.
F: How will we know when we have addressed issues?	Sustained reduction in the number of incidents and an improvement in staff morale measured through staff survey and workforce KPIs such as sickness levels and recruitment and retention levels.

Birmingham and Solihull Mental Health NHS Foundation Trust

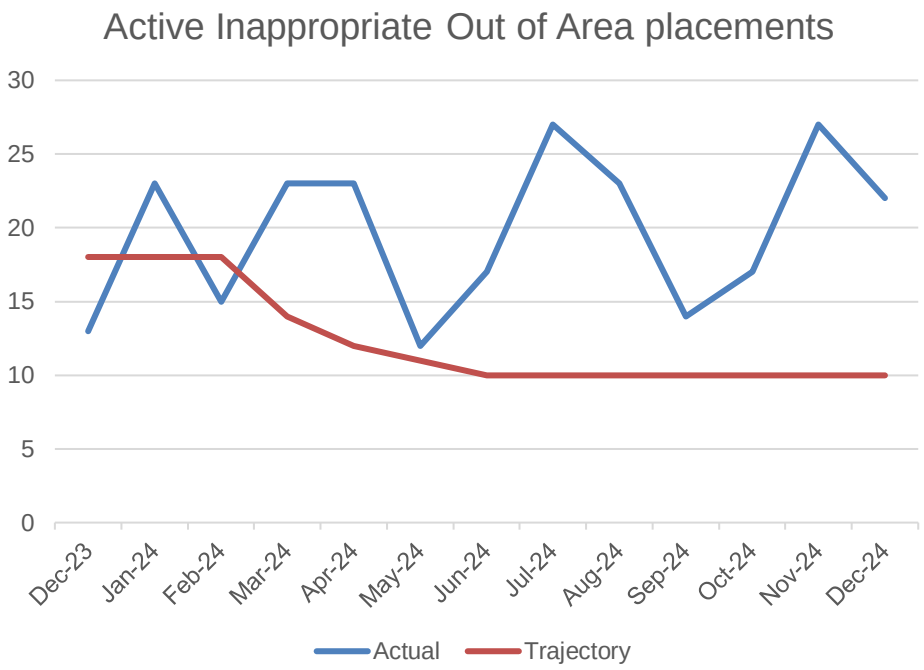
Appendix I - FPPC 15th January 2025

2024/25 Performance metric Improvement Trajectory update

During 2023/24 the following metrics were identified by FPPC for improvement. Action plans and trajectory updates have been provided.

Active Inappropriate Out of Area Placements

New Metric for 2024/25



The 2024/25 planning guidance introduced a revised metric for assessing the reduction of inappropriate out of area placements 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.

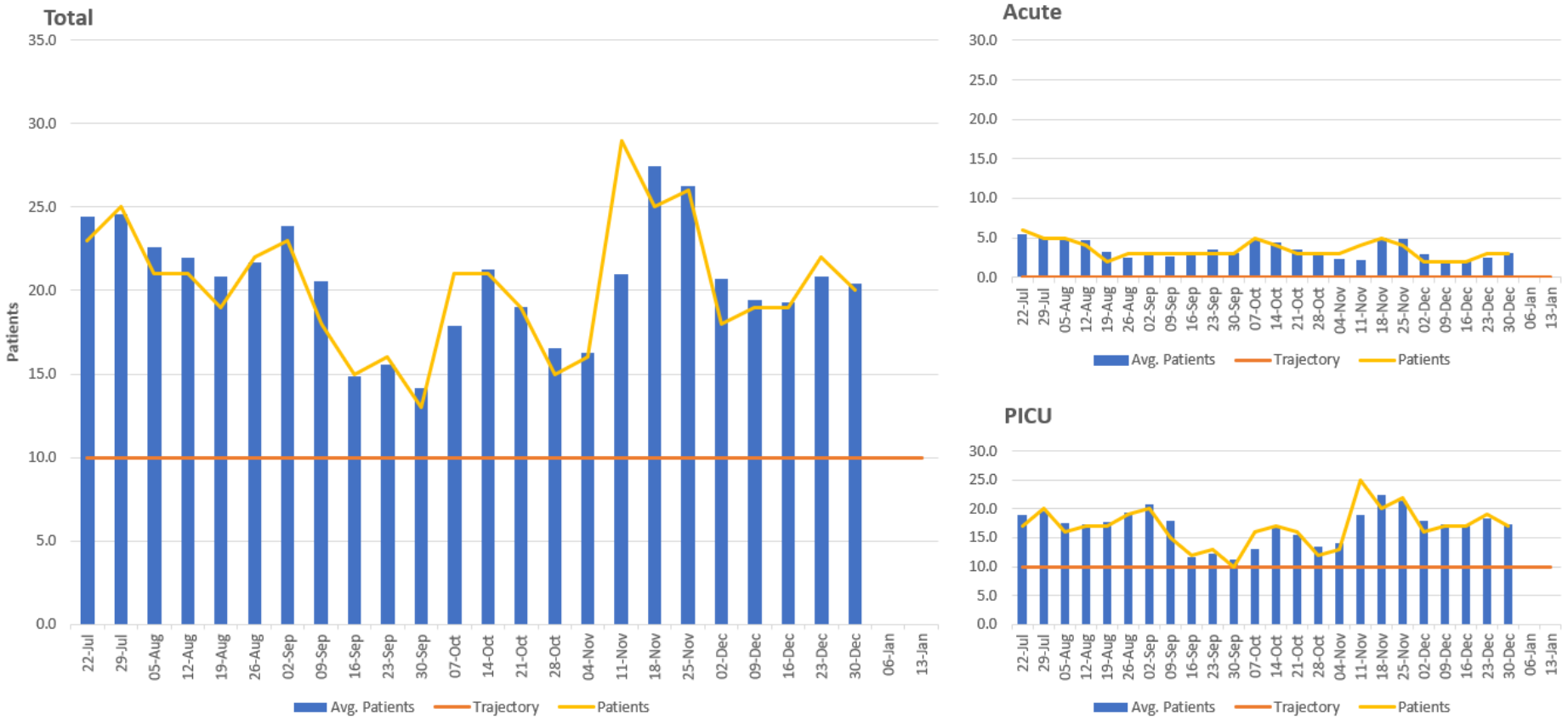
December 20204 - Improved performance – Total at 22 (target 10) inappropriate placements, 5 acute (target 0) and 22 PICU (target 10).

The Trust's productivity action plan continues to focus on workstreams to better manage demand, focus on reducing CRFD patients, 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.

A key pressure point remains the impact of Clinically Ready for Discharge (CRFD) patients that are not within Trust control, particularly social care and housing impacting on reducing the available Trust capacity to support repatriation and reduce all out of area placement position.

2. Inappropriate Out of Area Placements - BSMHFT



Slides 5 outlines progress in each of the productivity plan workstreams.

Productivity Plan – update

FPPC is asked to note that a separate update on the Productivity Plan will be provided by the AD for Acute & Urgent Care.

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)

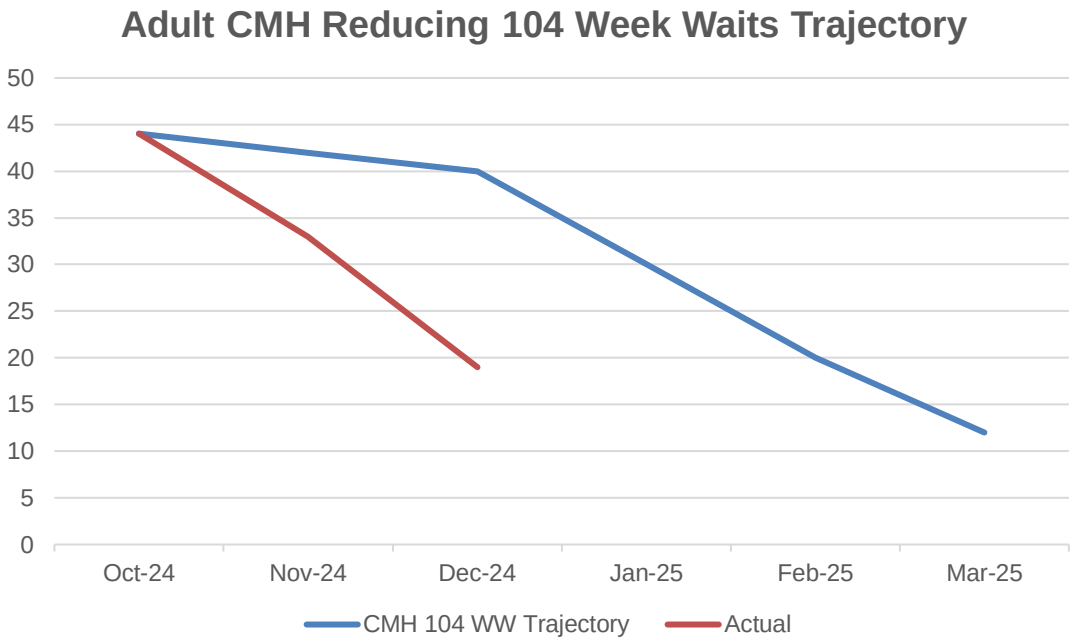
In progress

- **Demand Management/Gatekeeping**
- High volume users project - to identify users and establish a management plan to prevent admission and support/enable these service users to be supported in the community where appropriate.
- **Reducing LOS/Clinically Ready for Discharge (CRFD)** – continuation of daily and weekly partnership meetings, discussions also escalated to senior system level.
- **Clinical Oversight Team -** senior medical cover to have oversight of patients on the bed list, support locality model implementation and review length of stay where appropriate.

Longer term and/or requires additional support from Partners/ICS

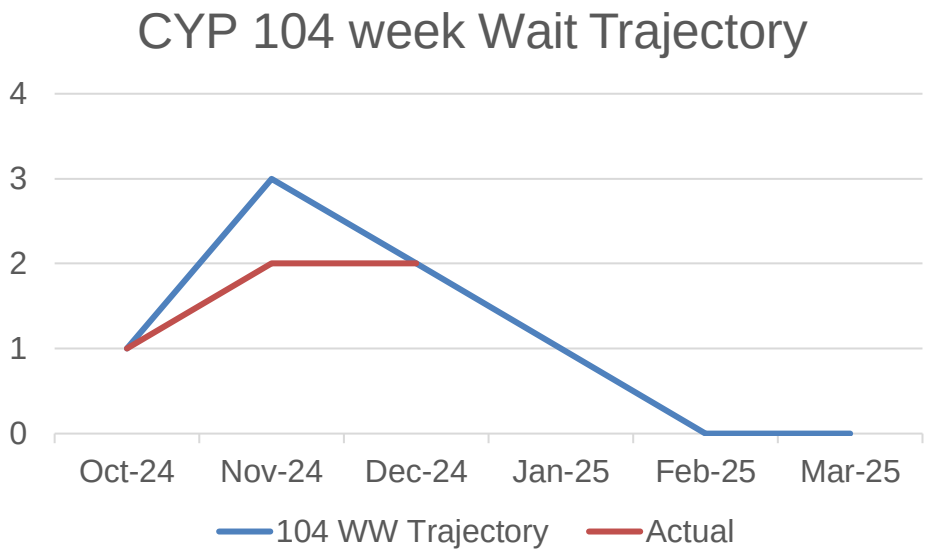
- **Reducing LOS/CRFDs** - weekly internal bed management, ICB deep dive weekly, EDD Confirm and challenge process (more proactive approach for patients with longer LoS) Renewed focus on Clinically Ready for Discharge.
- Looking to embed social workers into the locality model. 8 Social workers have been allocated to the Trust and the first 2 will commence in January 2025

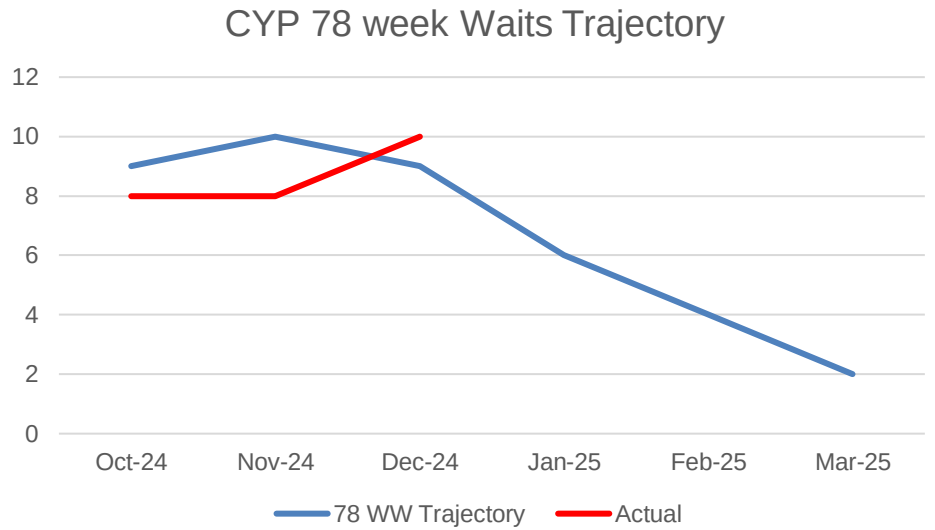
Adult CMHTs - Reducing Long Waits
Progress against national reduction trajectories



- Following the national planning guidance for 2024/25, a trajectory was agreed with service leads and submitted to NHSE 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 moving from 45 service users to 12 by end March 2025.
- December has seen a continuing reduction, with 14 service users now waiting for more than 104 weeks, ahead of trajectory.

CYP - Reducing Long Waits
Progress against national reduction trajectories





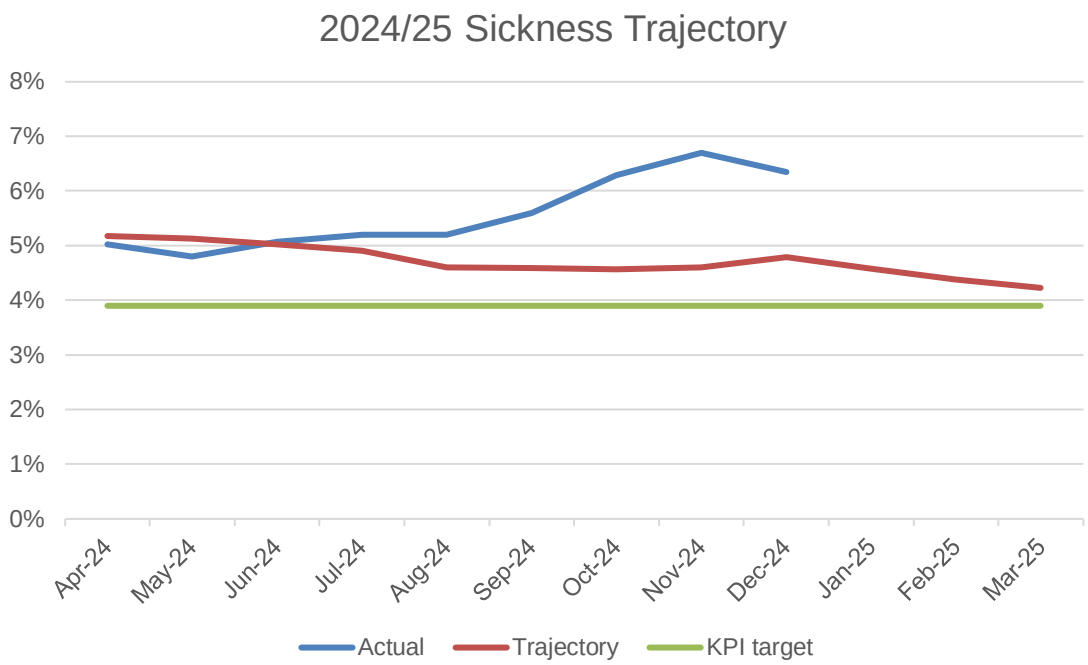
- For CYP services (Solar and ADHD), as the number of service users waiting for first contact over 104 weeks is small in volume, further improvement is required to reduce long waits over 78 weeks. As a result, improvement trajectories have been agreed for both areas.
- For CYP the Trusts focus is to 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. As at December 2024 - 104 week waits at 2 and 78 week waits at 10 just over trajectory.

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



Note - Trajectory and commentary provided by People team

Sickness levels decreased to 6.3% for December 2024- remains above the improvement trajectory of 4.7%. Long-term sickness has decreased to 4.0% and short-term sickness has decreased to 2.3%.

Action Plan:

Continued Development of HR Clinics:

Action is ongoing to refine the structure and underlying data to support insight and action driven conversations, support early manager intervention, manager confidence, enhance people management practices and ensure compassionate, timely support for colleagues (both unwell and their teams).

HR Case Management Developments:

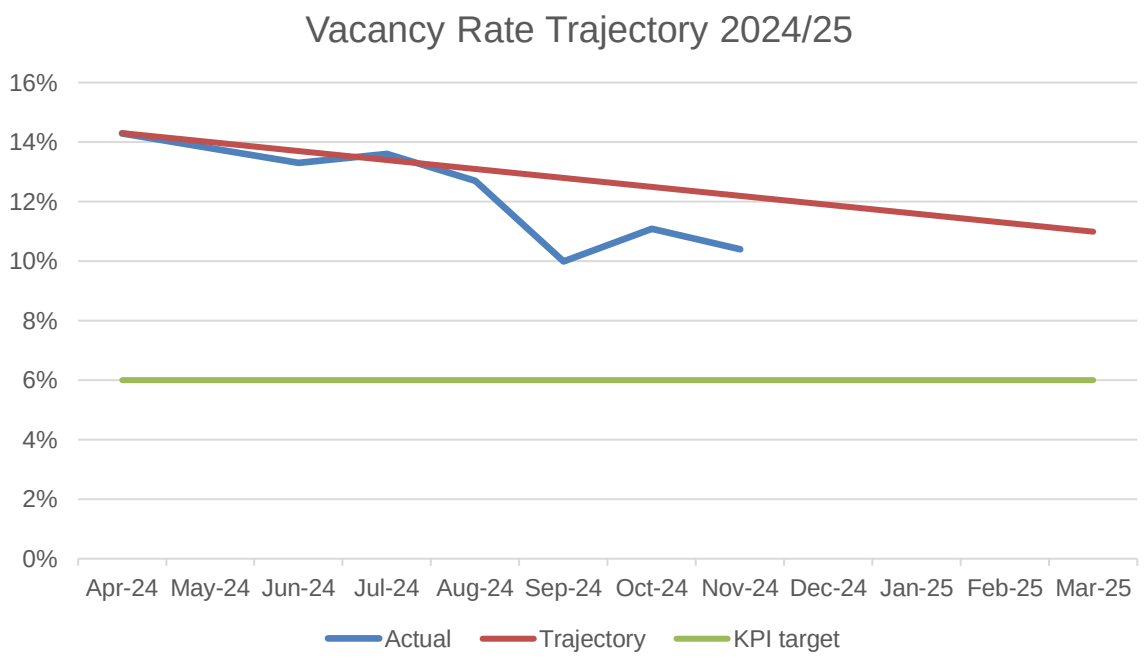
Action is ongoing to refine the management of People Relations cases, supporting prompt action and wellbeing intervention should a colleague become unwell during a formal process.

Renewed People Management Masterclasses:

New Masterclasses introduced to support people management competency development and confidence. Health and Wellbeing Masterclasses, which focus on practical employee support and processes. Delivery routes for these courses are being reviewed.

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. December data not yet available.

The trust, in conjunction with universities, education facilities, and with the assistance of ICB members, is currently rolling out actions from it's seventh 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 15th 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.

Note - Trajectory and commentary provided by People team

Vacancies

Action Plan update:

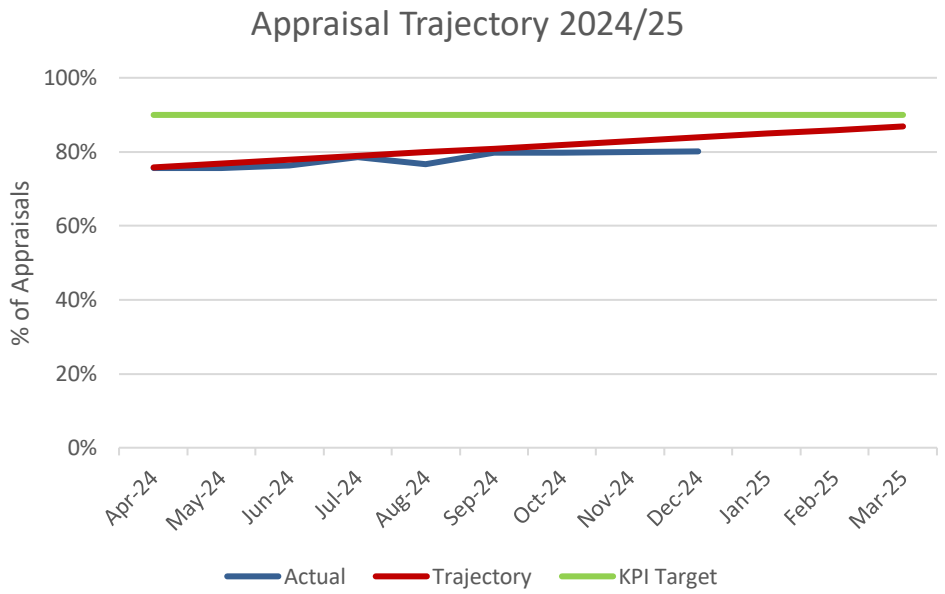
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 December 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.

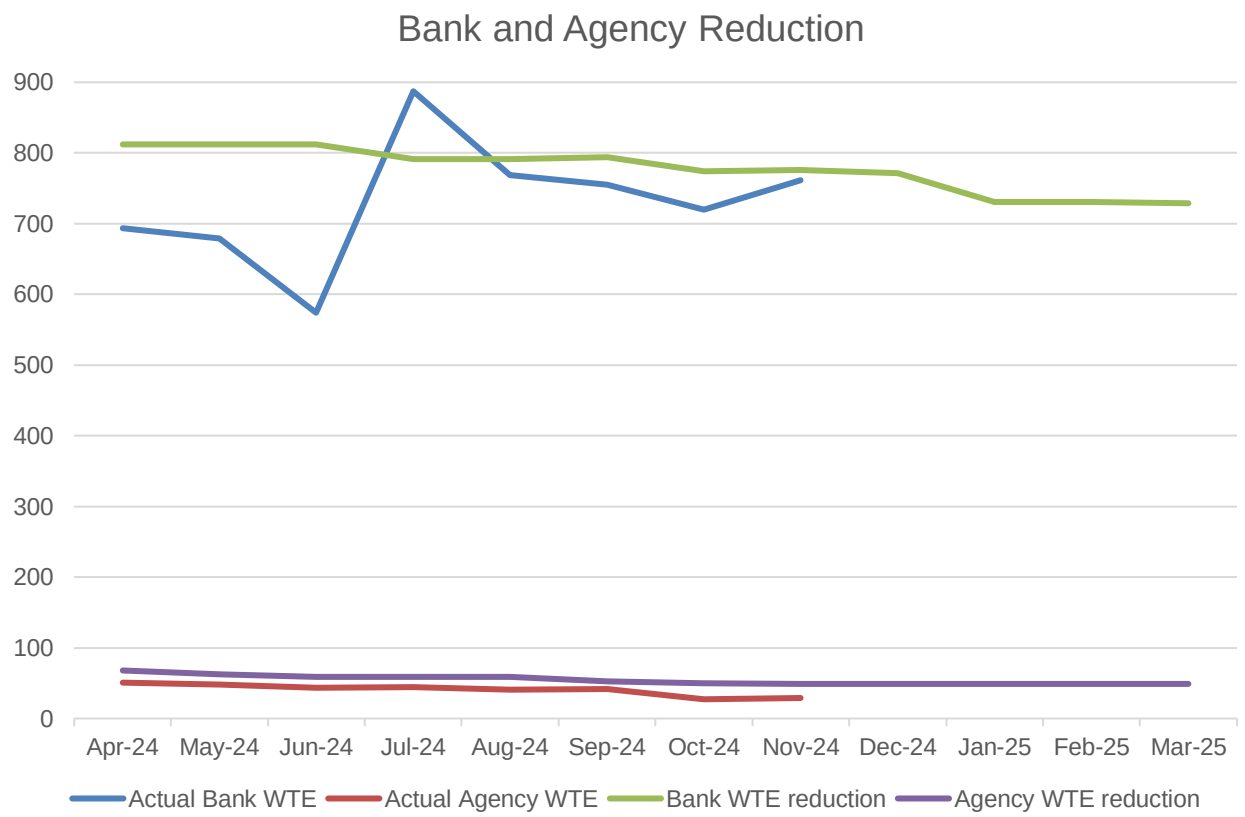
December 2024 appraisal performance has increased to 80.2% just below trajectory.

Actions:

- QI appraisal project - Working group meeting held alongside regular project group to discuss and support the implementation of change ideas. The next QI catch-up is scheduled mid Jan to review progress.
- The VBA QI paper will be presented on Thursday 9th Jan to the Strategy and Transformation Management board to provide an update.
- In addition to the BAU activities, L&D are continuing to provide VBA support interventions to staff/hot spot areas.

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.

December data awaited at the time of writing.

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 (currently 80% of all expenditure via TSS is block bookings). There is a deadline of the end of January 2024 for all current agency nursing and AHP block bookings to be migrated across to NHS Professionals. 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.

- 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 of the end of January 2024 has been 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 will 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.

- In December 19 bank workers started with the trust, helping to alleviate the need for agency.

FPPC is asked to note that from March 2024, a revised framework is being implemented with a monthly Performance Delivery Group meeting and granular level service area deep dive meetings. 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 agreed with the service area senior leadership team.

FPPC members are asked to note that since the last FPPC meeting in November 2024, a Performance Delivery Group meeting has not been held and therefore no update provided this month.

Service Area Deep Dive Meetings – Update

1. Introduction

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

- Secure and Offender Health Deep Dive – 20th December focusing on Men's secure Services

  The summary RAG ratings for all services can be found at the end of this update

2. Secure and Offender Health – 20th December 2024

The focus for the service area deep dive was on Men's Secure Services. The related service area presentations are included as Appendix IIa, IIb, IIc, and IId. A summary of the agreed service line RAG rating is outlined in the table below:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Note: For some domains, revised RAG ratings agreed at the deep dive meeting and therefore differ from the service area presentations for some domain areas.						
Reaside	Green	Amber	Green	Amber	Green	
Tamarind	Green	Green	Green	Green	Green	
FIRST	Green	Amber	Green	Green	Green	

Overall: Discussion summary

- Referring to 2023/24 NHS benchmarking data for medium secure services, it was noted that the service is amongst the highest in terms of admissions per 10 beds and that of the admissions, there is an over representation of the BME population in our care compared to the national average. Use of prone restraint is also above the national average. Areas where we compare well include length of stay, number of admissions made under the Mental Health Act and overall staff vacancy rates.
  The data has been reviewed and informed domain level service discussions.
- Consistent performance levels being achieved at Reaside and Tamarind across a range of KPIs, some examples include, low levels of nursing and staff vacancies, no medical

vacancies, improved completion of physical health assessments, % of patients who have had a CPA review within the last 6 months, % service users accessing GP service, clinical supervision levels, % of staff completed annual safeguarding vulnerable adults training at 95%.

- Review of incident data during November 2024 highlighted slightly higher levels at Tamarind including, incidents of moderate harm, number of restraints, assaults on staff and use of seclusion.
- Plans to pilot Secure Care social workers becoming trusted assessors to assess service users social care needs.

Cross service area action include:

- Embed culture of care 12 standards with clear measurable outcomes across inpatient services. These relate to: Lived experience, Safety, Relationships, Staff Support, Equality, Avoiding harm, Needs led, Choice, Environment, Things to do on the ward, Therapeutic support and Transparency.
- Quality of care: planned action over next 2 quarters on developing outcome-based quality measures using the RCPsych guidance for forensic secure services.
- Better understand and mitigate staff sickness absence levels.
- Activities : patient choice and therapy which leads to improved health, risk reduction thereby discharge and hope.

Action: to provide an update at a future deep dive meeting on health inequalities work and implementation of the Patient, Carer, Race Equalities Framework (PCREF), focusing on how these challenges are being met.

Tamarind: Discussion summary

- No agency use, but bank use due to sickness and EPC and observations which can be claimed back from REACH OUT.
- Service Users & Carers regularly attend Tamarind Clinical Governance Committee as core members.
- High Acuity – Sycamore routinely accepts challenging partnership service users who have progressed through Tamarind rather than their host units impacting on length of stay.
- 16 International Nurses recruited and embedding.
- Working with nursing staff to review skill base as majority trained during COVID.

Reaside: Discussion Summary:

- No agency use, but use of bank due to sickness levels.
- Complaints to the CQC – 4 anonymous complaints, 3 due to building/environment issues and 1 where a culture piece of work recommended regarding night shift working.
- Building/environment actions: fix showers, toilets, ventilation , furniture etc
  SSL are now part of the daily huddle and Clinical Governance discussions, improving communication on action plans to address environment issues.
- Interviewed for an ANP post for physical health
- Improvements needed in following HR processes
- Clinically Ready for discharges:

- The Chief Executive reported that a strategic meeting has been requested with Birmingham City Council to discuss social care input and support and will feedback outcomes.
- Service Lead highlighted that the number of CRFDs was higher than reported in the data.

Action: Data quality review of CRFDs recording and reporting to be undertaken to confirm position.

- Action agreed that senior leadership development remains an area of focus to include new staff members.

FIRST: Discussion Summary

- Sickness levels low and where related to stress this is largely not work related.
- KPIs require improvement – these are being reviewed at individual clinical team level.
- Plans to increase caseload by starting to work with patients due for discharge in the next 12 months (currently 6 months) and to increase the amount of liaison work undertaken with these patients to aid transition and discharge.
- The team look after patients who come from out of area, St Andrews or within BSMHFT and need to make sure there is an equity of service for patients regardless of referral route.

Area of focus over next 2 quarters:
Deliver FIRST service specification by:

- Increasing number of patients under FIRST
- Develop Liaison Offer around risk management and supporting internal teams within acute and urgent care and ICCR.
- Short term solution to office space challenges include working from Ardenleigh, Tamarind and Reaside and medium term solution is Main House which will not be available for 12 months.

Summary RAG ratings across service areas

The overall summary of the service level RAG ratings across all service areas to date has been updated and outlined below for reference.

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
27-Jan-25		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
17-Jan-25		SPS						
11-May-25		ICRT						
8-Jul-25		Cascade						
9-Sep-25		ADHD						
11-Nov-25		Enhanced Team for Personality Disorder						

Service Area Deep Dive Self Assessment

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
11-Apr-24	Secure	FIRST			Green	Green	Green	
21-Jun-24		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	Green	Amber	Green	Amber	Green	
20-Dec-24		Tamarind	Green	Green	Green	Green	Green	
20-Dec-24		FIRST	Green	Amber	Green	Green	Green	
21-Feb-25		Ardenleigh/Offender Health/Liasion and Diversion						
15-Apr-25		Reaside/ Tamarind/FIRST						
20-Jun-25		Ardenleigh/Offender Health/Liasion and Diversion						
15-Aug-25		Reaside/ Tamarind/FIRST						
17-Oct-25		Ardenleigh/Offender Health/Liasion and Diversion						
19-Dec-25		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						

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 February 2025**
Date(s) of Committee Meeting(s) reported	**22 January 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Reaside Report • Zinnia Report • PEAR Group Assurance Report • Patient Safety Incident Responses Framework, SI Reviews, Patient Safety Alerts, Complaints and PALS Report • Freedom to Speak Up Guardian Report • Right Care Right Person Progress Report • Integrated Performance Report • Clinical Governance Committee Assurance Report • Culture of Care Report • Quality and Safety (Bronze Silver Gold) Framework
Alert:	• The Committee remained significantly concerned about culture and leadership issues within Reaside clinic, however the ongoing improvement plan was acknowledged. • The Section 64 issued to Zinnia Centre was a key discussion; the Committee received the remedial action plan and acknowledged that actions had been implemented around staff training and management structure realignment. • The Committee wished to raise that there was no dedicated Medical Device Officer for the Trust. • Further work would be undertaken to determine nurse establishment on Trust wards that were particularly affected by acuity.
Assure:	The Committee was assured on the following areas: • Assurance was provided on the Quality and Safety Framework which aimed to provide a focused, timely response to address and resolve identified issues in alignment with the Trust's governance and regulatory requirements. The framework would adopt a Bronze, Silver, Gold approach to encourage greater ward to board oversight and collaboration. • The Committee noted ongoing positive work in relation to Right Care Right Person, and was particularly encouraged that 33 section 136 detainments had been prevented through the collaborative approach.

	• The Committee noted the additional responsibilities around the Taskforce for Climate-Related Financial Disclosure, which would be reflected in the terms of reference. • The Committee approved the updated terms of reference for the Patient Experience and Recovery Group.	
Advise:	The Committee was encouraged by the Trust's involvement in the Culture of Care Quality Improvement project, a national programme that focused on twelve coproduced standards for inpatient care. The Committee noted that the Trust had requested support with the implementation of the programme at scale across all inpatient wards during 2025, with an in-depth diagnostic provided by the national team for Reaside.	
Board Assurance Framework	The Committee reviewed the revised Board Assurance Framework risks and was satisfied with the progress made so far, noting that the BAF provided greater clarity and strategic oversight and would continue to mature.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Linda Cullen Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance Manager

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**22 January 2025**
Date(s) of Committee Meeting(s) reported	**5 February 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • People Dashboard • Shaping our Future Workforce Group Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • Race Equity Network Report • Freedom to Speak Up Guardian Report • Safer Staffing Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Progress against Values Based Appraisals compliance was raised as a key concern as it remained below target (90%) at 80.1% and would be the subject of a People strategy session in June. • Nursing continued to be a hotspot area for vacancies, particularly senior Band 6 nurses with a vacancy rate of 22.7%. Other hotspot areas included Occupational Therapists and Administrative staff. • Sickness absence remained challenging, and the Committee was keen to understand the outcome of a deep dive undertaken by the Transforming our Culture and Staff Experience Group. The Committee noted challenges with sickness absence across the system.
Assure:	• The Committee was assured by the ongoing work of the Freedom to Speak Up Guardians, particularly in relation to increased contacts. Some additional work was required to ensure inequalities data was being captured. • The Committee was assured by the Safer Staffing Report, noting that over 200 staff had completed the rostering e-learning package. • A positive staff story from the Medical Workforce Team, who won at the Values Awards in 2023, was shared. The story reflected on the importance of recognising staff and celebrating success. • The Committee noted the additional responsibilities around the Taskforce for Climate-Related Financial Disclosure, which would be reflected in the terms of reference. • The "stay" conversation pilot was now established and a number of conversations had been held with individuals.
Advise:	The Committee received an update on activities and plans from the Race Equity Network. The discussion focused particularly on streamlining HR processes for staff to increase accessibility and further review and simplification of the Unacceptable

	Behaviours Policy. The Network was encouraged to link in to the People team and the Transforming our Culture and Staff Experience Group.	
Board Assurance Framework	The Committee had identified the following revised risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. SR2 (Inability to attract, retain or transform our workforce in response to the needs of our communities) would be reviewed to include rationale around succession planning for retiring workforce.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Report to Board of Directors						
Agenda item:	**12**					
Date	5 February 2025					
Title	Freedom to Speak Up Guardian Report					
Author/Presenter	Emma Randle, Lead Freedom to Speak Up Guardian					
Executive Director	Lisa Stalley-Green, Director of Quality and Safety & Chief Nurse.	**Approved**	**Y**	✓	**N**	

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

Summary of Report					
Alert		**Advise**		**Assure**	☒

Purpose

To provide assurance to the Board of Directors that the Freedom to Speak Up Guardians in partnership with the Trust are taking action to promote the following:

Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up

Speaking up policies and processes are effective and constantly improved

Senior leaders role model effective speaking up

All colleagues are encouraged to speak up

Individuals are supported when they speak up

Barriers to speaking up are identified and tackled

Information provided by speaking up is used to learn and improve

Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

This report reflects activity from Quarter 2 (July-September 2024):

Key Issues and Risks

The author requests that the Board note section 4.2 of this report involving perceptions of eclipse censorship at Reaside.

The QPES committee has been made aware of this and actions taken to remedy it.

Recommendation
The Guardians will deliver bespoke training and workshops for leaders and managers at Reaside to improve the speaking up culture. This will form part of the planned work on the Culture of Care Programme – ‘ Reimagining Reaside’.
Enclosures
N/A

1. INTRODUCTION AND BACKGROUND

1.2. This report provides an update on activity from the Trust's Lead Freedom to Speak Up Guardian (FTSUG) following the previous Board report in October 2024. This report covers Quarter 2 (July-September 2024).

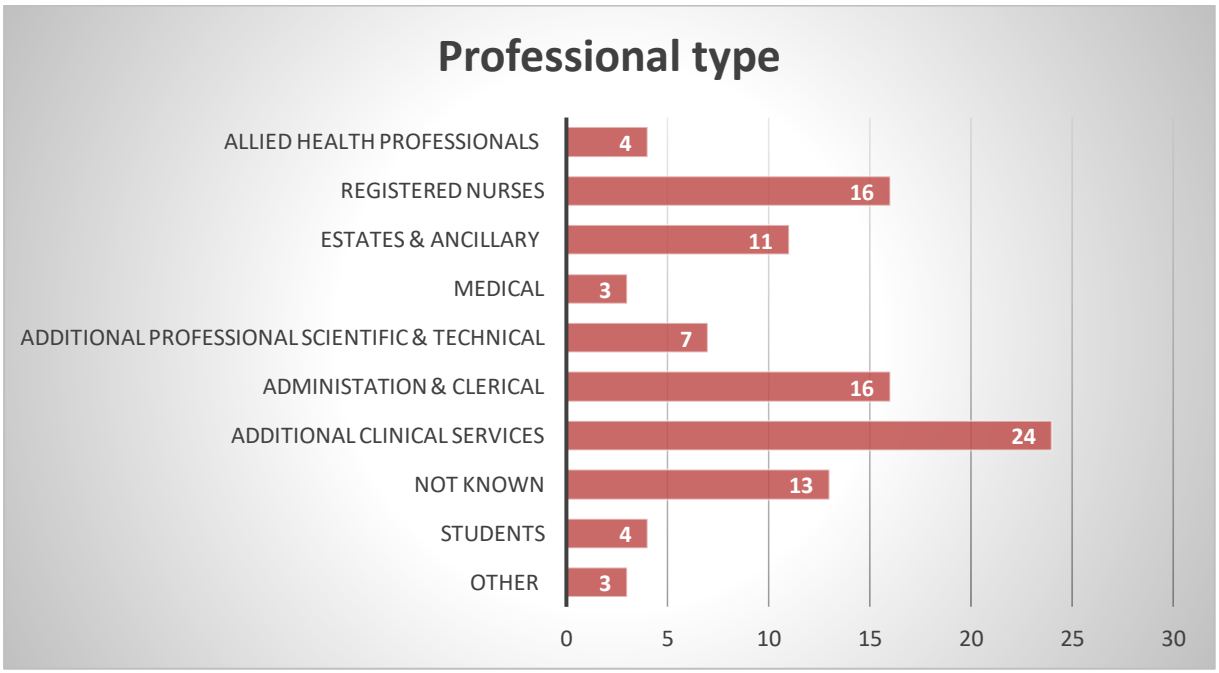
2. WHO IS SPEAKING UP TO THE SPEAK UP GUARDIANS?

2.1 The Freedom to Speak up Guardians and Champions have received **101** speaking up concerns. Last quarter this was 110 cases suggesting we continue to be perceived as a trusted alternative route.

2.2 For the first time, the figures also include Champion activity. This is collected from the Champions quarterly. If enquiries appear to involve more than signposting and listening, speakers were directed to the Guardians.

2.3 Guardians are only one route of speaking up and other routes are embedded within the organisation.

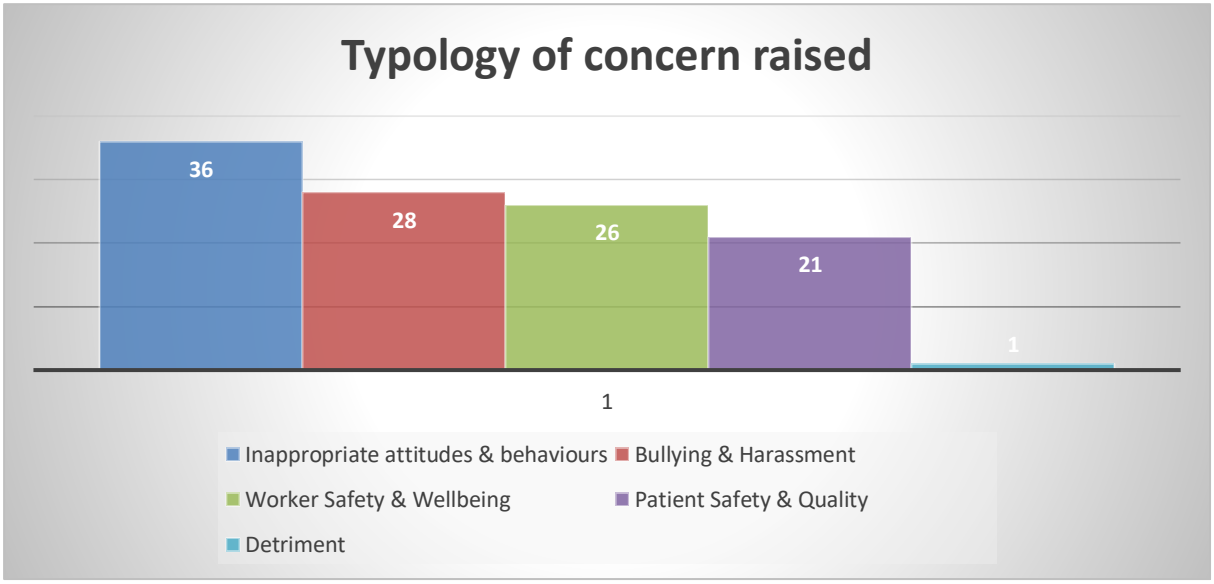
2.4 Below is a breakdown of data; with concerns raised by professional grouping:



This quarter, for the first time, the highest category of workforce representation was from Additional Clinical services (support to doctors and nurses, including bank staff) which

accounted for 24% of contacts. Second was Registered Nurses accounting for 16%, half that of the previous quarter.

For context, data from NHS Digital [i] showed that in February 2024, nearly 30 per cent of workers in NHS hospitals and community health services were registered nurses and midwives with Additional Clinical services making up 21% of the NHS workforce.

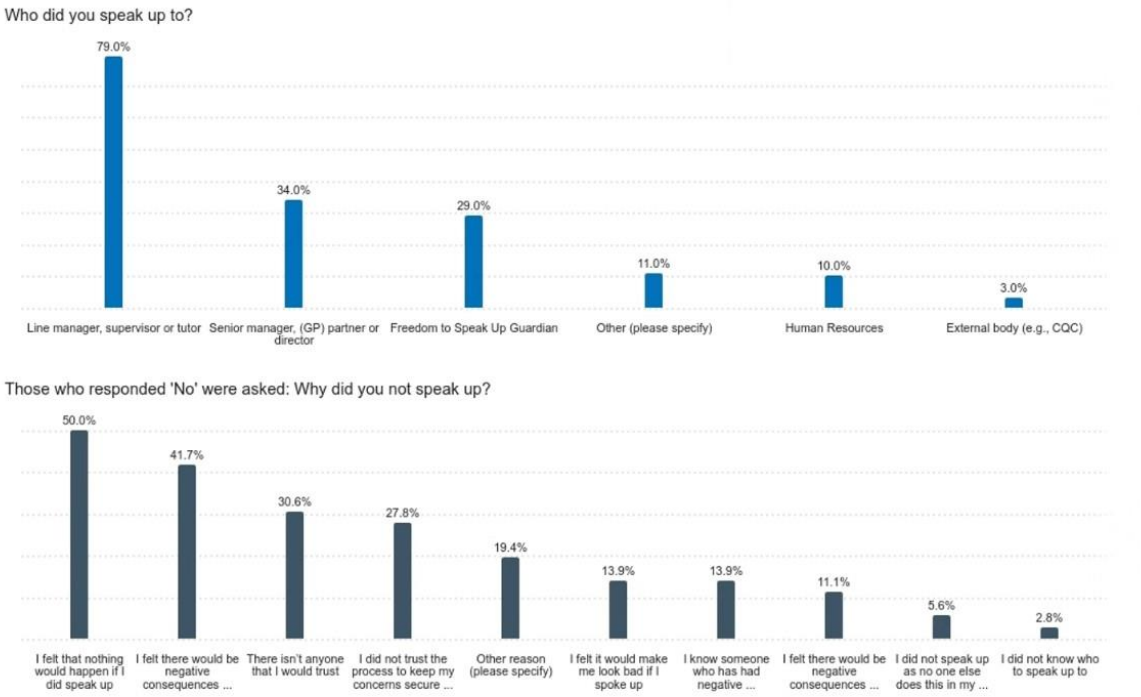


The above graph shows that concerns that have an element of inappropriate attitudes and behaviours continue to make up the highest proportion. This category includes themes such as disrespectful attitudes, incivility, micro-aggressions, unhelpful communication styles, relational conflict and unprofessional behaviour contrary to our values. The next highest category is bullying and harassment.

2.5 In July, the National Quarterly Pulse Survey (NQPS) asked participants (for the first time) questions about speaking up safely. We can see that the vast majority of colleagues who responded (79%) spoke up to a line manager, supervisor and tutor followed then by senior manager or director. This is positive and what we would expect to see aligning with policy and good practice. Guardians are the next commonest route and three times higher than the Human Resources/People Team.

2.6 In this survey, participants were asked for the reasons why they did not speak up. We have previously described these themes as “fear and futility” and they also appear to be replicated here.

2.7 The table below displays the other barriers to speaking up:



3. ANALYSIS OF OUR TRUST WITH NATIONAL COMPARATORS

3.1 Twenty one percent of concerns featured an element of patient safety and quality this quarter roughly in line with last quarter (19%) and is broadly line with the national figure of 18.7%.

3.2 Twenty eight percent of our cases contained features of bullying and harassment against 22% nationally. Although we have seen an increase from last quarter, care must be exercised when interpreting these numbers from our figures alone as without workforce data to inform this analysis, it is unclear whether there has been a corresponding amount of new Bullying and Harassment cases through formal procedures.

3.3 Worker safety and wellbeing was a feature for almost one in every four of our cases less than the national figure of one in three. Staffing levels and high workloads remain challenging in some areas and can result in incivility and poor behaviours affecting health, wellbeing, and performance at work.

3.4 Historically, few colleagues raise concerns anonymously amongst the cases we handle. The majority of colleagues raise concerns confidentially with us suggesting we are seen as a

trusted and independent route. However, this quarter we have seen two individuals presenting anonymously in person at a Reaside surgery; two anonymous voicemails from a Northcroft CMHT regarding recruitment and appointment and a further voicemail regarding a different recruitment and appointment process at Osborn House. This accounts for 5% of our enquiries but less than the national figure of 9.5%.

3.5 We are very concerned that the identification badges of colleagues were removed before approaching the Guardians at a Reaside surgery. This suggests an unacceptable level of distrust and fear. Although we appreciate this cannot be generalised across the Reaside estate it must be taken seriously as a symptom of a closed culture.

3.6 The Guardians contributed to the Trust's CQC response following concerns raised to them by Reaside staff in the autumn. Executive colleagues have accepted our offer of support to facilitate bespoke information, training and workshop sessions for staff and leaders. This work will focus on three themed areas and will form part of the Culture of Care programme:

- ✓ The role of the Guardians and Champions
- ✓ Creating a safe and effective speaking up culture
- ✓ The role of leadership

4. TYPES AND THEMES OF ISSUES RAISED

4.1 A number of patient safety and quality concerns were raised by staff working at Reaside. A number of these were also reported to the CQC.

4.2 Other themes at Reaside were:

- Newly qualified colleagues do not feel supported and valued
- Colleagues are fearful of repercussions should they raise concerns
- When concerns are raised, they are not always acknowledged and followed up
- Cultural tensions amongst night staff
- A perception was developing whereby eclipses needed to be checked first by managers before eclipsing incidents resulting in censure
- Alleged unfair treatment, discrimination and bullying & harassment of facilities staff by managers

4.3 In other areas of the Trust, these themes were also raised:

- Exit interviews still inaccessible to some staff
- A number of bank staff pay enquiries to include hourly pay rates, backpay and arrears
- A number of complaints of bullying and harassment between peers
- Relational issues between managers and junior staff; and between peers
- Perception of unfair recruitment and appointments
- Unsatisfactory communication between TSS staff and bank colleagues

5. IMPROVING OUR SPEAK UP CULTURE AND ARRANGEMENTS

5.1 We have held FTSU drop-in surgeries and listening events at Ardenleigh (including *CAMHS* team) the Zinnia Centre, Mother & Baby unit (Jasmine ward) and Reaside on multiple occasions. We also visited and listened to staff on Eden and George wards (Northcroft).

5.2 We continue to raise awareness of the Guardians as an alternative route and Lucy attended the Professional Education Team meeting raising awareness of the Guardian and Champion roles, strengthening our joint working plans.

5.3 Our induction activity has seen us take part in corporate induction events this quarter.

5.4 Kerry is leading on the work we are doing with our International Educated Nurses (IEN). A Nurse herself, she is providing safe spaces for our colleagues in their supervision sessions and working with the IEN leadership and local leadership teams to identify and remove cultural and other barriers to raising concerns.

5.5 The Guardians have been working in collaboration with the Safeguarding team and have completed the Level 3 Safeguarding Children and Young People and Older Adults training. This ensures that the Guardians have adequate up to date knowledge and are competent to support colleagues who may access the service with safeguarding concerns.

5.6 Hailey McConnell was successfully appointed as permanent FTSU Team Administrator after competitive interview.

5.7 The Guardians have now embedded the Freedom to Speak Up Guardian Development Guide in their supervision framework enabling the team to build upon their existing skills and experience as well as identify ongoing learning and development to include resources on inclusivity and psychological safety.

Guardians are also supported with supervision and coaching provided by an external Consultant Clinical Psychologist.

5.8 We have seen a low uptake on the *Speak Up Listen Up and Follow Up* e-learning. Our Executive Lead has committed to making completion of all modules a Quality objective for 2024/25. Completion of these modules assures us that:

- ✓ Our managers have the capability, knowledge, skills and confidence to consistently respond well when someone speaks up, to speak up themselves and to create a healthy speak up culture in their area
- ✓ That our divisional leaders effectively model speaking up, identifying and removing barriers
- ✓ That information received from speaking up is shared and used to learn and drive improvements locally

6. SUPPORTING AN INCLUSIVE SPEAK UP CULTURE

6.1 We continue our out of hours surgery work targeting our clinical areas engaging our colleagues on nights and long days as well as bank, estates, and facilities staff who may find it harder to speak up and do not have regular access to Trust comms and a computer.

6.2 We continue to receive a high number of enquiries from TSS bank staff.

6.3 This quarter Kerry has completed the Active Bystander Training.

6.4 Emma attended the NHS E training on “Anti Semitism, what it is, it’s roots and modern manifestations” and “Understanding Islamophobia” training events

6.5 The team attended and/or watched the “Awesome Charlie” presentation from Esi Hardy an event hosted by the Disability and Wellbeing Staff Network.

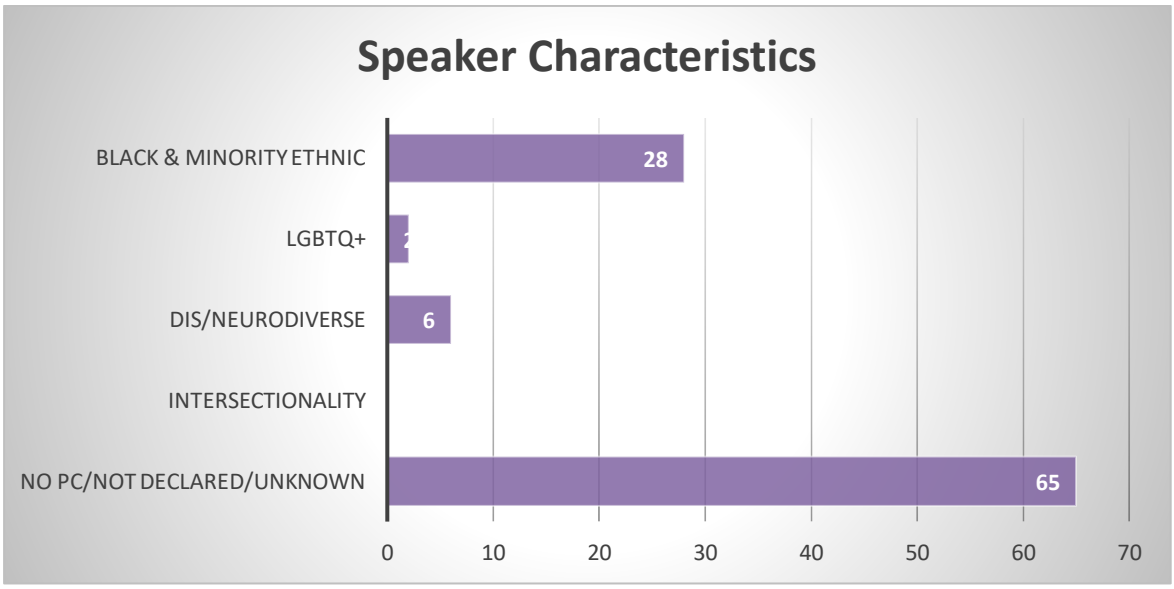
6.6 Lucy supported the Caring Minds Charity Zumbathon in September hosted by our Recovery Lead.

6.7 In September, Emma and one of our Champions Charity Justin, presented at the AGM. The team also manned a stall. Charity, a student Nurse and our first student Nurse Champion focused on the work she has been doing supporting and empowering her peers to speak up safely. Charity’s placement ended with us in December 2024, but she will be continuing her work as a Champion as a bank HCA.

6.8 We continually monitor the protected characteristics [ii] of our speakers, committed to ensuring our arrangements are inclusive. This quarter, less of our Black and minority ethnic

speakers accessed the service compared to the last quarter (28% versus 35%- of those we recorded and knew about).

Below is a breakdown of this data:



6.9 Six percent of our staff that identity as having a disability or long -term health condition contacted FTSU last quarter, significantly less than Quarter 1 (16%) which can be viewed as a statistical outlier. The overall year on year trend is increasing.

6.10 For those colleagues who identify as being part of the LGBTQ community, 2% accessed the service versus 3% last quarter.

6.11 We constantly evaluate where our Champions are located and the nature of their substantive posts. This enables us to identify where and what type of gaps there are enabling us to tailor recruitment. We have worked with the Head of Nursing from Older Adults who has supported us in identifying a second international student Nurse Champion who will receive her foundation training this month.

6.12 The CEO hosted an informal "Lunch with the Champions" event to meet some of the new FTSU Champions

7. ORGANISATIONAL LEARNING – originating from FTSU enquires/ concerns / feedback

7.1 The People Team leadership have listened and acted on the feedback and recommendations we have provided from speakers who have entered a formal

investigation process following initial contact with FTSU. There are a series of planned actions to include, training of more Investigation Officers; protected time agreed to complete investigations; robust monitoring of case work at all stages; working with witnesses to engage in a timely manner and a new target of reducing employee relations casework by 30 days.

7.2 Further, we are supporting the People Team to embed the expectations of the Guardians when a case is handed over and will contribute to the new "Roles & Responsibilities" document.

7.3 We will be working with the People Team to ensure all Commissioning and Investigating Managers are aware of their joint responsibilities when working with the Guardians.

7.4 We have supported a number of bank staff with various banding enquiries. Learning from these cases (and also arising from the recommendations of the audit) means that a new salary variation form will be actioned.

7.5 Themes and intelligence from George & Eden wards (and other sources) has been shared with leaders who have told us that these wards will be included in a national Quality Improvement programme.

7.6 Colleagues will be aware that Eden PICU is subject to an Enhanced Framework plan- by sharing intelligence and themes from casework, we have informed this process.

10. RECOMMENDATIONS

10.1 To contribute towards the Culture of Care programme- 'Reimagining Reaside' by providing bespoke FTSU training for leaders and managers to improve the speaking up culture.

Report by Emma Randle, Lead Guardian, updated January 29th 2025.

[i] NHS Workforce Statistics - February 2024 (Including selected provisional statistics for March 2024) - NHS England Digital

[ii] The protected characteristics we monitor are pregnancy & maternity, ethnicity, sexual orientation and Disability. (The Equality Act; 2010).

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 February 2025**
Date(s) of Committee Meeting(s) reported	**22 January 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • Taskforce on Climate-Related Financial Disclosure Report • Productivity Plan • Bank Reduction Plan • Forward Planner 2025/26
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Group position at Month 9 was a reported surplus of £1.2m. This was £587k adverse to plan and was mainly driven by non-Trust beds and slippage on savings delivery. • The current financial position was positive, however the Trust's underlying deficit was significant at c£16m, mainly driven by non-Trust beds expenditure and insufficient recurrent savings. • The draft month 9 BSOL system position was a reported £87m deficit, which was £74m adverse to plan. The BSOL system had been placed into segment 4 of the NHS Oversight Framework, and system partners were working through the process and implications. • Non-Trust bed overspend remained significant, with year-to-date expenditure reported at £16m; the full year forecast was £22m.
Assure:	• The Committee received a detailed plan to reduce bank spend and was assured by the work that was being undertaken. The Committee highlighted the need to see the outputs of the plans to drive improvement. • The Committee received a detailed overview of the productivity plan, focused on out of area beds, and was assured by the work that was being undertaken. The Committee highlighted the need to see the outputs of the work to drive further significant improvement. • Reflections from the Insightful Provider Board session would be incorporated into the continued review of the Integrated Performance Report format.

	• Recommendations from the Taskforce on Climate-Related Financial Disclosures were noted; these would be reflected in all committee terms of reference, an Executive lead had been identified, and the four pillars (Governance, Strategy, Risk Management, and Metrics and Targets) would be periodically reported through the governance structure and set out as a requirement in the Annual Report. • The Committee noted the improvements being made in Talking Therapies.	
Advise:	Planning guidance for 2025/26 had not yet been received, however the local planning process had progressed. The Month 9 capital expenditure was reported at £4.8m year to date, which was £0.5m behind plan. The total forecast expenditure for 2024/25 was £12.5m.	
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 SR7 (Failure to deliver optimal outcomes with available resources) required further development and would be considered by the Director of Finance and Chief Nurse for February's meeting.	
	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

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors						
Agenda item:	**14**					
Date	5 February 2025					
Title	Finance Report Month 9					
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy 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 9 consolidated Group position is a surplus of £1.2m. This is £587k adverse to the original year to date plan, mainly driven by expenditure on non-Trust beds and slippage on savings delivery which is part offset by pay underspend and non-recurrent income. It is currently forecast that the planned surplus of £2m will be achieved, mainly via release of balance sheet flexibility, reduction in bank spend and no worsening in non-Trust beds expenditure. There is ongoing work across the BSOL system to identify opportunities for significant financial improvement in quarter 4 to enable a balanced system position. Further non recurrent and technical adjustments could lead to the BSMHFT outturn exceeding the £2m surplus forecast.

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

- **BSOL system deficit** - The draft month 9 BSOL system position is a deficit of £87m which is £74m adverse to plan. The BSOL system has been moved to segment 4, the highest level, of the NHSE system oversight framework. KPMG are working with partners across the system regarding the Investigation and Intervention process.
- **BSMHFT Underlying deficit** – Although the BSMHFT 2024/25 financial position appears positive as described above, the underlying position is a significant deficit of circa £16m, with key drivers being non-Trust bed expenditure and insufficient recurrent savings (see below).
- **Non-Trust Beds overspend** – The 2024/25 non Trust beds expenditure plan is £14m. Year to date expenditure at month 9 was £16m. The current full year forecast is £22m (£8m overspend).
- **Savings** – The 2024/25 savings target is £17.8m. £11.4m has been delivered in the nine

months to December, this is a slippage of £1.2m. It is currently forecast that the full target will be achieved but with £7.7m being via non recurrent means. To date, £6m savings plans have been identified for 2025/26, with £3.8m being recurrent and cash releasing, leaving a significant financial gap to be addressed.

- **Trust cash position** – The group cash position is healthy at £92m, however given the underlying deficit, the cash flow forecast for the Trust based on a series of assumptions, indicates that provider cash could be below £10m by the end of the financial year.

Advise:

- **Financial Planning** – In the absence of NHSE planning guidance for 2025/26, the local planning process has progressed. Draft BSOL system operating planning principles have been developed by the ICB, which we have indicated that we support in principle.

Capital position:

The month 9 Group capital expenditure is £4.8m year to date, this is £0.5m behind year to date forecast. The total forecast expenditure for 2024/25 is £12.5m.

Cash position:

The Group cash position at the end of month 9 was £92m, with £21m relating to the provider element.

NHS Oversight Framework 2024/25 – BSMHFT position:

BSOL ICB have confirmed that BSMHFT remain at segment three for a range of reasons. While the Trust accepts this, the Director of Finance intends to write to the ICB Chief Executive to emphasise our contribution to the system and recent improvements, while confirming our commitment to continue with a system's first approach.

Recommendation

The Board is asked to review the month 9 financial position and discuss the key alerts. It is recommended that the draft BSOL system operating planning principles are endorsed.

Enclosures

Month 9 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 December 2024

Month 9
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	661,355	494,817	496,957	2,141
Other Income	21,117	15,838	21,270	5,432
Total Income	**682,472**	**510,654**	**518,227**	**7,573**
Expenditure				
Pay	(300,247)	(224,934)	(221,490)	3,444
Other Non Pay Expenditure	(341,092)	(254,615)	(268,576)	(13,961)
Drugs	(7,150)	(5,363)	(5,826)	(464)
Clinical Supplies	(539)	(404)	(521)	(117)
PFI	(14,388)	(10,791)	(10,611)	180
EBITDA	**19,056**	**14,547**	**11,202**	**(3,345)**
Capital Financing				
Depreciation	(9,765)	(7,323)	(7,210)	113
PDC Dividend	(16)	(12)	(12)	-
Finance Lease	(8,479)	(7,420)	(7,468)	(49)
Loan Interest Payable	(972)	(729)	(739)	(9)
Loan Interest Receivable	1,899	1,424	4,081	2,657
Surplus / (Deficit) before taxation	**1,722**	**486**	**(147)**	**(633)**
Taxation	(380)	(285)	(241)	44
Surplus / (Deficit)	**1,342**	**201**	**(387)**	**(589)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	4	4	0
Adjust PFI revenue costs to UK GAAP basis	722	1,591	1,592	2
Adjusted financial performance Surplus / (Deficit)	**2,069**	**1,795**	**1,208**	**(587)**

Month 9 2024/25 Group Financial Position

The month 9 consolidated Group position is a surplus of £1.2m This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£1.6m year to date).

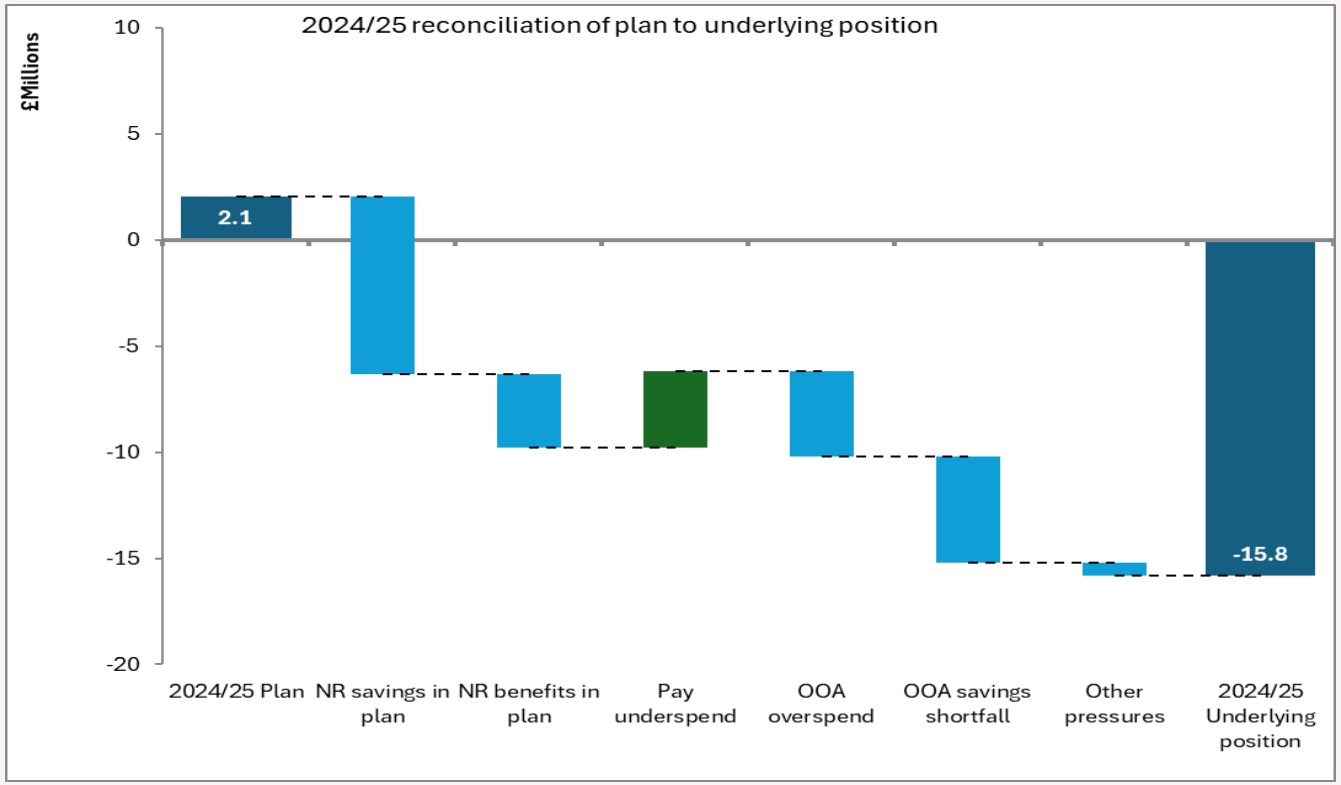
The month 9 outturn is £587k adverse to the original year to date plan. This is mainly driven by significant expenditure on non-Trust beds and slippage on savings delivery which is part offset by pay underspend and non-recurrent income. It is currently forecast that the 2024/25 planned surplus of £2m will be achieved, however, the underlying position is a significant deficit, see page 3 for more detail.

The Group month 9 position is mainly driven by a surplus of £1m in the Trust, £292k surplus for Summerhill Services Limited (SSL), a break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £190k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Birmingham and Solihull ICS position

The draft month 9 BSOL system position is a deficit of £87m which is £74m adverse to plan. This is mainly driven by £90m deficit for UHB, £3m deficit for both BWCH and ROH and £8m surplus for BSOL ICB. Given the financial position, the BSOL system has been moved to segment 4, the highest level of the NHSE system oversight framework. KPMG are working with partners across the system regarding the Investigation and Intervention process.

Underlying Deficit position



Significant Underlying deficit

As per ongoing discussions with executive and senior leadership teams, although the BSMHFT 2024/25 financial position appears positive, the underlying position is a significant deficit of circa £16m.

A key driver of the underlying deficit position is the non-Trust bed expenditure, forecast at £8m overspend (see page 10). The 2024/25 forecast position includes circa £12m one off benefits, including non recurrent funding, release of balance sheet flexibility and non recurrent savings. It is essential that a pipeline of recurrent cash releasing savings plans is identified to address the underlying position. Progress to date on 2025/26 savings is limited (see pages 18 to 19). If the underlying run rate does not improve, the ability to achieve a balanced financial position for 2025/26 onwards is doubtful and the cash balance will continue to reduce. 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.

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	281,124	-	125,448	329,083	(238,697)	496,957
Other Income	21,115	21,633	-	-	(21,479)	21,270
Total Income	**302,239**	**21,633**	**125,448**	**329,083**	**(260,176)**	**518,227**
Expenditure						
Pay	(208,668)	(9,389)	(1,532)	(2,115)	213	(221,490)
Other Non Pay Expenditure	(67,114)	(6,186)	(125,015)	(328,064)	257,802	(268,576)
Drugs	(6,089)	(1,606)	-	-	1,869	(5,826)
Clinical Supplies	(521)	-	-	-	-	(521)
PFI	(10,611)	-	-	-	-	(10,611)
EBITDA	**9,236**	**4,453**	**(1,099)**	**(1,096)**	**(291)**	**11,202**
Capital Financing						
Depreciation	(4,783)	(2,131)	-	-	(297)	(7,210)
PDC Dividend	(12)	-	-	-	-	(12)
Finance Lease	(7,448)	(287)	-	-	266	(7,468)
Loan Interest Payable	(739)	(1,515)	-	-	1,515	(739)
Loan Interest Receivable	3,198	13	1,289	1,096	(1,515)	4,081
Surplus / (Deficit) before Taxation	**(547)**	**533**	**190**	**(1)**	**(322)**	**(147)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(241)	-	-	-	(241)
Surplus / (Deficit)	**(547)**	**292**	**190**	**(1)**	**(322)**	**(387)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	4	-	-	-	-	4
Adjust PFI revenue costs to UK GAAP basis	1,592					1,592
Adjusted financial performance Surplus / (Deficit)	**1,049**	**292**	**190**	**(1)**	**(322)**	**1,208**

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 £446m
- Month 9 position break even
- Month 9 cash balance £26m.
- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

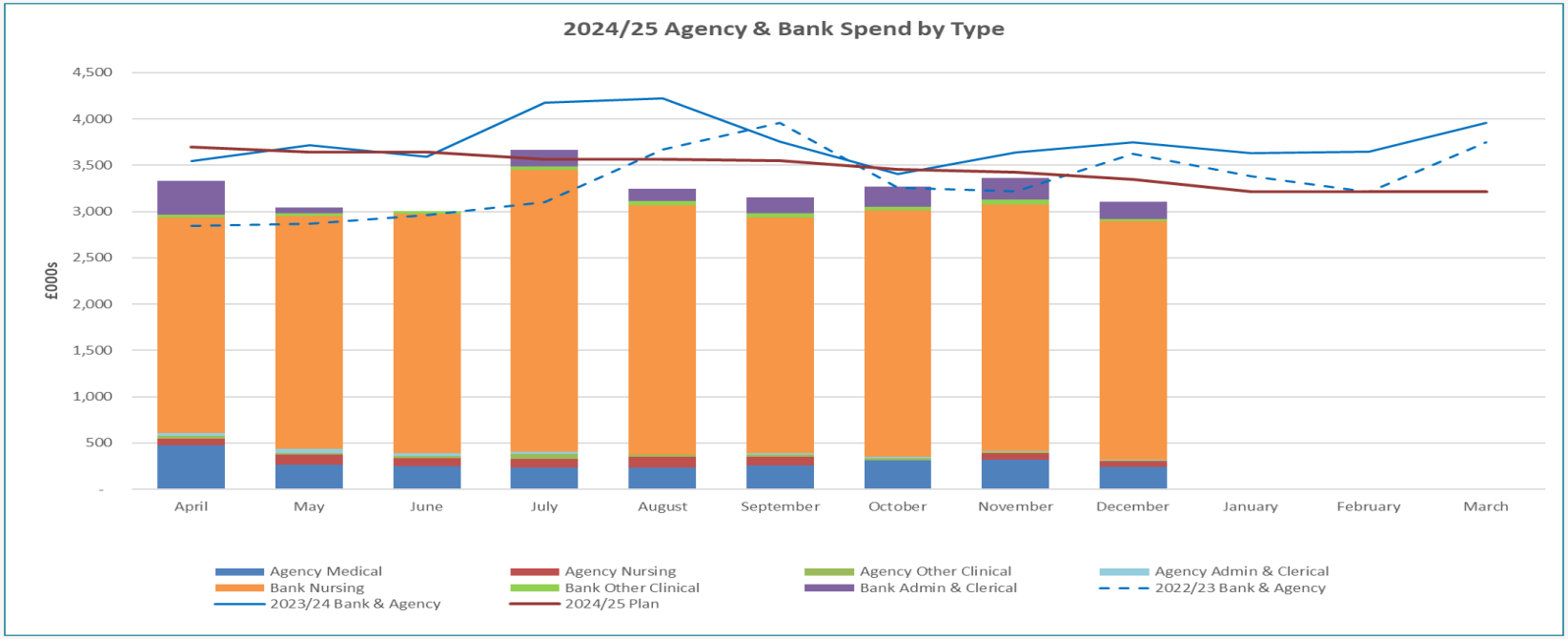
Reach Out

- £165m annual income in current plan
- Month 9 position £190k surplus – in line with agreed contribution to Trust overheads.
- Month 9 cash balance £41m.
- Key risks:
- Clinical concerns around expected growth in out of area numbers and EPC costs.

Temporary staffing expenditure

Bank

Agency

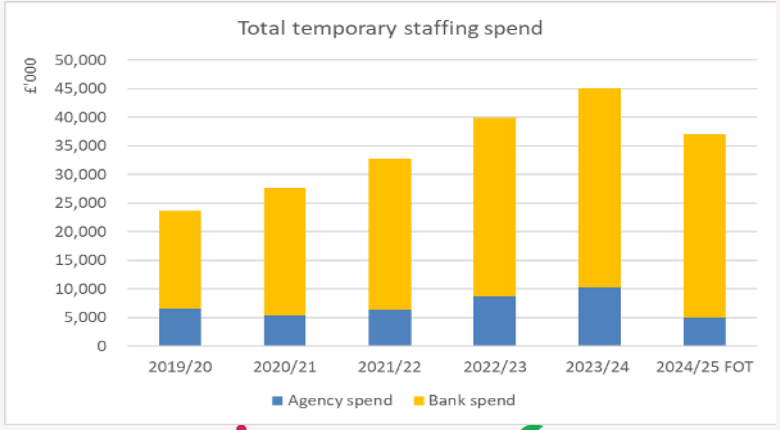


Month 9 temporary staffing expenditure is £29m, this is £2.8m less than plan.

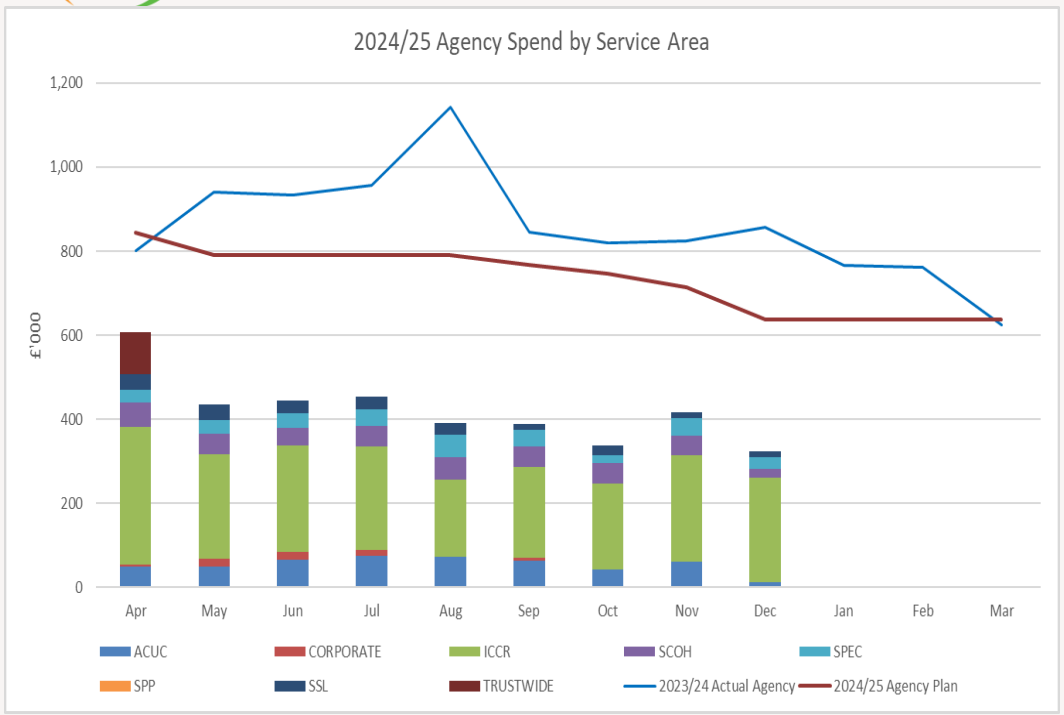
Bank expenditure £25.4m (87%) – the majority of bank expenditure relates to nursing bank shifts - £23.6m

Agency expenditure £3.7m (13%) – the majority of agency expenditure relates to medical agency - £2.6m.

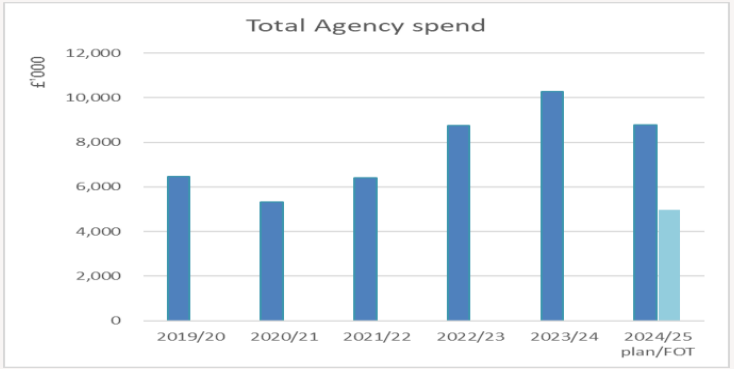
For further analysis on bank and agency expenditure, see pages 8 to 9.



Agency expenditure



KPIs	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Agency spend as % of pay bill (YTD)	3.2%	1.9%	1.9%	1.8%	1.7%	1.7%	1.7%
Above price cap bookings - medical	0	12	11	9	9	9	9
Above price cap bookings -nursing	0	7	7	7	5	4	4
Admin & Estates bookings - Trust	0	0	0	0	0	0	0
Admin & Estates bookings - SSL	0	6	5	4	4	5	5



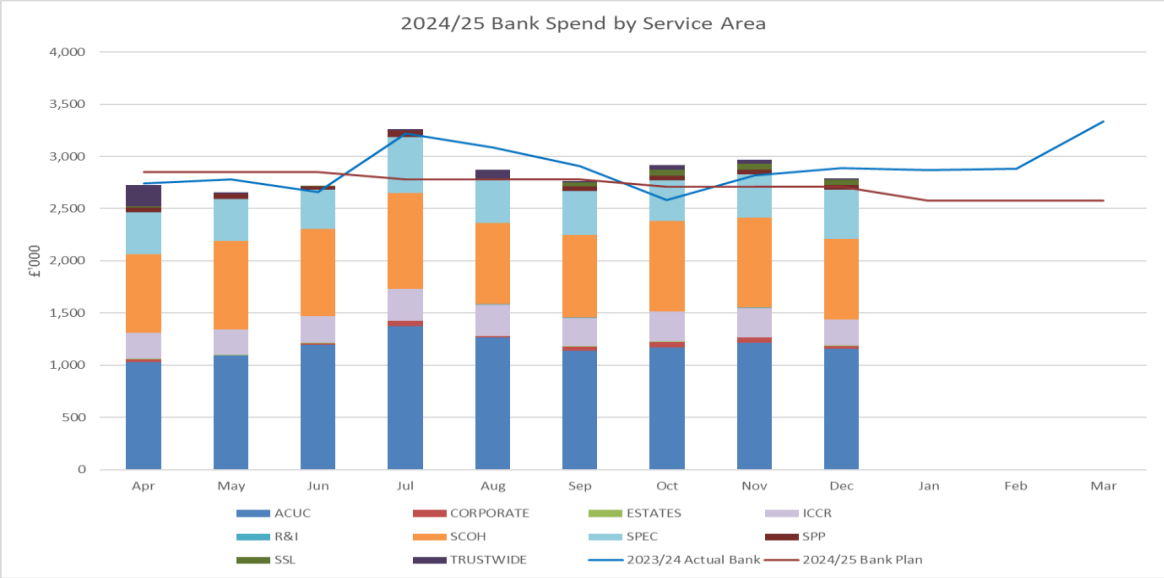
	2024/25 YTD
	£'000
Agency Expenditure	3,679
NHSE Ceiling	7,088
Variance to NHSE ceiling	3,409

		% of total sub category
Agency Medical	2,600	7.4%
Agency Nursing (Registered)	689	1.1%
Agency Nursing HCA	6	0.0%
Agency Other Clinical	201	0.5%
Agency Admin & Clerical	184	0.4%
Agency Expenditure	3,679	

Agency expenditure

- The month 9 year to date agency expenditure is £3.7m. This is an underspend of £3.2m.
- The agency expenditure of £323k in December is the lowest monthly spend of the year to date and is £93k less than November spend. The reduction is mainly related to Acute and Urgent Care medical agency spend and Secure and Offender Health nursing agency spend.
- Year to date agency expenditure is 1.7% of the total pay bill which is £3.4m below the NHSE threshold (3.2% of pay bill).
- The full year forecast spend is £5m which is £4m less than plan and £5m less than last year.

Bank expenditure analysis

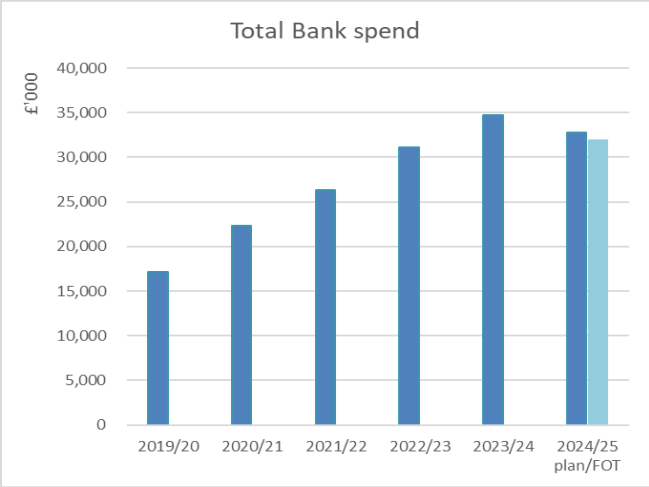


	2024/25 YTD	% of total sub category pay
	£'000	
Bank Nursing (Registered)	9,223	14.7%
Bank Nursing HCA	14,383	40.4%
Bank Other Clinical	335	0.9%
Bank Admin & Clerical	1,471	3.0%
Bank Expenditure	25,412	

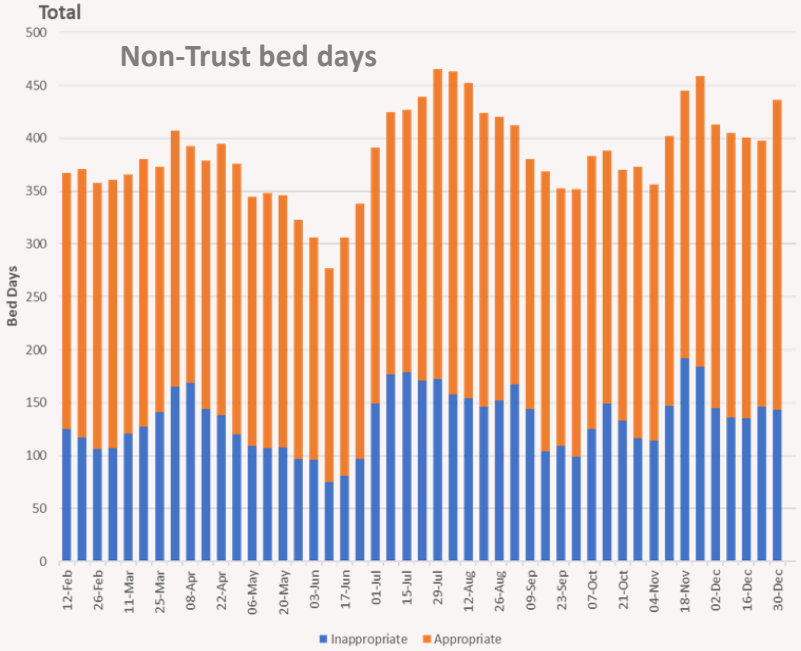
Operational service areas	YTD Bank spend £'000	Bank as % of service area pay
Acute & Urgent Care	10,645	26%
Secure & Offender Health	7,419	19%
Specialties	3,817	33%
ICCR	2,450	5%

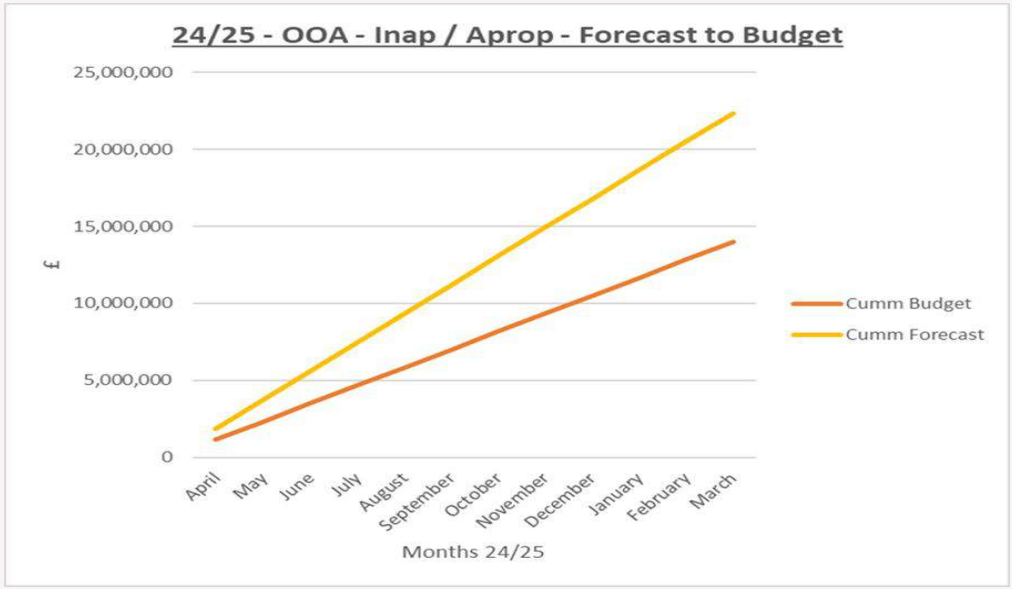
Bank expenditure

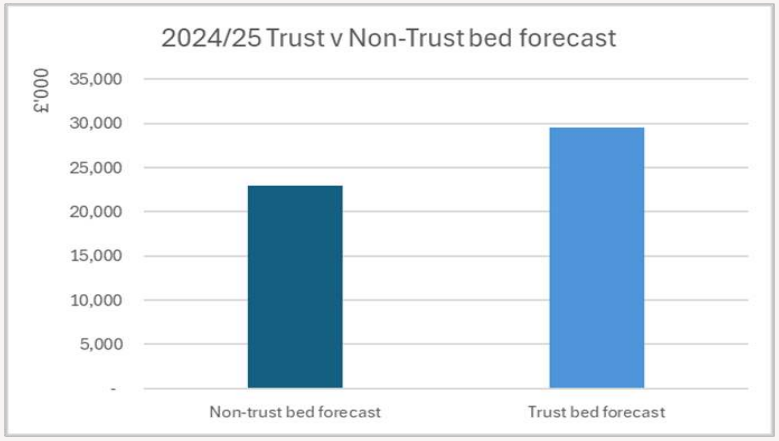
- The month 9 year to date bank expenditure is £25.4m. This is £392k adverse to plan.
- Bank expenditure in December of £2.8m is £160k less than November spend. The reduction is mainly in bank nursing in Secure and Offender Health and Acute and Urgent Care.
- 93% of total year to date bank spend relates to nursing (57% unregistered, 36% registered). The unregistered bank spend of £14m to date equates to 40% of total unregistered nursing pay spend.
- One third of Specialties pay spend and over a quarter of Acute and Urgent Care pay relates to bank.
- The bank reduction plan is a separate January FPP agenda item, it includes a review of e-rostering practice and tighter bank controls.



Non-Trust Beds overspend







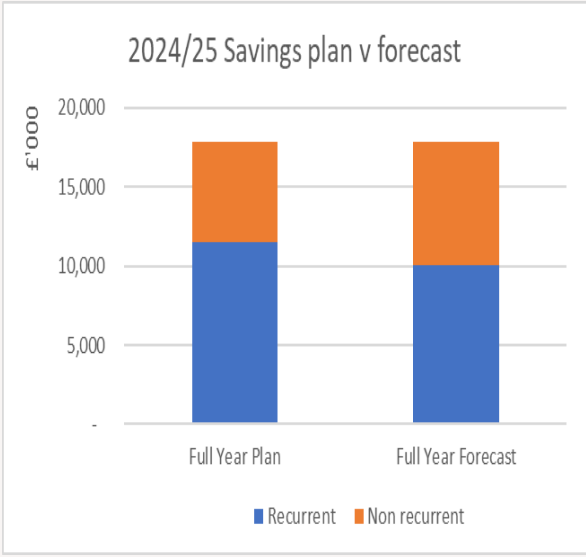
- The total 2024/25 plan for non-Trust bed expenditure is £14m.
- Month 9 year to date expenditure is £16.4m which is £5.9m adverse to plan.
- There has been a 3% increase in non-Trust bed days usage in December compared to November.
- The current full year forecast is £22m (£8m overspend).
- An extension of the inpatient bed arrangements with Priory has been agreed until 30/9/25. The tender for the new inpatient bed contract, with BSMHFT as commissioner, is due to go live on 20/1/25.

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent						
Pay - Recurrent	1,874	5,121	3,247	3,489	7,057	3,568
Non-pay - Recurrent	6,010	1,778	(4,232)	8,013	3,013	(5,000)
Income - Recurrent	-	-	-	-	-	-
Total recurrent efficiencies	7,884	6,899	(985)	11,502	10,070	(1,432)
Non recurrent						
Pay - Non-recurrent	311	311	-	416	416	-
Non-pay - Non-recurrent	1,622	300	(1,322)	2,162	2,261	99
Income - Non-recurrent	2,801	3,884	1,083	3,735	5,068	1,333
Total non-recurrent efficiencies	4,734	4,495	(239)	6,313	7,745	1,432
Total Efficiencies	**12,618**	**11,394**	**(1,224)**	**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 9, the savings achieved is £11.4m, this is £1.2m 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 and non recurrent balance sheet flexibility release.
- It is 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 2025/26 savings plans returned to date are undergoing the CQEIA assessment phase, for an overview of total plans submitted by service area, see page 18.



Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-24 £m's	NHSI Plan YTD 31-Dec-24 £m's	Actual YTD 31-Dec-24 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	218.0	215.7	217.8
Prepayments PFI	1.2	1.2	2.2	1.2
Finance Lease Receivable	0.0	-	0.0	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	219.2	217.8	219.0
Current assets				
Inventories	0.4	0.4	0.2	0.4
Trade and Other Receivables	21.4	21.4	25.5	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.6	91.6	93.1
Total Curent Assets	114.0	113.4	117.4	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(77.5)	(80.0)
Tax payable	(5.8)	(5.8)	(5.9)	(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)	(50.8)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(138.9)	(136.0)
Non-current liabilities				
Deferred Tax Liability	(0.1)	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(23.0)	(22.2)	(20.8)	(20.8)
PFI lease	(78.3)	(81.9)	(79.7)	(78.8)
Finance Lease, non current	(6.8)	(4.5)	(4.1)	(5.8)
Provisions	(3.0)	(3.0)	(2.6)	(3.0)
Total non-current liabilities	(111.2)	(111.8)	(107.3)	(108.5)
Total assets employed	88.6	84.8	89.0	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)	(74.8)	(73.7)
Total taxpayers' equity	88.6	84.8	89.0	89.4

SOFP Highlights

The Group cash position at the end of December 2024 is £91.6m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 13 to 14.

Current Assets & Current Liabilities

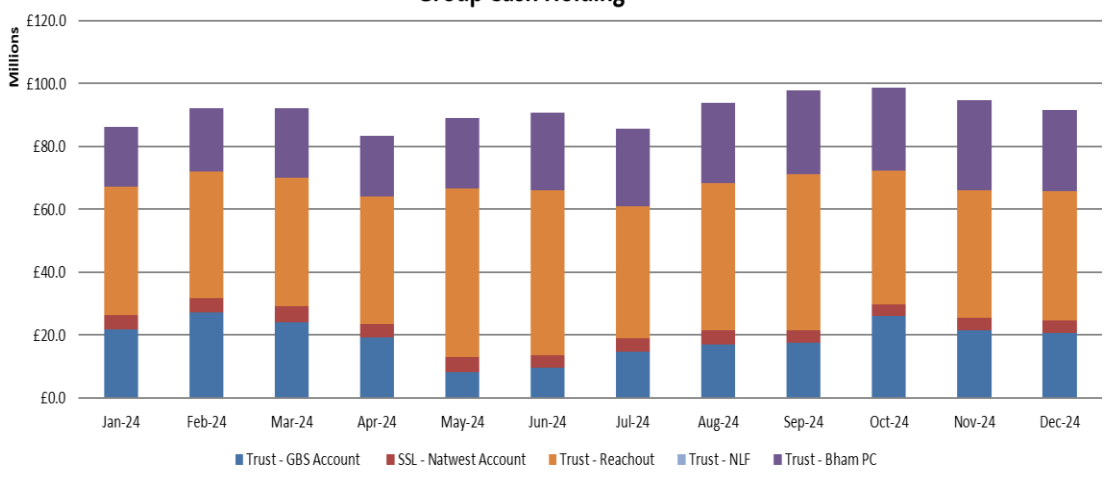
Ratios

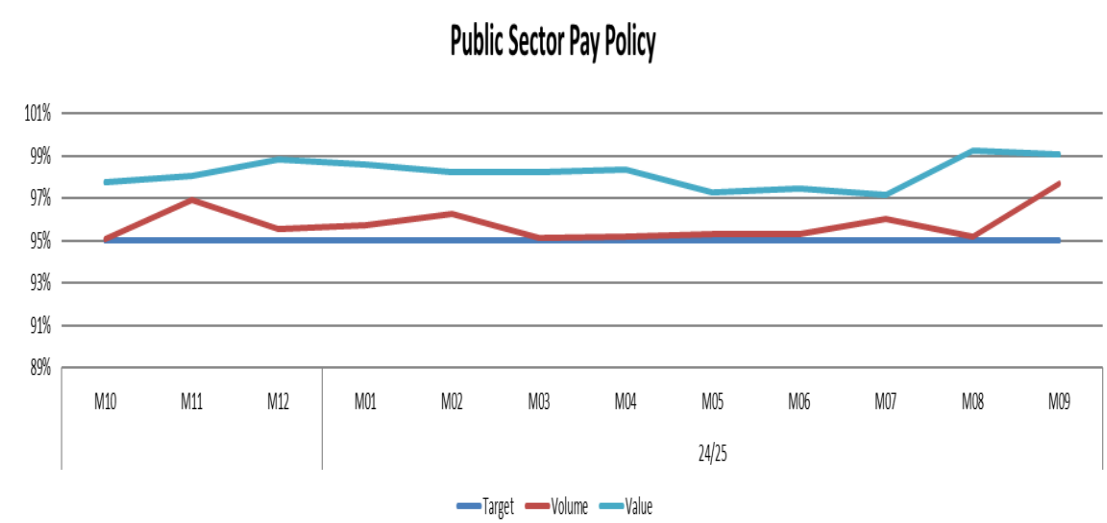
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	117.4
Current Liabilities	-138.9
Ratio	0.8

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of December 2024 is £91.6m. This comprises of Trust £20.6m, SSL £4m, Reach Out Provider Collaborative £41.2m and Mental Health Provider Collaborative £25.8m.

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.

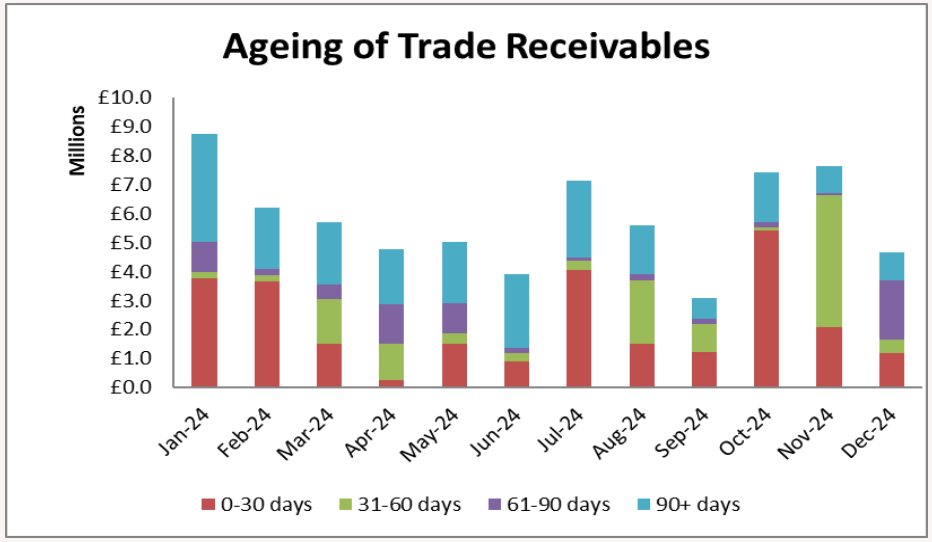
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

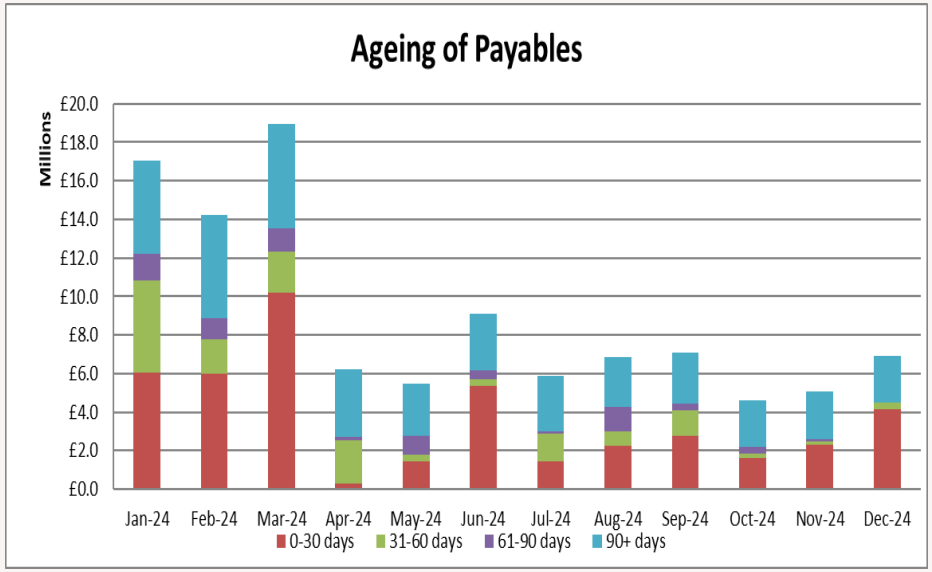
This performance was consistent throughout 2023/24 and the aim is to maintain this during 2024/25.

Better Payment Practice Code :

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

Trust Receivables and Payables





With a focus in the NHS currently around intra-NHS debts and the completion of the month 9 accounts, BSMHFT have been working with NHS colleagues to ensure as far as possible any issues are rectified.

Trade Receivables :

- **0-30 days-** Overall Balance £1.2m – decrease in balance as invoices settled in a timely manner. *Approved:* several debts have been cleared in January 2025.

- **31-60 days-** Overall Balance £502k - significant decrease in balance – mainly due to payment of £2.9m received from Midlands Partnership. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £2m- Significant increase due to unpaid invoices for BWC and SWBH. *Awaiting authorisation: BWC £975k, Birmingham CFT £16k*. *In query*: various balances including Nacro £225k, Solihull MBC £38k. Remaining balance mainly staff overpayments (on payment plans).

- **Over 90+ days-** Overall Balance £975k - Slight increase**.** *In query:* BWC £90k, University of Birmingham £79k, UHB £309k, Ethypharm £87k, Parexel £56k, Access To Work £27k, Kings College £42k, various other small balances. Remaining balance mainly staff overpayments (on payment plans).

Trade Payables:

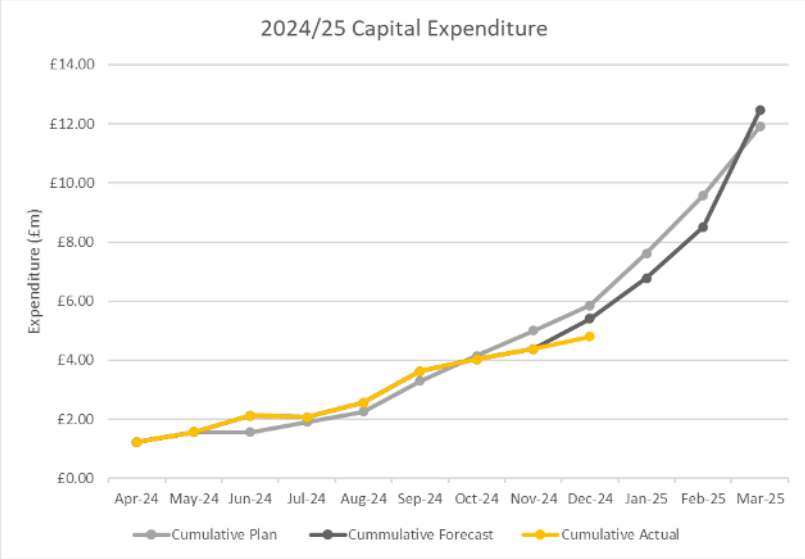
- **Over 90 days**

- NHS Suppliers £1m: NHS Property £139k-historic invoices with Estates & Facilities, UHB £649k in query.

- Non-NHS Suppliers (53+) £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 January 2025.

Month 9 Capital expenditure

Capital schemes	Annual Plan	Annual Forecast	YTD Forecast	YTD Actual		Variance to Forecast
	£'m					£'m
Approved Schemes:						
Critical Infrastructure Risks (CIR)	0.0	0.7	0.1	0.0		0.1
Highcroft Build	0.0	0.6	0.1	0.1		(0.0)
Minor Projects (inc Carry-Forward)	2.3	3.3	2.5	2.6		(0.1)
SSBM Works	2.0	2.0	0.8	0.7		0.1
Doorsets	0.7	1.5	0.5	0.4		0.0
Lease Vehicles	1.4	1.4	0.9	0.8		0.1
Recognition of IFRS 16 Leases	0.2	0.2	0.2	0.2		0.0
R&D rTMS Machines	0.7	0.7	0.1	0.0		0.1
Design Work for Forensics Capital Bid	0.8	0.0	0.0	0.0		0.0
Medical Device Replacement	0.1	0.1	0.0	0.0		0.0
ACUC PDC Funded Programme	0.8	0.8	0.1	0.0		0.1
Other IFRS 16	1.0	0.7	0.1	0.0		0.1
Unallocated Core Spend	0.4	0.0	0.0	0.0		0.0
ICT	0.0	0.5	0.0	(0.0)		0.0
System Capital	1.6	0.0	0.0	0.0		0.0
Total	11.9	12.5	5.4	4.8		0.5



Group Capital Expenditure

Group capital expenditure is £4.8m year to date, this is a slippage of £0.5m against the forecast. Forecast capital expenditure for 2024/25 is £12.5m. A breakdown of the movement in available funding since the plan submission is included below:

	£000's
Original plan	11,905
SCIF allocation	(1,605)
Highcroft funding	1,793
CIR funding	650
IFRS 16 Reduction	(287)
	12,456

Birmingham and Solihull Mental Health NHS Foundation Trust

2025/26 Budget setting update

2025/26 Planning Update

In the absence of NHSE planning guidance for 2025/26, the local planning process has progressed. The proposed principles for the BSOL planning approach are outlined in Appendix 1.

BSMHFT budget setting

- Financial management teams and budget holders have completed a review of recurrent expenditure budgets and have made budget realignments within service area budgetary envelopes to best reflect expected utilisation of resources. Pay budgets have been updated to reflect 2024/25 pay awards.

- We await planning guidance for confirmation of the cost uplift factor (CUF) which is based on inflation assumptions for key costs such as pay, drugs and capital. This will be offset by the national efficiency requirement to determine a net CUF to be applied.

- The BSOL financial planning principles propose that the start point for all system organisational allocations from the ICB will be:
    - 2024/25 closing recurrent contract value (this is a move away from underlying exit run rate as the start point, as per previous years)
    - minus Service Development Funding, or other targeted allocations, where ringfencing has been removed
    - plus/minus 2025/26 CUF, adjusted for any national efficiency targets

Cost Pressures

Given the underlying financial position, there is no cost pressure funding set aside for 2025/26. Budget holders have been informed that any pressures will need to be managed within their overall budget envelope.

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. For an overview of progress to date, see page 18.

Children and Young People's (CYP) transformation programme

The current planning assumption is that financial plans for the CYP division at BWCH, which is due to transfer to BSMHFT during 2025/26, will be included in the BWCH 2025/26 financial plan submission.

BSMHFT
2025/26 Savings identified

- All corporate and operational areas were requested to develop recurrent and cash releasing 2% savings plans as an initial contribution to 2025/26 planning.
- The 2% savings target of £5.8m was calculated based on 2025/26 start point budgets, adjusted for ring-fenced budgets that cannot be reduced, such as PFI. The actual 2025/26 savings requirement, including rollover of savings targets from 2024/25 is expected to exceed £20m.
- Plans totalling £6.3m have been identified to date, with £3.8m being recurrent and cash releasing. This is a significant shortfall to the financial gap to be addressed in 2025/26, see next page for further detail.

	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	10,365	0	0
Medical	201,426	25,083	0	0
Resources	288,109	506,959	477,435	0
Nursing & Quality	203,478	45,749	0	0

BSMHFT Financial Gap

	£'m
Underlying deficit position	(16)
3% savings requirement	(11)
Savings plans identified	6
Financial Gap	**(21)**

Given the underlying deficit position (which includes recurrent savings shortfall) and an anticipated 2025/26 savings requirement of circa 3%, there is a significant recurrent financial gap to be addressed as part of the 2025/26 planning process. Items for consideration include:

- Non-trust bed expenditure reduction
- Temporary staffing reduction
- Efficiencies and economies of scale in relation to the Children and Young People's transformation programme
- Review of non-clinical roles and recent growth in workforce
- Digital solutions
- System opportunities in relation to the Intensive Community Rehabilitation Team (ICRT) and section 117 packages of care

Appendix 1

Planning principles

Briefing for Executive Team – 20th January 2025

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

- Draft Operating Planning principles have been developed for the BSol system by the ICB
- Request from the ICB that the following slides are reviewed by providers with comments back by 23/1/25
- Extracts have been included in presentations to Senior Leaders and Board Strategy session
- Key new issues for BSMHFT to be aware of:
  - Any allocations (including SDF allocations) where previous ringfencing has been removed will be subject to a full system review to determine the relative value of continued investment against other system priorities – PENDING DETAILS IN PLANNING GUIDANCE
  - Conduct a robust review of establishment growth with a view to reduce spend in support functions. It is expected that support functions should represent not more than x% and providers should plan for a reduction of y% of the growth seen over the last 4 years. – PENDING DETAILS IN PLANNING GUIDANCE
  - The cost of our workforce will not grow in real terms outside of fully funded investments. In addition, providers will be expected to reduce spend on support functions in line with planning guidance requirements, whilst the ICB will be expected to manage running costs within their reduced allocation
- Recommendation that principles are supported

Draft Primary Principles

- In line with the clear directive from NHSE, every attempt should be made to submit a **balanced financial plan, whilst maintaining a safe service and delivering the reduced number of key operational priorities for 2025/26.**
- **The cost of our workforce will not grow in real terms outside of fully funded investments.** In addition, providers will be expected to reduce spend on support functions in line with planning guidance requirements, whilst the ICB will be expected to manage running costs within their reduced allocation.
- **We will improve our overall productivity**, ensuring clear plans are in place to address outlier areas with Model Health System and GIRFT.
- **We will make data-led decisions, focusing on building a better understanding of value across the system.** As a result, we will take steps to reduce spending where value is lower and, where possible, investing in other areas where increased value can be demonstrated.
- We will set out **a clear roadmap, and Year 1 actions, to meet the Secretary of State's three key priorities**:
  - Analogue to Digital – Workshop in January across CIOS to start to outline this strategy and approach
  - Treatment to Prevention – Addressing the 10 prevention priorities agreed by the ICS
  - Acute to Community – 1 - 3 year plan to build up neighbourhood health service starting with specifications of INTS and localities
- **We will maintain triangulation** – in order to achieve this, we will work across workforce, operational and financial plans and also across funding flows from the ICB into provider plans to ensure consistency of assumptions.
- Where the system is unable to meet key national and local requirements in 2025/26, a clear medium-term plan with agreed actions will be set out through this year's planning process to demonstrate how these will be delivered in the future

Need to ensure……

- A timed and costed plan regarding the implementation of the Integrated Neighbourhood Health Service;
- The UEC plan and contracts needs to account for an inevitable surge in winter – ideally without expanding the recurrent bed base;
- The financial framework should demonstrate a route map to show greater investment in community and primary care compared to secondary care;
- The focus of planning and implementation should be through provider collaboratives, with a focus on locality working;
- A quickened push towards greater cost-effectiveness through shared services in back office and clinical support services;
- Our commitment to addressing health inequalities through the above changes is baked in, as is our commitment to improving equality diversity, anti-racism and working in an inclusive way across all protected characteristics;
- Greater investment in prevention than previously

Likely National and Local Planning Priorities

	National focus	Local Focus	
Urgent & Emergency Care	• Hold or Improve Emergency Performance	• Single Point of Access • UTC re-provision • Discharge & Flow • Out of hospital beds	Locality Working & Integrated Neighbourhood Teams: 3 year large-scale plan to move to the neighbourhood health service and support the specifications for out of hospital care (i.e. primary care , targeted prevention , admission avoidance, discharge and Population health agendas)
Elective Care	• 52 week target • Improve 18 week target by 5% TBC or 65% TBC • Cancer recovery • Elective Productivity • Diagnostics recovery		
Access to Primary Care	• Access to general practice • Access to urgent dental care		
Mental Health	• MH Crisis • CYP waiting times	• MH Access and OOA pressures • Expansion of PDU • LDA improvements	
Other	• NICE TAs (e.g. Tirzepatide / HCL) • Reduce inequalities in line with Core 20plus5 • Improve safety in maternity & neonatal services		

Draft Financial Principles

- **System allocations will continue to be transparent,** and providers and the ICB "provider arm" will be treated equitably through the allocation process.

- **The start point for all organisational allocations is as follows:**
  - 2024/25 closing recurrent contract value
  - - Service Development Funding, or other targeted allocations, where ringfencing has been removed (see below)
  - +/- Adjustment for new ERF allocation / rules
  - +/- 2025/26 Cost Uplift Factor (CUF), adjusted for any national efficiency targets

- **All organisations will be expected to submit breakeven plans for 2025/26. Where the current run rate would result in an organisational deficit, organisations should set out:**
  - Additional **recurrent** internal efficiencies and/or productivity improvements, up to a minimum of 3% of turnover.
  - **Areas of service change** that could deliver further cost reduction, but would **require system transformation and/or commissioning changes**
  - **Non-recurrent savings that could support in-year financial delivery** – where these are required, organisations will be expected to set out a roadmap to underlying financial balance by 2027/28, incorporating the actions within the above 2 bullet points.

- **Any allocations (including SDF allocations) where previous ringfencing has been removed will be subject to a full system review** to determine the relative value of continued investment against other system priorities

- Any growth funding, and/or previously ringfenced funding clawed back through the review process set out above, will be allocated through a separate process to key system priorities or, in the exceptional circumstances set out below, used to support the system financial position

- Through the allocation of growth funding, the **system will demonstrate delivery a commitment to realign the split of funding between acute and non-acute services back to pre-Covid levels over the next 5 years.**

- **In exceptional circumstances, where the current run rate would mean that breakeven plans could not be delivered without a clear impact on safety and/or national operational priorities, a system solution will be required to manage the enable delivery of financial balance at an overall system level.** In these circumstances, the organisation will be expected to deliver a deficit of no more that 50% of their current run rate, as determined by 2024/25 plan or 2024/25 recovery plan (where a recovery plan is in place).

Operational Planning Principles

As a System, it is important we are acting in a unified way to ensure we have a shared understanding of System priorities, pressures, opportunities and planning assumptions to make sure we have an aligned set of plans.

To help deliver operational plans from 25/26 onwards, the key operational primary principles which should be adopted by all organisations are as follows (please note these may change once guidance is finalised by NHSE)

- The providers COOs are to sit on the system operational & clinically planning prioritisation group and will help shape the agreements on priorities and movements of investments and disinvestments for delivery of activities. They will act as the link back into providers' execs on aspects of the operational delivery of the planning guidance 25/26.
- This set of operational principles need to work alongside the agreed financial and workforce principles set out to the system F&P cttee January and this group cannot work in isolation of these.
- Activity plans must reflect the absolute must do national priorities e.g. the return to the 18-week targets (it is essential activity to achieve these are calculated by providers with built in productivity and a clear understanding of this at a system level for what this quantum of activity brings)
- Productivity plans must feature strongly in the delivery on the operational targets and support finance and workforce challenges
- COOS are to bring to the group a list of priorities they feel are essential for 25/26 delivery (known no new monies , monies would need to be found else where) that are not covered in their block arrangements or activity baselines and also services they are providing either in or outside block arrangements that could be disinvested in for discussion
- ICB to provide a list of things funding outside the blocks in other arrangements for discussion from evaluation of spend group
- Services being provided and not funded over the years will need to be discussed and agreed next steps at OPP

Workforce Principles

Whilst many of our workforce principles will inevitably be focussed on workforce planning, and alignment with financial and operational principles, it is important that the common thread of our **BSOL New Staff Offer** feeds through into all of our local and system plans, namely:

- Pledge 1 - Compassionate and inclusive leaders and managers support everyone to grow, and you are recognised for your contributions across health and care
- Pledge 2 - Collaborating is made easy and includes everyone
- Pledge 3 - It is safe and worthwhile to raise issues
- Pledge 4 - Work is flexible and moving roles is easier

In the context of workforce planning, **national guidance is clear that organisations are expected to reduce spending on temporary staffing and support functions by:**

- **Improving productivity** to achieve close to 100% delivery before accessing capacity at premium rates
- **Reducing Agency expenditure** to no more than 2% of workforce expenditure in 25/26
- **Reducing Bank Use,** optimising bank rates as close as possible to substantive rates
- Conduct a robust review of establishment growth with a view to **reduce spend in support functions**. It is expected that support functions should represent not more than x% and providers should plan for a reduction of y% of the growth seen over the last 4 years.

Given the local financial position, and the continued substantive growth seen in 24/25, it is expected that some of the **local pay controls** introduced in 24/25 will continue:

- **The cost of our workforce will not grow in real terms outside of fully funded investments**. In addition, providers will be expected to reduce spend on support functions in line with planning guidance requirements, whilst the ICB will be expected to manage running costs within their reduced allocation
- **The following temporary staffing controls should be in place, with exceptions signed off by organisational Executives and a system panel:**
  - There should be no off-framework agency shifts, and all shifts should be within agency price cap rates (non-medical) or in line with regional procurement framework rates (medical).
  - No enhanced bank pay rates (non-medical) with trajectories in place to reduce enhanced bank pay rates (medical)
  - No non-clinical or Band 2/3 agency

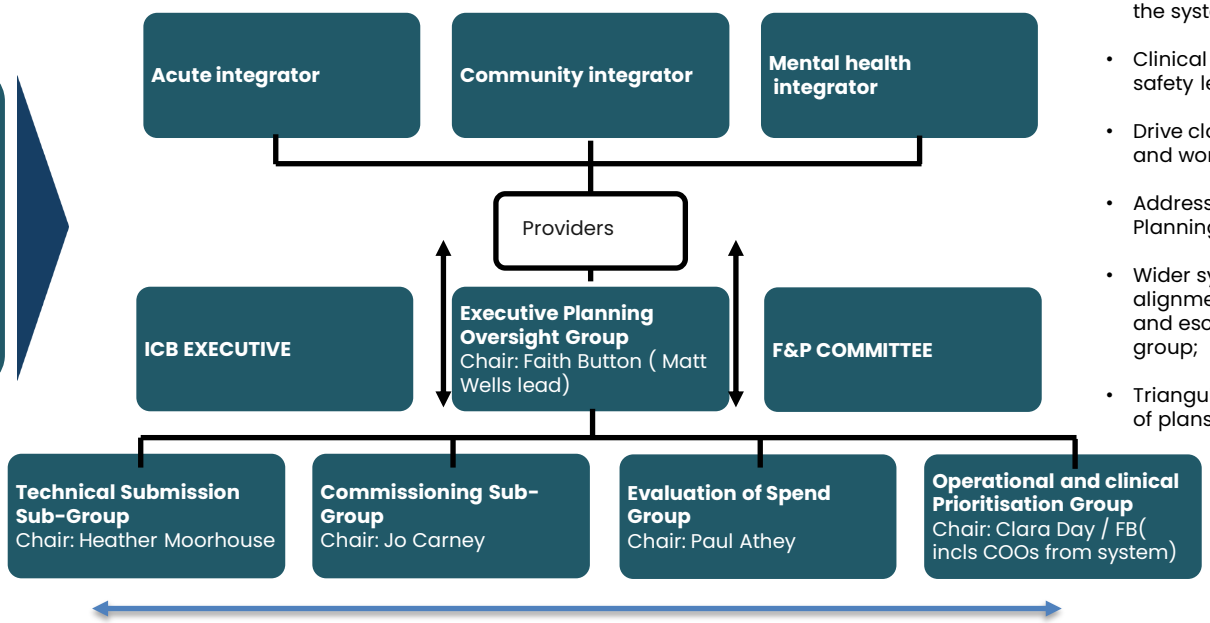
Prevention priorities 25/26 – 10 agreed and working to tackle Health Inequalities

- We will **increase the number of people who successfully stop smoking** with a particular focus on smoking in pregnancy, manual workers and people with learning disabilities and mental illness.
- We will **decrease the number of people drinking to harmful and hazardous levels** by improved identification and access to brief interventions and treatment, support and recovery
- We will **improve the identification and management of hypertension** optimising clinical and non-clinical prevention treatment pathways. We will aim to increase the number of people identified with hypertension (BP>140/90) and the percentage of these who are treated to target.
- We will **improve respiratory outcomes by increasing uptake of flu vaccination** with a particular focus on older people and adults with a pre-existing health conditions.
- We will **prioritise access to and quality of LDA and SMI Health-checks.**
- We will **accelerate plans to tackle adverse infant outcomes** by focusing on women with existing health conditions ensuring that there is good access to pre-conception advice and early booking.
- We will **accelerate the take up of all childhood immunisations** including MMR
- We will take steps to **improve the oral health of children by** maximising public health interventions and access to NHS dentistry

- We will **review our systems approach to child and adult obesity** including community level interventions, NHS programmes and new pharmaceutical interventions
- We will **improve early diagnosis of cancer**; we will commission a deep dive on local cancer screening uptake and performance as well as reviewing diagnosis with symptoms. This will set system baselines prior to any delegation of screening responsibilities

Draft Governance for planning Draft

National planning guidance and expectations. Financial envelope (pre 3 year SR).



- Creation of planning framework across the system;
- Clinical involvement from quality and safety levels;
- Drive closer alignment between finance and workforce across system partners;
- Address learning from 24/25 Operational Planning Round;
- Wider system communication and alignment with provider planning leads and escalation through professional group;
- Triangulation and review and assurance of plans including data validation checks

Birmingham and Solihull Integrated Care System
Caring about healthier lives

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Birmingham and Solihull

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15 January 2025

Via Email

Roisin Fallon-Williams
Chief Executive Officer
Birmingham & Solihull Mental Health Foundation Trust

Dear Roisin

NHS Oversight Framework 2024/25 – Quarter 2 Segmentation and Quarter 3 Requirements

Thank you for everything that you and your team have been doing over the last quarter to support the improvement of outcomes for our patients, citizens and staff across the health and care system. The purpose of this letter is to confirm the ICB's proposed 2024/25 Quarter 2 position, and the next steps (actions and timescales) required for the 2024/25 Quarter 3 segmentation review, highlighting some key deliverables for the remainder of 2024/25. I can confirm that your rating remains at a segment three.

As a new oversight framework was expected to be implemented in the autumn, NHSE colleagues did not undertake any proactive reviews of segmentation for Quarter 2. Discussions are ongoing regarding the appropriate timescale to introduce the new framework and therefore NHSE will re-instate their standard segmentation review process for Quarter 3. Provider segmentation templates with the ICB's proposed position will be submitted to NHSE by Friday 31st January 2025.

Quarter 2 Segmentation Review Outcome

- Quality of care, access, outcomes and delivery

  There continues to be Section 29a notices in place for the Trust, with a further one being issued within Q2 in relation to Reaside. It is recognised that there continues to be significant challenges on demand for services, in particular inpatient capacity and the acute and urgent care pathway, BSMHFT have supported a recent audit led by the ICB on the ED pathway and have taken on board recommendations made for improvement and onward monitoring including agreeing quality metrics. There continues to be a high level of risk within community settings. It is recognised that Community services were reinspected by CQC and have now been given a 'Good'; rating.
  The implementation of RCRP across the BSol system has been supported by BSMHFT, with on-going reporting on impact through SQG and Quality Committee.

  Your organisation continues to experience significant challenges in areas such as out of area placements (OOA), talking therapies and children and young people (CYP) access. Work towards eliminating inappropriate adult out of area placements remains extremely challenging with 29 being in place in October against a planned trajectory of 20. I acknowledge the achievement in hitting both recovery and reliable improvement targets for talking therapies during August.

Support into the UEC agenda for patients in emergency departments with mental health issues and on acute wards continues to be a focus for the system and your participation in the UEC Board with a plan for this cohort of patients working alongside the acute trust is a priority. Your team have participated in this agenda so thank you; it is now important that pathways and protocols for the management of patients remaining within EDs for considerable lengths of time need to be agreed with UHB both clinically and operationally. We have agreed that Dr Clara Day will help bring together colleagues to address this issue this winter.

- Preventing ill-health and reducing inequalities

  All NHS bodies have a responsibility to collect, analyse and publish information in connection with health and equalities and healthcare. As an NHS Provider you should familiarise yourselves with the available sources of data and tools via https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities-duty/ and publish progress in your annual report.

  I know your Board is fully committed to preventing ill-health and reducing inequalities and signed up to support some specific actions agreed at the Chief Executive Group. I look forward to seeing these developed and translated into clear outcomes to measure by January 2025, supported by baseline measures which we will provide.

- Finance and use of resources

  The year to date system position at the end of Quarter 2 is £69.9m deficit, £51.3m adverse compared to plan. Pay spend is the biggest driver of the deficit position with a £51.3m overspend compared to plan, with overspends of £38m on Substantive pay and £23m on Bank pay being offset by underspends on Agency staff of £8m. Agency spend at the end of Q1 sits at 2.4% of total pay, compared with a national target of 3.2%. System efficiencies are £12m less than planned for the year to date, with 63% delivered recurrently, compared with planned 71% recurrent efficiencies. As a result of the deterioration of the system financial performance, BSOL has now moved to a level 3+, with greater intervention by the Regional team. BSMHT's specific financial performance was as follows:

  - £0.06m deficit delivered YTD at Q2, £1.31m behind plan. Forecast £2.1m surplus, in line with plan.
  - Total efficiencies £0.6m lower than plan for the first two quarters, with recurrent efficiencies at 58% of the total, less than the 61% of total efficiencies that was planned.
  - Pay spend £2.8m lower than plan
    - Substantive spend £0.5m below plan
    - Bank spend £0.1m below plan year to date, with bank spend 11.8% of total pay
    - Agency spend £2.2m below plan year to date, with agency spend 1.8% of total pay

  Thank you for your recent commitment to deliver against your financial plan and the continued joint working across the system.

- Leadership and capability

  The ICB continues to progress its system operating model. Your own leadership around the mental health collaborative and the People' Board is much appreciated as is your input into the ICB Board.

  The strategic intentions for the service integrators for the mental health collaborative have been agreed and will form the delivery plans underpinning the Joint Forward Plan. The option for the

transfer of children and young people's mental health provision is also a vital development to embed; thank you for your work in this area with Matthew Boazman.

Provider Segmentation and Quarter 3 Requirements

The Quarter 2 provider segmentation rating was informed by the ICB's assessment of performance against the metrics, as well as additional qualitative views and intelligence. The RSG will resume their review of the ICB's recommendations for the forthcoming Quarter 3 period. We believe that BSMHT should remain in segment three.

For BSMHFT specifically the Trust will need to continue to improve their overall performance against the National Oversight Framework, as well as addressing the other workforce and quality challenges to have their segmentation rating improved. As a result, BSMHFT remains in segment three.

We will continue to work with you over the coming months, to support the improvement journey and have oversight of the delivery of the areas we discussed. The key areas that will potentially facilitate entry into segment two going forward are:

1. The Trust should progress a clear and credible improvement plan against the NOF drivers covering: out of area bed days, which despite improvements, remains high and off plan. The system remains an outlier even though positive progress in reducing adult acute numbers continues.

2. Talking therapies recovery rates, access and waiting times - as a system, we continue to lag below national levels although again there has been improvement in the delivery against the plan during 2024/25 but waiting times are not being consistently delivered.

3. Learning disability and autism inpatient trajectories remain an outlier across the region and we need to deliver against trajectories set. I recognise the continued work that you are doing with Richard Kirby and the engagement and involvement of your team in focusing on those patients with the longest waits through the system-wide meetings, which will remain in place until progress in the overall position is obtained.

4. Good progress has been made on developing the mental health collaborative and the strategic commissioning intentions and over the next few months this requires further embedding and delivering to mitigate the collective risks within the system. This involves bringing governance and oversight from FTB within the mental health collaborative.

5. Ensure actions are taken to deliver the agreed surplus target for 2024/25. Drive forward the delivery of efficiency schemes, with a particular focus on increasing the proportion of schemes delivered recurrently.

Next Steps

NHS England will work with the ICB to review the segmentation drivers, plans to address the key issues underpinning the segmentation, support needs, and how we work together. Given the dual responsibilities of the ICB and NHS England, we will continue to adopt a joint approach to provider segmentation and oversight of performance. Ensuring the ICB has access to support from NHS England's Regional System Co-ordination and Oversight Team where required.

Thank you for your continued input and contribution to this process. Should you have any questions on any of the above please contact me.

Yours sincerely

David Melbourne
Chief Executive

Cc Paul Athey, ICB Deputy Chief Executive and Chief Finance Officer
Faith Button, ICB Executive Chief Delivery Officer
Rebecca Farmer, Director of Strategic Transformation (West Midlands), NHSE
Katrina Boffey, Deputy Director of Strategic Transformation, NHSE

Summerhill Services Limited (SSL) Business Report

April 2024– Oct 2024

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

The first seven months of this year remain very busy, with implementing the numerous capital projects across the Trust, installing a new estates management tool, which will provide more in-depth information on maintenance tasks, and developing a complex new food and catering system for the trust called Symbiotics.

SSL and the Trust are both aware that Reaside continues to be a challenging site. Reaside is currently the only Trust building with High-risk backlog and has the highest Significant backlog, due to this it has been added to the risk register. At present the building is ageing faster than the investment in backlog so over time the condition of Reaside will only deteriorate further. SSL has been working closely with the Trust teams to address these challenges. We have reviewed the domestic and catering services in line with clinical operations. From an SSL perspective the physical environment is the most challenging, as an example there are no ensuites at Reaside, showers, baths and toilets are shared and due to low availability, all facilities are very heavily used. We have agreed a significant replacement program on all showers and sanitary ware over the next few months, however this will not address the issue of low availability and no ensuites on the wards. SSL will continue to work with Trust teams to maintain Reaside while we continue to review options to replace potentially Reaside with a new building.

SSL is focussed on reducing additional pay costs including agency and overtime. SSL has successfully reduced these costs by over 60% over the past few months by utilising our new staff bank, thereby significantly reducing the cost per hour.

SSL continues to develop and support our staff, and we have recently introduced our new training development programme which seeks to review all staff and the business training requirements, across all levels.

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

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

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

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

Facilities Management

Domestic and Housekeeping Services

- Successful implementation of the New National Cleaning Standards completed.
- SSL have an accredited training course– thought to be the only provider in the country with a fully accredited training course for the New National Cleaning Standards
- Level 2 Infection prevention in cleaning training offered to all Facilities teams. Efficacy cleaning audits are scheduled and where sites have in patients they are conducted by the SSL Team and IPCT as a requirement in the NHS Cleaning Standards.
- A review of all COSHH, Risk Assessments and Cleaning methods, SOP will be completed and updated for all facilities teams across SSL to maintain compliance standards, support procurement when purchasing chemicals and identify any future training needs.
- Ward kitchen food safety audits undertaken by SSL to support IPCT - ongoing as requested
- Risk Assessments and Safe working Methods due for review for Catering & Domestic departments in Nov 2024

Catering Services

- Master Catering Programme progressing well.
- Review of Cultural / Theme day menu is underway with discussions scheduled with Trust EDI lead and head of Spiritual Care – All meat purchased will be Halal.
- Sandwiches and Salads – As part of the menu review purchasing sandwiches and salads rather than producing them on site is going to be implemented across all sites. This is due to potential food safety risks as most production kitchens don't have cold prep areas.
- **Trust Food Safety Specialist** – Recruitment complete by SSL , as agreed with the Trust.
- The EHO inspected kitchens all achieving a **5-star** rating.
- SSL have been working collaboratively with NHS Supply Chain; Food (Tower 10) integrating the Multi-Temperature Distribution model to achieve value for money.
- Compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS "Plastic Pledge".

Laundry and Linen Management

- New laundry provider Oxwash to commence January 2025. This is unique to BSMHFT.

Transport & Logistics

- Non-Urgent Patient Transport (NEPT) – expansion of NEPT and Taxi core hours from 06:00 am to 22:00 is still available, proposal submitted to the Trust.

- **Fleet Update:**
  - **Hydrogen Trial**

    We have a Vauxhall Hydrogen vehicle on trial from 16/12/2024-16/01/2025.This will be trialled with General Transport, warehouse & Estates. All data will be provided by Vauxhall and Hydrogen site at Tyseley to make comparisons against Petrol & EV
  - **Replacement Fleet Programme**

    SSL has implemented a vehicle replacement program for 24/25 and into 25/26. We would have replaced 33 vehicles by March 2025 which represents 41 % of SSL's current operational fleet. A further 12 vehicles will be replaced in 25/26

- **NEPT / Portering**

The FM First software is scheduled to be introduced in Q1 2025. This software will enhance portering operations by improving the planning and monitoring of job requests, idle time, and ad hoc requests from Trust teams.
Aborted jobs remain a challenge. SSL commenced a communication campaign in Q2, but unfortunately, we have seen no significant improvement.
We plan to address this issue with the various responsible Trust managers, to hopefully address this issue.

- **UBook**

SSL is nearing the completion of our UBook trial. UBook is a room booking and space planning system which SSL has been requested to review to see if we could potentially increase the space utilisation across the Trust, as there is increasing pressure for space as the Trust continues to expand.
The trial has gone well, and we have demonstrated improvements, however we have identified some concerns which need to address before potentially progressing the project further. Full report due pre-Christmas.

- **Warehouse**

We have been working with the Trust developing a proposal awaiting on Resus Packs. The proposal aims to centralise the ordering, storage, and distribution processes at the SSL HUB. This initiative would improve operational monitoring, free up storage space in clinical areas, and streamline the exchange and delivery of resus bags.

Over the past 12 months the SSL warehouse has continued to take on new projects for the Trust.: PPE, Trust Uniforms, Covid tests, Tissue Viability Products, Blood pressure monitors, Recycling Bins / Ecig Bins / Food Bins and sharps bins, and Physical health equipment.

Water Management
Water management is a well-documented and structured process for all members of the Trust and SSL staff. SSL and Trust operate and manage over 50 sites across BSOL, however, over the past year one building has been more challenging more than others – Forward House.
We are pleased to report that Forward House is now in a GOOD position based on reports from our Authorised Engineers & Microbiologist.

The building is fully open and occupied. The site is now at circa 99% clear of Legionella, these outlets have 3 + consecutive Non – detected results. Trust Water Safety Group have approved testing to be moved to 3 monthly sampling for assurance.

New Facilities Systems

- Our new Estates Management System is now operational in all community sites and is due to roll out to our secure sites from December 2024.

- Our new Food Management System will initially be implemented and tested at Ardenleigh in early January. Following any amendments as result of the trial, we will hopefully be able to roll out on a phased basis to others from March 2025.

Capital Projects

Capital Programme 24/25 progressing ahead of plan, with a current forecast of £12.56m which includes £1.60m of System Capital for 2024/25.

We have a number of key projects including:

- **Highcroft New Hospital Development** – £25m approved Scheme @ outline design stage, planning approval to be sought Feb/Mar 25 and procurement stage to be progressed.
- **Reaside** – As the Trust is aware, Reaside continues to be a challenging site mainly due to the age of the building, layout and the functional suitability. SSL is working closely with the Trust teams to address these challenges. We continue to invest significant capital to maintain the building. As there are no ensuites at Reaside, showers, baths and toilets are shared and due to low availability, all facilities are heavily used. We have agreed a significant replacement program on all showers and sanitary ware over the next few months, however this will not address the issue of low availability and no ensuites on the wards.
- **Main House Redevelopment** – This is redevelopment of a previously unused site. The project will deliver new office space for the expanding First Team.
- **24/7 Service** – SSL has been working with the clinical and operational teams to locate a suitable operational site for this new service. Several options have been reviewed. Short-term option approved.

SSL PFI/Contract Management

- SSL completed the ERIC submission on time July 2024
- SSL finalised Settlement Agreements across both PFI's following performance management challenges of services. These agreements delivered high six figure settlement values. Plus, Energy Management settlement of six figure sum. Total circa **£2m** income to the Trust.
- The SSL PFI Team have been invited by PFU to act as an exemplar Trust to support and share good practice with other Mental Health NHS Trusts with PFI Projects. SSL will continue to develop relationships with other trusts to assist them with their PFI needs and requirements.
- SSL are starting our 9th Market Test, this being the BNHP Joint Services Market TestProgramme over 24/25 for conclusion March 2025. This will set new cost baselines for the next 5 years, and will however be a cost pressure.

ICS Primary Care

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

- Significant progress has been made in the reporting period with the completion of Locality Clinical and separate Locality Estates Strategies.
- With focus on delivering the objectives detailed in the Fuller Report, SSL have been providing Estate support and advice to set up and support several Primary Care Hubs. These provide significant reduction to secondary care pressure by providing a clinical pathway for same-day urgent GP appointments.
- Void and Underused Bookable Space reports completed on CHP/ NHS PS properties.
- SSL is also leading a project to assess the accuracy of the information held for system wide void and bookable space. National rollout of ADEPT with BSol as a pilot in scope.
- Capital Programme, working in conjunction with NHS PS, SSL are overseeing the refurbishment circa 25 GP medical records rooms to become clinical rooms for circa £800k, which is incredibly cost-effective verses building a new Health Centre at £20m for 15 Clinical room provision.

Property Management

- Significant challenge re William Booth centre (WBC) – City Council have with immediate effect ceased to fund the Salvation Army for its provision of services to homeless persons who have temporary accommodation at this site. This decision means from end Nov24 the BSMHFT homeless team that operate out of WBC are effectively without a base. Significant time and energy spent working across ICB to establish potential opportunity in Attwood Green Primary care centre – works underway at site to get to a point where with managed risk it is Fit for purpose. Plan to support team move w/c 25 Nov 2024.

- Public Sector Decarbonisation Fund – SSL are expending considerable resources to help drive forward Detailed Designs for Heat Decarbonisation schemes at some of our sites. Initial findings given funding criteria and VFM suggest that Juniper and Ardenleigh may be the best fit at this time. Funding if successful will come from central government could be circa £5 million in total with it is hoped BSMHFT match being no more than circa 15%.

- In support of the BSMHFT Waste Management Policy, SSL have from September 2024 commenced waste support visits across Trust sites. The aim of these visits being to support individual sites with their waste management helping improve financial, environmental, quality and safety efficiencies. The aim being to complete a visit at every Trust site annually and to help ensure positive changes are implemented and challenges are managed with a view to continuous improvement.

Outpatient Dispensing Services Apr-24 to Oct-24

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 18 externally reportable incidents during this period. No service users were harmed as a result of these externally reportable incidents and all of them have been dealt with promptly.
- SSL implemented an upgrade to its Prescription Tracker which tracks our pharmacy prescriptions (Please see Appendix C). The upgrade has improved accessibility, systems security, and provided resilience to staff members covering multiple sites.
- SSL Pharmacy is underway upgrading its compliance aid machine.
- SSL robot continues to deliver an accuracy of 99% on compliance aids (see appendices)

Feb-24	Mar-24	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24
99%	99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance

SSL is £351K (2%) ahead of budgeted revenue after the first 7 months of this financial year. This is mainly due to the NHS pay increase of 5.5% that came into effect in April 2024. As in previous years, SSL is committed to reward all SSL staff and has mirrored this increase with across SSL.

SSL is focussed on reducing additional pay costs including agency and overtime. SSL has successfully reduced these costs by over 60% over the past few months by utilising our new staff bank, significantly reducing the cost per hour.

Revenue from External work is steady for our 3 main revenue streams, namely Primary Care, Trusts/ICS and PFI Consultancy.

- Primary Care – We continue support over 270 GPs across BSOL. The focus of work has now moved away from COVID and now more around monitoring Rent, Space Utilisation and Capital work. In terms of Capital, the team will now be managing circ £800k worth of work which will be coming through SSL accounts.at 5% margin.
- Trust/ICS – We are supporting the ICB with their Sustainability/Green plan along with providing Project Management support for two key ICS developments.
- Our support work with The Black Country NHS Trust Capital Team stopped at the end of September but we are hopeful further work may come our way during the 2nd half of the year.
- PFI Consultancy – We have been commissioned by 2 organisations to complete our patented "PFI HEALTHCHECK". There is an additional pipeline of projects for the 2nd half of the financial year which the team are working on. This project is being reviewed constantly to ensure we are managing any risk.

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

Resourcing

- SSL first Graduate Scheme has been launched with two Graduates commencing September 2024, in growth areas for SSL being Capital and PFI. SSL has also launched a degree apprentice programme and commenced with a Sustainability and Waste Apprentice to support the Trust.
- SSL since the introduction of its own weekly bank has reduced considerably it's spend on overtime, and agencies due to its procedures ensuring Bank Staff are always utilised first.
- SSL continues to maintain its current staffing profile of 390 employees with vacant positions being filled through it's refer a friend scheme, working with charities, recruitment fairs, and also external advertisement.

- SSL has carried out a Strategic Review of its Resources and conducting a talent map across the organisation aligned to its business plan to identify where it will appoint future apprentice positions for commencement 2025 and also to focus on future development of staff.
- SSL has recruited on behalf of the Trust a Food Safety Manager to work in conjunction with the Trust Nutritionist.
- SSL has appointed a new Early Years, Leadership and Training Manager whose focus has been on settling in our Apprentices and Graduates, and now will be focussing on internal leadership and talent management development.

Reward and Recognition

- SSL has recently reviewed it's Pay Policy and agreed a set of key principles to strengthen its policy and provide further guidance for the Senior Leadership Team. SSL will be presenting the principles to the Strategic Board prior to sharing with its Senior Leadership Team.
- SSL has also appointed Gallaghers to carry out a Strategic Review of its NEST Pension Scheme, to ensure that SSL is maximising employee's and company contribution to get a better return for its staff. Gallaghers will also provide pension roadshows to SSL colleagues to sign post people when considering pension and retirement options.

Health Surveillance

- SSL has now completed over 70% of staff health surveillance reviews aligned to its health surveillance matrix produced by H &S and HR for all personnel.
- SSL has also reviewed its pre-employment health profiles and has commenced a programme of ensuring all its employees vaccinations records are upto date. Greater focus will be given to ensuring all staff records are complete, once Health Surveillance has been completed.

Equality, Diversity & Inclusion

- SSL has introduced a support pack for EDI advocates, and all advocates continue to utilise this to actively deal with issues.
- SSL has recently recruited a range of new advocates and will be providing additional training in 2025.
- A range of SSL SLT also completed the Trust's Active By Stander training and further courses will be arranged in 2025.
- SSL has reviewed its EDI Forum actions from 2024 which have included training to advocates to support them representing our staff, Advocates engagement events and meetings with staff, our benefit offering, and support to our first YOURS Survey. The Committee has also identified areas to be developed next year which will focus on Health and Well Being and Neuro Diversity to commence with.

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Staff Attendance

- SSL has seen a reduction on its long term sick and short cases since the last quarter due to training being provided to staff and a focus being given to the management information provided to line managers.

Business Development, Opportunities and Plans

Corporate, Property and Sustainability

- SSL will be developing further the 'Green Plan' for the Trust set against baseline data & target. Plus looking to bid for decarbonisation opportunities @ circa £5m.
- Birmingham Council leased premises- Phoenix refurbished to create enhanced Secure service provision in Erdington.
- For the Trust and BSoL ICS – SSL have reviewed, gathered information and completed in full- and on-time returns required by NHSE. Including Transport, Green NHS, and Property.
- SSL will be introducing both food waste recycling (sites with preparation kitchens) and a 'OPT in' waste recycling option for the Trust
- SSL developing an EV charge-point option for Trust to consider for staff, visitors , and patients.
- SSL have developed its 'fleet' to support BSMHFT Services by adopting Plug in Hybrid and/or electric vehicles where it can, within costs and range permit.
- SSL has managed energy procurement on behalf of the Trust with 100% directly procured electricity from Zero Carbon sources.
- The B1 lease break has now been activated, with high level property negotiations underway, looking for Trust early exit from their lease obligations.
- SSL developed Sustainable Development Strategy & Action Plan (Green Plan) on behalf of Trust

Business Development, Opportunities and Plans

PFI Consultancy

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

ICB / BSol

- SSL is working with the ICB and the BSol trusts to identify potential services where trusts can collaborate and enhance services across BSol.

Training

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

Governance and Assurance

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

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix A – Financial Statement April 24 – Oct 24

SSL Financial Position	Annual budget	M7		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	15,095	8,806	8,952	147
Lease & Long License	3,135	1,829	1,949	121
Contract Management	2,071	1,208	1,188	(20)
Facilities Services	4,149	2,420	2,412	(8)
Grounds and Garden	399	233	166	(67)
PPE & Warehouse	166	97	200	103
Pharmacy	2,485	1,449	1,414	(35)
External Services - Primary Care	289	168	363	195
External Services - ICS Support	103	60	40	(20)
External Services - CCG Vaccine Pro	0	0	0	0
External Services - PFI	250	146	77	(69)
External Services - FM	40	23	28	5
Total income	28,181	16,439	16,790	351
Pay costs	(11,759)	(6,859)	(7,316)	(457)
Drug costs	(2,112)	(1,232)	(1,211)	21
Non pay costs	(8,114)	(4,733)	(4,773)	(40)
Clinical supplies costs	52	30	(10)	(40)
Total Expenditure	(21,933)	(12,794)	(13,311)	(516)
EBITDA	**6,248**	**3,645**	**3,480**	**(165)**
Depreciation	(2,886)	(1,683)	(1,657)	26
Interest Payable	(2,003)	(1,168)	(1,184)	(16)
Interest Receivable	0	0	0	0
Finance Lease	(369)	(215)	(223)	(7)
Profit / (Loss) before tax	**990**	**577**	**415**	**(162)**
Taxation	(380)	(222)	(177)	44
Profit / (Loss) after tax	**610**	**356**	**238**	**(118)**

SSL

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Mental Health
NHS Foundation Trust

Appendix B – 5 Yr Forecast and Benefits Statement

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

Appendix C: Dispensing Performance Community Teams

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

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

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

	Percentage Completed in Target Date/Time						
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Average
Compliance aid	96	95	97	95	96	97	96
Outpatient	95	97	98	97	98	98	97
Outpatient(urgent)	98	96	100	100	100	100	99
To-follow	100	95	99	98	99	96	98
Repeatable Prescription	97	95	97	96	98	97	97
Repeatable Compliance aid	96	95	97	95	98	97	96

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 February 2025**
Date(s) of Committee Meeting(s) reported	**23 January 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • Commissioning Board Assurance Framework • SSL Risk Summary • Internal Audit Progress Report • Internal Audit Action Tracking Report • Internal Audit Reviews: Medical Job Planning; Discharge Management; Key Financial Controls: General Ledger and Budgetary Control; Bank Staff Management Follow-Up • Local Counter Fraud Specialist Progress Report • Single Tender Waivers Report • Annual Report and Accounts Timeline 2024/25
Alert:	The Committee wished to alert the Board of Directors to the Annual Report and Accounts Timeline which set out deadlines for receiving draft and final versions for 2024/25. The Committee received assurance from the Company Secretary that work on the Annual Report had commenced, and review points had been included prior to final sign off in June.
Assure:	The Committee was assured on the following areas: • The Committee was fully assured by the positive assurance rating given to the **Key Financial Controls: General Ledger and Budgetary Control** internal audit review. • The Committee received assurance on the significant progress made from the positive follow-up review into **Bank Staff Management**, particularly noting that 21 out of 22 recommendations had been implemented. • Positive assurance was received on the action tracking report. Good progress had been made to respond and close recommendations in line with deadlines. Outstanding actions related to Complaints would be raised with the Executive lead. • Positive assurance was received through the Local Counter Fraud Specialist Report, highlighting good progress against plan and

	significant and proactive engagement with the organisation around fraud awareness.	
Advise:	The **Medical Job Planning** internal audit review had received a **partial assurance rating**. The Committee received an overview of actions and recommendations from the Medical Director and was satisfied with the plans in place to strengthen improvements. The Committee was encouraged by the advisory internal audit report into **Discharge Management**; challenges around Out of Area beds and the ongoing dedication to make significant and sustainable change were noted. Discharge management processes had potential to significantly improve performance and would continue to be overseen by the Finance, Performance and Productivity Committee.	
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 and would continue to mature. The Corporate Risk Register was received, and the Committee was encouraged by the progress made and by the process for reviewing and escalating risks through the Risk Management Group. Positive assurance was received on the SSL Risk Summary, and the Committee continued to note the development of the Commissioning Board Assurance Framework once the strategy was in place.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary