BOARD OF DIRECTORS MEETING PART I

Schedule	Wednesday 7 December 2022, 9:00 AM — 12:30 PM GMT
Venue	Plymouth Room, Uffculme
Organiser	Hannah Sullivan

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
Time: 09:00AM, WEDNESDAY 7th DECEMBER 2022
Venue: Plymouth Room,
The Uffculme Centre,
52 Queensbridge Rd, Birmingham, B13 8QY

Purpose and Ambition
The Board is accountable to the public and stakeholders; to formulate the Trust's strategy; ensure accountability; and to shape the culture of the organisation. The Board delegates authority to Board Committees to discharge its duties effectively and these committees escalate items to the Board, where Board decision making and direction is required.

Values
The Board will ensure that all its decisions are taken in line with the Values of the Trust: Compassion, Inclusive and Committed
Patient Story
Valerie Theay

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Apologies for absence & Declarations of interest	*Interim Chair*	09.30	*Verbal*	
2.	Minutes of the previous meeting		09.35	*Attached*	Approval
3.	Matters Arising/Action Log		09.40	*Attached*	Assurance
4.	Chair's Report		09.45	*Attached*	Assurance
5.	Chief Executive's and Director of Operations Report	*R. Fallon-Williams*	09.50	*TO FOLLOW*	Assurance
6.	Board Overview: Trust Values	*A. Baines*	09:55	*Verbal*	Assurance
7.	**QUALITY**				
7.1	QPES Chair's Assurance Report	*L. Cullen*	10:00	*Attached*	Assurance
8.	**PEOPLE**				
8.1	(a) People Committee Chair's Assurance Report (b) People Committee Terms of Reference	*R. Beale*	10:05	*Attached*	Assurance Approval
8.2	Quarterly Report Guardian of Safe Working	*S. Muzaffar*	10:10	*Attached*	Assurance
9.	**SUSTAINABILITY**				
9.1	(a) Audit Committee Chair's Assurance Report (b) Audit Committee Terms of Reference	*W. Weir*	*10:15*	*Attached* *Attached*	Assurance Approval
9.2	(a) Finance, Performance & Productivity Committee Chair's Assurance Report (b) Finance, Performance & Productivity Committee Terms of Reference	*R. Beale*	*10:20*	*Attached*	Assurance Approval

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
9.3	Integrated Performance Report - Front sheet Enclosure 1: Integrated Performance Report Enclosure 2: Overall October 2022 data	*D. Tomlinson*	*10:30*	*Attached*	Assurance
9.4	Finance Report Enclosure 1: Finance Report	*D. Tomlinson*	*10:40*	*Attached*	Assurance/ Approval
9.5	Trust Strategy Mid-Year Update	*P Nyarumbu*	*10:50*	*Attached*	Assurance
10.	**GOVERNANCE & RISK**				
10.1	Charitable Funds Committee Chair's Assurance Report	*W. Weir*	*11:05*	*Attached*	Assurance
10.2	Governance Task and Finish Group	*P. Gayle*	*11:10*	*Attached*	Approval
	Enclosure 1: Process to Select a Lead Governor & Deputy Lead Governor	*D. Tita*	*11:15*	*Attached*	Approval
	Enclosure 2: Appointment Process for Senior Independent Directors	*D. Tita*	*11:20*	*Attached*	Approval
	Enclosure 3: Governors Code of Conduct	*D. Tita*	*11:25*	*Attached*	Approval
	Enclosure 3a: Code of Conduct Everyday Behaviours Guide	*D. Tita*	*11:30*	*Attached*	Approval
	Enclosure 4: Process for receipt of a complaint against a Governor	*D. Tita*	*11:35*	*Attached*	Approval
	Enclosure 5: Process for Complaints received against Chair or Non-Executive Directors	*D. Tita*	*11:40*	*Attached*	Approval
10.3	Fit & Proper Persons Policy Enclosure 1: Appendix: Fit & Proper Persons	*D. Tomlinson*	*11:45*	*Attached*	Approval
10.4	Governance Action Plan: Six monthly Review	*D. Tomlinson*	*11:50*	*Attached*	Assurance
10.5	Move to Shadow Governance Arrangements for Lead Provider Responsibilities	*P. Nyarumbu*	*11:55*	*TO FOLLOW*	Approval
10.6	Board Assurance Framework	*D. Tomlinson*	*12:00*	*Attached*	Assurance/ Approval
10.7	Summerhill Services Limited (SSL) Business Report April 2022–October 2022	*S. Bray*	*12:10*	*Attached*	Assurance
10.8	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:15*	*Verbal*	-
10.9	Any Other Business *(at the discretion of the Chair)*	*Chair*	*12:25*	*Verbal*	-
10.10	**FEEDBACK ON BOARD DISCUSSIONS**	*Chair*	*12:30*	*Verbal*	-
11	**RESOLUTION** The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
12	**Date & Time of Next Meeting** 1st February 2023, 09:00-12:30		*12:30*	*Chair*	

A – Attachment ***V - Verbal*** ***Pr - Presentation***

At the Chair's discretion, there will be an opportunity for Governors and other visitors to ask questions on agenda items at the end of the meeting

Procedure for questions from the public at board meetings

The Board meetings are held in public rather than being public meetings: this means that the public are very welcome to attend but cannot take part. Nevertheless the Chair is happy to conduct a short question session at the conclusion of each board meeting held in public to respond to questions which have been raised by the public or members of staff at the meeting.

Questions

Members of the public, staff and governors are permitted to ask questions at meetings of the Board of Directors.

The Chair will invite questions at the end of the meeting.

Relevance of questions

Every question must relate to the items received or considered by the Board of Directors at the meeting.

Questions should not refer to or require discussion of confidential information, including personal information about any individual.

The Chair may interrupt to stop a question being asked where it is not relevant to the matters at the meeting or it discloses confidential information.

Notice requirements

There is no need for notice to be given to ask a question at the meeting. However, members of the public are encouraged to give notice of their question to the Trust Secretary by 12 noon on the working day before the meeting to enable a full response to be prepared.

Limitations on numbers of questions or time allowed

No member of the public may ask more than one question at any meeting unless the Chair allows otherwise.

There are no limits to the questions for Governors.

The time allowed for questions by the public and governors is limited. The Chair may curtail the time available for questions at his discretion.

Response to questions

Where possible a response to a question asked will be given at the meeting and recorded in the minutes. Where this is not possible a written response will be provided within ten working days, with the response being reported to the next meeting for information. If a question has been asked previously, the Chair may refer to the response recorded in the minutes rather than repeating the response.

1. Opening Administration:

Apologies for absence & Declarations of interest

2. Minutes of the previous meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	**BOARD OF DIRECTORS**
Date	**5th OCTOBER 2022**
Location	**VIA MICROSOFT TEAMS**

Purpose and Ambition
The Board is accountable to the public and stakeholders; to formulate the Trust's strategy; ensure accountability; and to shape the culture of the organisation. The Board delegates authority to Board Committees to discharge its duties effectively and these committees escalate items to the Board, where Board decision making and direction is required.

Attendance	Name and Title		
Present	Danielle Oum	-	Chair
	Roisin Fallon-Williams	-	Chief Executive
	David Tomlinson	-	Director of Finance
	Vanessa Devlin	-	Director of Operations
	Fabida Aria	-	Medical Director
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	Russell Beale	-	Non-Executive Director
	Linda Cullen	-	Non-Executive Director
	Philip Gayle	-	Non-Executive Director
	Anne Baines	-	Non-Executive Director
	Winston Weir	-	Non-Executive Director
In Attendance	Sharan Madeley	-	Company Secretary
	Tim Hamilton	-	Associate Director of Communications
	Jas Kaur	-	Head of EDI (item 9)
	Vanessa Wright	-	Deputy Director of Quality & Safety
Observers	Leona Tasab	-	Clinical Staff Governor
	Mustak Mirza	-	Service User Governor
	John Travers	-	Staff Governor
	Faheem Uddin	-	Service User Governor
Apologies	Sarah Bloomfield	-	Director of Quality & Safety (Chief Nurse)

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** The Chair welcomed Governors who were observing the meeting, along with representatives of the public.	
2.	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meetings held on the 29th June 2022 and the 27th July 2022 were approved as a true and accurate record of the meeting.	

Agenda Item	Discussion	Action (Owner)
3.	**CHAIR'S REPORT** The Board received an overview of the Chair's key areas of focus since the last Board meeting. The report detailed that the Chair had been on site visits to Northcroft and Brooklands where significant improvements have been made despite environmental challenges and workforce shortages, colleagues displayed a high level of commitment to patient centered care. The third session of '*Pull up a chair with the Chair'* had taken place and it was reported that to date there have been a wide range of issues discussed including organisational culture, progress on inclusivity, LGBTQ+ and ideas on improvements for patients. The overall feedback from staff has been very positive and sessions have now been booked up until December 2022. A review of the initiative will be completed after this time and feedback through the People Committee. The report was received and noted.	
4.	**CHIEF EXECUTIVE'S AND EXECUTIVE DIRECTOR OF OPERATIONS REPORT** R. Fallon-Williams presented the Chief Executive and Director of Operations report. The recent BBC Panaroma programme was highlighted regarding the Edenfield Unit in the North West. The Executive Team had met to discuss the programme and discussions were being held with Matrons of inpatient services. The areas being reviewed would be discussed further at the Quality, Patient Experience and Safety (QPES) Committee. The Trust has ensured that families were aware of how to contact the Trust if they had any concerns. Local services were planning to establish reflective events and wider reflective events would be undertaken across the Trust. A week prior to the airing of the programme, the QPES Committee had already discussed an increase in assaults and seclusions, particularly concentrating on the learning from the restrictive practice collaborative. In addition, the Trust was also reviewing the areas that were yet to engage with the restrictive practice collaborative. The Executive Team had taken the decision that there was an expectation that all areas would be required to engage with the quality improvement programme. The Trust would be looking at the levels of harm and the experiences of staff to identify which areas needed to be engaged in this work. The Trust was seeking additional assurance on the issue of falsification of records seen on the programme. One assumption was that because observations were taken digital, these could not be amended. The team has asked Kathryn Allen to look into how the Trust could commission experts by experience to undertake a piece of work on the experiences of inpatients. The Trust has received a letter from Clare Murdock, national Lead for Mental Health, which sets out elements of work which the regulator was expecting the Trust to undertake, which the Trust was already addressing. R. Fallon-Williams stated that in relation to the programme, it was important to ensure that staff were reminded how they could access wellbeing support. In addition, stressing the importance of staff sharing their concerns and how this could be undertaken.	

Agenda Item	Discussion	Action (Owner)
	It was reported that during October the Trust would be celebrating Black History Month UK as a platform for the whole community to share their stories in their own words. In addition, it was also Freedom to Speak Up Month. The Board was informed that Steve Forsyth would joining the Trust on an interim basis as the interim Director Quality & Safety. It was reported that the Trust was in the process of reviewing business continuity regarding any potential strike action. There would be a lengthy discussion at the afternoon Board session on the mental health provider collaborative to understand the opportunities and risks for the Trust. The Board received two additional supporting papers which included the Solihull Metropolitan Borough Annual Report was published. The report showcased case studies from around the borough which illustrated the progress in implementing the Council Plan priorities. It was noted that the second ICB meeting was held in September and discussions included the BSoL Mental Health Provider Collaborative and delegation process. The draft Health Inequalities Strategy would be taken forward through wider engagement and consultation. R. Fallon-Williams highlighted that BSMHFT hosted the Jabali Men's Network celebration this month. The network was launched in February 2020 for men in nursing from African, Caribbean, and Asian heritage at band 8C and above to ensure greater diversity in our workforce at the most senior levels. This was chaired by Patrick Nyarumbu, our Executive Director of Strategy, People and Partnerships. R. Fallon publicly thanked and commended staff for all they did regarding the death of a member of staff with colleagues currently being supported. V. Devlin reported that within community mental health team and Community Transformation, further work had taken place across all experts by experience (EBE) groups connected with the community transformation programme. EBE groups have now signed off on a suite of service user communications including digital screens, posters, leaflets and pull up banners for sites. The report was received and noted.	
6.	**BOARD OVERVIEW TRUST VALUES** L. Cullen provided the Board with an overview of how Trust values were seen in operation during the month L. Cullen reported on site visits undertaken which included Community, Older Adults, Inpatients Services and Psychological Services which support University Hospital Birmingham. L Cullen was struck by how passionate staff were in seeing patients recover and do well. All staff have reflected on the last two years and how they have adapted to new ways of working. Staff were discussing demand and the complexity of patients being seen and how important system working was to address these issues. There was a specific example highlighted during the visits within the Older Adult Service.	

Agenda Item	Discussion	Action (Owner)
	This related to how they had identified that BAME patients were presenting late with symptoms and have piloted an on-line tool, which was a self-reporting tool, which had no cultural bias. There had been excellent communication within the Trust following the Panorama programme and looking at the emphasis on Freedom to Speak Up and ensuring staff were supported to solve problems that may arise. The Chair thanked L. Cullen for the overview.	
7.	**QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE CHAIR'S ASSURANCE REPORT** The Board received the assurance report from the Quality, Patient Safety and Safety Committee following the meeting on the 21st September 2022. The Committee received an update on the Care Quality Commission (CQC) Improvement Plan and was assured that CQC was satisfied that the Trust remained on track with improvement plan. The Committee received an update on the new CQC reporting framework which had a strong focus on patient safety through learning by means of an inclusive culture that focusses on what matters to patients and families and communities. The governance team were reviewing how the Trust remained compliant with new standards. In addition, the Committee was informed that the Trust has received the final report for the CQC Unannounced inspection which took place in June 2022 on Meadowcroft. The Committee was assured that actions have been underway since the first week of the visit by the CQC to address the remedial actions necessary and a report was to be sent to the CQC this week. The learning from this inspection was being developed to use in audits to review all other ward areas . These audits would take place at least monthly and there were plans to make real time data immediately available to further strengthen assurance. R. Fallon-Williams stated that what was seen in the programme was a dysfunctional culture and an abuse of power. The real triangulation needed to be through a cultural lens, ensuring a safe place for staff to raise concerns; this would commence through the induction process reminding staff they were able to safely share their experiences. A report was received regarding a review into seclusion, with the plan for a more detailed analysis of seclusion which would include individual characteristics, reasons for seclusion, ward areas, ethnicity, workforce capacity and skills . There will be a comprehensive report presented at a future committee meeting. The committee received a detailed report relating to serious incidents and work was ongoing to review trends, particularly analysing underlying health inequalities. The monthly report on quality metrics was received which indicated an increase in incidents of self-harm and physical assault which were of concern to committee members. The committee was informed of anecdotal clinician feedback noting an increase in suicide of patients in their clinical practice.	

Agenda Item	Discussion	Action (Owner)
	It was reported that it was well known that social hardship and economic depressions could lead to an increase in population suicide rates. Executives agreed to raise these concerns within the organisation to raise awareness, and stress the importance of early recognition and intervention, signposting and working with partners. It was noted that work was underway to review the format of the quality report and how data was analysed and presented. The Committee was pleased to note that deep dives have commenced into selected services reviewing performance, people, finance and quality issues and these have led to reports with clear action plans. The Chair thanked L. Cullen for the detailed report.	
8.	**PEOPLE COMMITTEE CHAIR'S ASSURANCE REPORT** P. Gayle reported that in relation to the key performance indicators, The committee were informed that given the increase in establishment no assurance could currently be provided on reaching the 6% target in the next two quarters, despite efforts to fill these roles. The Committee was still not assured with the effectiveness of the e-rostering process, but reassurance was given that a comprehensive paper would be brought next month to the People Committee. In relation to fundamental training, the committee were pleased with the improvement made but reassurance and not assurance could be given as we have yet to achieve our target and we need to sustain the improvement that we have seen. The Committee discussed the sickness rate and assurance could not be given that this slight decrease was likely to be sustained given the approach to the winter period. There would likely be an increase over these months, but the Committee was informed that work was ongoing to reduce the long-term sickness and short-term sickness absence through HR colleagues and managers which has resulted in a downward trend over the past few months although the Trust was not meeting the target. The committee was updated on the work converting locum doctors to permanent staff and was unable to receive assurance at this stage as the sub-committee would be receiving an update on progress at their December 2022 meeting. A report was received on the organizational values and it was accepted that the Trust still had work to undertake to eradicate some long-standing cultural issues within the Trust. The committee noted the WRES/WDES report and commended J. Kaur and her team on the presentation and content of the report. The committee recognised the work that has been done to date. There was an acknowledgement that we can see green shoots of improvements which was encouraging. Nevertheless, the committee noted the Trust needed to sustain the improvements. D. Oum stated that when Committees were not assured in specific areas, Committees did need to seek specific clarification regarding what was required to address the assurance issue.	

Agenda Item	Discussion	Action (Owner)
	P. Gayle stated that the Committees would need to take a different approach on areas where it was clear targets could not be met because of specific issues. D. Tomlinson added that there were two issues regarding a) impact and the (b approach and plan which would be helpful for all Committees to review. For example, Impact (i.e. were things changing and were they likely to achieve target and Approach (i.e. does the Committee feel confident that the plans to address performance were robust and adequate) ***DECISION: All Committee Chairs would review how assurance to the Board was presented***.	*Committee Chairs*
9.	**EQUALITY STANDARDS REPORTING 2022** P. Nyarumbu introduced the report on equality standards reporting for 2022 adding it was important that the momentum was maintained. J. Kaur attended the meeting and reported that the item outlined the Trusts current position relating to the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard. The Board received a detailed presentation on the Workforce Race Equality Standard 2022 where it was reported that our black and minority ethnic workforce representation was 37.6% and in 2022 a small increase was reported at 37%. In relation to career progression, 41.2% of black and minority colleagues believed that the Trust provided equal opportunities for career progression as opposed to 53.7% of white colleagues. It was noted that all colleagues experienced less harassment, bullying or abuse from patients, relatives or the public compared to 2021. Board Member ship was at 53.8% of white colleagues and 38.5% black and ethnic colleagues with 7.7% unknown ethnicity. It was noted that 5.56% of colleagues across the Trust have reported a long term condition or illness. Colleagues with disabilities were now equal to those without disabilities to enter the capability process (reached equity). The next steps included reviewing and monitoring the disciplinary practices to ensure they were inclusive; to develop and implement an anti-racist framework; identify barriers to career progression for underrepresented staff; ensure the visibility of EDI team across the Trust, hold Data with Dignity Sessions and improve ESR reporting. The report and data have been presented at the Transforming Culture and Staff Experience Sub Committee and People Committee. The Chair thanked J. Kaur for the detailed presentation.	
10.	**FINANCE, PERFORMANCE AND PRODUCTIVITY COMMITTEE CHAIR'S ASSURANCE REPORT** R. Beale presented the Committee assurance report stating that the Committee was assured that, owing to balance sheet adjustments available, that the Trust would be on plan by the end of the financial year, but the slippage on items is noted and of some concern. Other cost pressures were understood and managed appropriately.	

Agenda Item	Discussion	Action (Owner)
	The Committee was not, however, assured of a pipeline of savings schemes and felt that there needed to be more emphasis put on transformative change in order to achieve the cost savings needed. In relation to the integrated performance report, the Committee has asked for further detail on the out-of-area bed improvement plans – these were expected to reduce OoA to near-zero by the end of the year but the Committee sought further assurance on this. The Digital Strategy, Improvement and Assurance report was received, and the Committee was delighted with the range and scope of activities presented, and was assured that the policies and internal processes were appropriately secure, resilient, and offering some improvements. However, there was to be more discussion on the role of digital when transformation was to be discussed in an upcoming meeting. The issues remained significant: no effective strategy for clinical engagement, which needed to be identified and drive the change. Many projects had stalled, and there was yet no evidence that clinicians at the different levels were seeing this as part of their remit. Without engagement there could be no effective transformation, and without that the Trust could not deliver the services needed to at the scale demanded within the budget. Therefore, this was a significant risk, and has remained so for a long period. The Reach Out Commissioning Sub Committee report was received. The CQC reported an unsatisfactory rating for Brooklands and this has not improved since the last report. The Committee remained to be assured that programmes of improvement would have the desired effect. The Chair thanked R. Beale for the report.	
11.	**INTEGRATED PERFORMANCE REPORT** The key issues for consideration at the Board Committees this month included Discussions at Finance, Performance & Productivity Committee regarding Out of area bed use; APT, CPA 12-month reviews, new referrals not seen, financial position and CIP. At the People Committee it was vacancies, sickness, bank and agency fill rate and at Quality, Patient Experience and Safety Committee risks due to waiting times. There was discussion at FPP in June regarding fitness for purpose of the report and it was agreed that the approach used in directing the attention of the Committee to relevant areas of concern was good. There was, however, concern about a lack of transparency around improvement plans with no information regarding how the Trust was doing against improvement trajectories. This area has been fed back to the relevant Associate Directors via the Performance Delivery Group (PDG) where it was agreed that relevant service areas would provide additional feedback and detail on the improvement plans. At the September 2022 PDG, the meeting was focused on the key metrics highlighted by FPP Committee with discussions focusing on identifying improvement plans and highlighting any challenges and area for further support. This has been led via the relevant Service Associate Directors and updates received from them have been included in the report. These relate to Service users on CPA with a formal review in the last 12	

Agenda Item	Discussion	Action (Owner)
	months; IAPT waiting times; Out of Area bed days and referrals over 3 months old with no contact The report was received and noted.	
12.	**FINANCE REPORT** The month 5 Group position had a deficit of £1.3m, this was £1.3m adverse to the break-even plan as submitted to NHSE on 20/6/22. The position comprised of a £1.6m deficit for the Trust, a £36k deficit for Summerhill Services Limited (SSL) and a £104k surplus position for the Reach Out Provider Collaborative. The month 5 Group deficit position was mainly driven by slippage on savings delivery and continuing out of area and staffing pressures. The cash position for month 5 was £69.6m. D. Tomlinson stated that it financial balance was expected at the end of the financial year. The ongoing position was of a concern. There were timing issues relating to the pay award that were also factored in. There was detail on the temporary staffing expenditure and the volume of bank was significantly higher than agency. Agency was mainly dependent upon the medical staffing side and there were a number of significant expense which was being reviewed by the Medical Director. The month 5 Group capital expenditure was £0.4m, which is £1m less than year to date plan and was below the submitted trajectory. This was because the trajectory was submitted before the cash flow was firmed up. The Capital Review Group had been reviewing the spend and the plans for the capital programme would be available before Christmas.	
13.	**BOARD ASSURANCE FRAMEWORK** D. Tomlinson presented a report to the Board on the development of the Board Assurance Framework. The current BAF was agreed by the Board in early 2021 and last received by Board in Committees in February 2022. This had recently been reviewed and refreshed it and some proposals have been developed regarding the way forward, including better linkages to strategic priorities and ongoing review processes. The report was seeking approval in principle to take an updated report to individual committees in October and then present to Committees on a quarterly basis. It was noted that role of the Audit Committee was clearly documented within the Risk Management Policy. The BAF was around risks to the delivery to the strategic objectives. It was reported that a Risk Management Group was being introduced at Executive level to review risk processes and scoring and would inform the updates being presented to the Committees. During the course of the month the risks would be reviewed by the Executive Team and a Board development session would be held on the various risk appetite statements. There would also be a requirement for a Board Assurance Framework for the commissioning arm of the Trust. W. Weir said that the report was helpful in seeing how the strategy linked to the work of the Committees and that the heat maps were helpful.	

Agenda Item	Discussion	Action (Owner)
	R. Fallon-Williams stated that as a Board we need to make sure the BAF was a dynamic document and linked to the strategy and the Board was assured through focus and attention that the risks were appropriately mitigated and the scores were improving. In relation to a separate commissioning BAF, D. Tomlinson said it was important that there was two perspectives as it would be confusing if the BAFs were not separate for provider and commissioner. ***DECISION: (a) The Board of Directors discussed and agreed the context to the paper.*** ***(b) The Board approved for short-term use the refreshed provider Board Assurance Framework*** ***(c) The Board noted he establishment of a Risk Management Group, to be co-chaired on rotation by the two Assistant Directors of Governance. The Group's first tasks will be to refresh the Risk Policy, and to provide a detailed roadmap for a change in culture and behaviour*** ***(d) The Board approved the proposal to develop a separate Commissioning BAF. This needs to be co-produced by the Board and would ideally be the subject of a dedicated board development session as a follow-on from 5 October.***	
14.	**USE OF TRUST SEAL** The report was presented to the Board for information regarding the application of the Trust Seal from June to September 2022 and was received and noted.	
15.	**QUESTIONS FROM GOVERNORS AND PUBLIC** Leona Tasab, Staff Governor, raised the issue of when staff were receiving abuse from patients in relation to zero tolerance. R. Fallon-Williams said that the Tryst had to change the culture regarding how the Trust responded to issues of concern. V. Devlin said that conversations were being held regarding being proactive regarding the expectations of patients with notices placed within Community Hubs. D. Oum said that colleagues heard the importance of the points raised by L, Tasab with the understanding that more needed to be undertaken. M. Mirza thanked Dr Aria for attending her first Board meeting as Medical Director.	
16.	**ANY OTHER BUSINESS** There was no further business raised.	
17.	**FEEDBACK ON BOARD DISCUSSIONS** W. Weir provided feedback on the discussions held at the meeting, ensuring discussions were held in line with the Trust Values. This commenced in discussing the Panorama programme with the Chief Executive providing a detailed explanation of the actions being taken by the Trust. V. Devlin talked about the involvement of the Experts by Experience within	

Agenda Item	Discussion	Action (Owner)
	reviewing services. L. Cullen spoke about compassionate leadership and the small acts of kindness, and it was important to hear about the visits made to services. There had been a good discussion regarding the areas debated at People Committee along with the presentation of the WRES and WDES information and the actions being taken by the Trust. The meeting covered a huge amount of ground and the compassion shown for patients and services users were at the center of all discussions. A. Baines said that the conversations at the Board were really open and felt like the Board was working as a team addressing the issues and thanked Board colleagues for their contributions at the meeting. L. Tasab said that there were strong governance processes in place along with respectful challenges and it was important to ensure that the discussions held at the Board of Directors were fed back to colleagues on the shop floor. F. Aria expressed her gratitude for the welcome and the sense of belonging at the meeting.	
18.	**RESOLUTION** The Board asked that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.	
19.	**DATE & TIME OF NEXT MEETING** • 09:00am • 7th December 2022	

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS – DECEMBER ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
June 2022 Minute 2	Service User Story The Quality, Patient Experience and Safety Committee to review the themes raised in the Patient Story relating to services for patients with autism including the inpatient environment; individual care packages and communication between teams and the communication between inpatient care and community mental health teams. To report back through the Chair's Committee Assurance Report to the Board of Directors.	L. Cullen/S. Bloomfield	November 2022		
July 2022 Minute 20	The issue of job planning and to be discussed in the Quality, Patient Experience and Safety Committee.	L. Cullen	November 2022		An update would be provided on job planning compliance at the November QPES Committee meeting

RAG KEY

Overdue
Resolved
Not Due

4. Chair’s Report

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	7 December 2022
Author	Phil Gayle, Chair
Executive sponsor	Phil Gayle, Chair

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

Executive summary & Recommendations:

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

Reason for consideration:

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

Previous consideration of report by:

Not applicable.

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

Select Strategic Priority

Financial Implications *(detail any financial implications)*

Not applicable for this report

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

Not applicable for this report

Equality impact assessments:

Not applicable for this report

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

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

CHAIR'S REPORT TO THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 Our vision is simple in that we are here to "*Improve mental health wellbeing*". I deliberately open with this statement, grounding this report in our core purpose.

1.2 Our values of compassion, Inclusive and Committed describe our core ethics and principles. They help guide our culture by inspiring people's best efforts and constraining unwanted actions that do not align with our values.

1.3 I am pleased to offer a brief report to the Board giving an overview of my key areas of focus since the last Board meeting with my intention to provide a regular update at each Board meeting.

2. CLINICAL SERVICES

2.1 A full schedule of site visits are now in place to enable members of the Trust Board and members of the Council of Governors to visit all sites over the coming months.

3. PEOPLE

3.1 I am pleased to confirm the 'Pull up a chair with the Chair's fourth session has taken place. To date there have been a wide range of issues discussed including organisational culture, progress on inclusivity, LGBTQ+ and ideas on improvements for patients.

The overall feedback from staff has been very positive and sessions have now been booked up until December 2022. A review of the initiative will be completed after this time and feedback and analysis of this iniative will be reported through the People Committee.

The schedule of sessions will continue as planned with support from Freedom to Speak Up Guardians.

I am pleased to have arranged introductory meetings with my Chair colleagues from Healthwatch Solihull. I look forward to being able to agree the priorities for the future.

I have held my first initial meeting with Professor David Sallah from Birmingham Community Healthcare NHS Foundation Trust and we have agreed to continue to meet on a regular basis. I have arranged an introductory meeting with Sir Bruce Keogh, Birmingham Women's and Children's Hospital Chair and with Tim Pile, from The Royal Orthopedic Hospital NHS Foundation Trust. I look forward to being able to continue the close working relationships.

I also had a meeting with Shane Bray, Managing Director of Summerhill Supplies Limited, to gain a greater understanding of the current arrangements and the priorities for the future.

4. QUALITY

4.1 I was pleased to be able to join the fourth development session with NHS Providers has taken place with a focused discussion on clarity of roles.

5. SUSTAINABILITY

5.1 I am pleased to confirm the Governor elections are now closed and newly appointed Governors have attended their first Council of Governor meeting and they will be engaging with Trust Board and Council colleagues over the coming weeks.

5.2 I am pleased to confirm the interviews and appointment for a Non- Executive Director and Designate Non- Executive Director were successful and both successful candidates will be joining the Trust in the coming months.

5.3 I was pleased to Chair the Council of Governors meeting in November where we held detailed discussions on processes developed by the Task and Finish Group.

PHIL GAYLE
CHAIR

5. Chief Executive’s and Director of Operations Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	7 December 2022
Author	Vanessa Devlin and Roisin Fallon-Williams
Executive sponsor	Roisin Fallon Williams

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

Our report to the Board this month provides context on our move to 'living with COVID 19' and. provides information on our areas of work focused on the future and other information of relevance to the Board, in relation to our Trust strategy, local and national reports and emerging issues.

Reason for consideration

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

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability. Quality. Clinical Services. People

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

CHIEF EXECUTIVE and DIRECTOR of OPERATION'S REPORT

COVID 19

We have moved to new Infection Prevention Control (IPC) guidance which includes the non wearing of masks in all settings except in specified and particular circumstances eg where there is an outbreak.
We have a well developed plan in place for responding to potential and actual outbreaks and we continue to offer the COVID 19 booster across our sites to both service users and colleagues.

PEOPLE

Organisational Development
People Committee
A paper was submitted to the November People Committee providing information and interpretation on how staff who are subject to the organisational change process have experienced the process. This report provided valuable insight into the strengths and areas for development within our current organisational change arrangements, and the People and OD Department have committed to reviewing our current policy as a response to this feedback.

Project Flourish
Project Flourish, our evolving talent management programme for our disabled and Black, Asian, and Minority Ethnic colleagues, has progressed within its cross team working party set up to support equitable access to development and growth, whatever that looks like for them to flourish, in the form of support, resources and tools. It is intended to engage with the wider workforce regarding this piece of work in January 2023.

Strategic Workforce Planning
Strategic Workforce Planning has been a key feature of our work during the month of November. The Workforce and Analytics Team have worked together to map our all recruitment and retention activities that are in place within the Trust, and will be engaging with the Senior Leadership Team during December to receive feedback on the current activities and how we can embolden them to enable the Trust to better meet its current workforce supply and retention challenges.

Cost of living
The Trust continues to establish both independently and with system partners approaches to support colleagues (and Service Users) with the impacts of the cost of living emergency. These include a further increase in mileage rates, highlighting opportunities for discounts, considering options for colleagues to sell annual leave (as we offered last year) and a commitment to use an organisation called Wagestream that will allow colleagues to draw down some of their salary in advance of the usual monthly payroll.
The Wellbeing Steering Group continue to meet, taking on board proposals and ideas that are shared with them on an on going basis, for example they are currently looking at the logistics and viability of establishing Pantry's at our sites.

Industrial Action Planning and Ballots

The Trust received information that BSol will lead on Emergency Planning activities on the 15 and 20 December 2022; the dates identified by the RCN on which they will enact their mandate for industrial action. Senior leaders are engaging with BSol colleagues to understand if there will be any implications for patients, service-users and staff.
Within BSMHFT, both the RCN and Unison balloted members to ascertain whether they would support industrial action. Both unions did not achieve the two tests that would have provided them with a mandate for industrial action within BSMHFT. The results of both ballots are as follows:

Royal College of Nursing

Number of individuals who were entitled to vote in the ballot 938
Number of votes cast in the ballot 406
Votes cast in the ballot as a % of individuals who were entitled to vote 43.28%
Question; Are you prepared to take part in strike action?
Number of spoilt or otherwise invalid voting papers returned 0
Result of Voting
Yes 386 95.07%
No 20 4.93%
“Yes” votes as a % of individuals who were entitled to vote 41.15%

Unison

Question: Are you prepared to take part in strike action?
Number of individuals entitled to vote: 1178
Number of votes received: 354
Yes: 318 90.86%
No: 32 9.14%
Number of spoiled or otherwise invalid vote papers returned: 4
Whether or not the number of votes cast in the ballot is at least 50% of the number of individuals who were entitled to vote in the ballot: No
Whether or not the number of individuals answering "Yes" to the question is at least 40% of the number of individuals who were entitled to vote in the ballot: No
Question: Are you prepared to take part in industrial action short of strike?
Number of individuals entitled to vote: 1178
Number of votes received: 354
Yes: 318 94.08%
No: 20 5.92%
Number of spoiled or otherwise invalid vote papers returned: 16

CLINICAL SERVICES

Summary

The post pandemic period has presented service areas with challenges in particular in terms of filling staff vacancies. Innovative and creative solutions have been considered with attractive offers and benefits of joining the Trust also now a feature. Despite these challenges colleagues are committed to delivering as high quality services as possible, always aiming for as easy access as achievable for all service users. The following report is a high-level summary of the activities of each service areas over the past couple of months.

Acute and Urgent Care

Workforce Updates

Staffing across the directorate continues to be a challenge coupled with the high levels of patient acuity. However, there are various efforts being implemented to help address these issues. For example,

- Acute care is now piloting the use of Medical Support Workers.
- Recruitment for other posts including diverse roles for the North pilot is progressing well,
- Assistant Psychologists have started working on the wards.
- A part-time Consultant Liaison Psychiatrist has been appointed to the City Hospital.
- The third room at the Place of Safety is functional and there is an ongoing campaign to recruit staff to enable optimal utilisation of our Psychiatric Decision Unit.

-We have drawn up a co-produced A&UC staffing action plan that has involved scheduled focus groups and questionnaires.

Clinical Updates

-The Reducing Restrictive Practice Plan has started on Meadowcroft, and this will help improve the patient journey.

-The first stage of the plan to amalgamate the bed management processes with Forward Thinking Birmingham (FTB) commenced last month.

- Efforts to identify and address potential obstacles in referring patients to beds at the Crisis House that remain underutilised are still ongoing.

-Several GP trainees' posts across the acute inpatient wards will become vacant leaving a potential clinical risk. The Clinical Director is working with the relevant teams to mitigate risks by bringing in locum doctors.

Care Quality Commission (CQC) updates

Verbal feedback received by CQC acknowledged the compassion shown by staff during the provision of care as well as the good local management systems in place at most sites.

Integrated Community Care and Recovery (ICCR)

ICCR community services are all undergoing transformation and growth, inclusive of: CMHT, addictions, homeless services, Community rehabilitation, Early Intervention Services and Solar CAMHS. This is welcomed and very positive investment into our community mental health services. Despite additional challenges to capacity to deliver on new investments and expectations, all services are delivering in accordance with plans.

In addition to transformation and growth plans in ICCR all services are focused on quality assurance projects that include readiness for regulatory inspections, waiting time initiatives, digital support projects and a focus on improving our service user experience. We are working towards increasing the uptake of the Friends and Family Test (FFT) as well as working on the outcomes of this year's community patient's survey.

Our Inpatient wards are focusing on reducing restrictive practice and building on and enhancing our recovery focused offer of care.

On a celebratory note, Our Early Intervention Service have won 'Team of the year' awarded by the Royal College of Psychiatrists. Our Solar Eating disorder Team Manager has developed a series of case studies that have been picked up and shared by NHS England & Improvement. One of our Nurses has been honoured with the prestigious queens nursing award. We are very proud of all of our teams' achievements.

Secure Care & Offender Health (Scoh)

These services continue to experience significant RMN shortages across the men's and women's services impacting on clinical activities. Ward managers and CNM/Matron's meet daily on each site to prioritise work and assess shortfalls. Sites offer support by sending staff to ensure there is at least 1 RMN on each ward. Ward Managers and Matron's work within approved staff numbers where necessary, and Occupational Therapy/Psychology is being utilised to support activities on the wards. All Ardenleigh wards are being managed safely.

There are capacity issues across our FIRST service due to medical gaps, with Community Psychiatric Nurses at capacity. FIRST is combining resources with Reach Out to assist with this gap.

HMP Healthcare, are also impacted by staff shortages in Birmingham Community Healthcare which impacts trust wide. Funding is being provided from Birmingham Community Healthcare to BSMHFT to recruit senior pharmacy technicians to support team gaps.

The Tamarind service will be celebrating today the anniversary of its opening with a number of events on the site involving colleagues, partners and service users.

Specialties

Dementia and frailty inpatients

Workforce updates

Nursing roles at Band 5 vacancies remain an area of focus. The service at Juniper is part of the international recruitment programme in the New Year and working to include additional supportive roles.

Delayed Transfers of Care have increased significantly mainly due to complexities of service users and limited places available to meet their needs. We are working closely with our Social care colleagues on addressing these.

Jasmine - Patient numbers remain low. Currently working through options to utilise beds for non-deaf patients should bed occupancy remain low. Consideration of the implications via a Clinical Quality and Equality Impact Assessment (CQEIA). The new Clinical Development Lead will focus on promoting the service across the region to ensure all deaf patients requiring beds in the region are being given access to the ward.

Neuro /Video Telemetry service – we have seen an increase in the number of patients in the service. One of our Occupational Therapist has recently presented at an international conference in Colombia on work done within the service to help patients with Huntington's Disease.

Older Adult Community Mental Health Teams (CMHTs)

Our Community transformation work continues and remains on track..

The high levels of acuity and increased numbers of people in crisis being managed in the community is impacting on the numbers needing admissions, the teams are working together to prioritise and manage risk.

Birmingham Healthy Minds (BHM)
Our work with the university educators grows from strength to strength as we continue to recruit both high and low Intensity Cognitive Behavioural Therapy trainees. Thank you to our Project Management and Communications Team for their support which enabled us to complete develop our recruitment pack. A task and finish group has been established to address the waiting lists challenges in addition to the service wide recovery action plan and four out of six of our GP walk-ins have now recommenced.

Bipolar Service
We are being asked more frequently by higher education institutions and other mental health providers to offer training in psychological interventions for bipolar conditions, as the Trust is viewed as a gold-standard and innovative service with a long history (over 30 years) of quality psychological care for this client group. We therefore plan to undertake this and aim to licence our materials for use by other services in 2023.

MERIDAN Family Programme
The new Deputy Head of the programme commenced last month has had a positive impact on the team. We have started involving affiliated trainers in the delivery of Health Education England (HEE) FI training.

Veteran's Service
Veterans' services are working closely with our partners in Lincolnshire and Coventry to plan team away days across the Midlands to ensure staff and patients are involved in the Older People clinical model discussions to ensure staff engagement.

SUSTAINABILITY

Funding
Additional funding for the NHS and social care was announced by the Government as part of the recent Autumn Statement. We await the detailed planning guidance but expect mental health commitments to be maintained. Early indications suggest that we will continue to see pressures next year as well as significant challenges around efficiency.

ICB update
Further changes to the leadership arrangements at University Hospitals Birmingham NHS Foundation Trust (UHB) and NHS Birmingham and Solihull Integrated Care Board (ICB), have been announced in month.

Harry Reilly, currently Interim Chair of University Hospitals Birmingham, will step down from the role on 30 November 2022.

Dame Yve Buckland, current Chair of the ICB, will become Interim Chair of UHB on a short term basis.

Patrick Vernon, the ICB's current Non-executive Director for Inequalities and Vice-Chair, will become Interim Chair of the ICB.

David Rosser has announced his departure From UHB to undertake a new system role in the new year, leading on digital development.

West Midlands Provider Collaborative
Governance

A Memorandum of Understanding (MoU) agreement now has been drafted and will be reviewed and approved by the Provider Collaborative Executive Board on 9th December 2022; this will then be discussed by each Trusts Board for agreement, with a view to the MoU becoming effective from April 2023.

Priority Development Areas

The Collaborative Partners have agreed that, supported by Collaborative colleagues, each priority area will be owned by one of the Trusts and their Director of Strategy who will be accountable to the Provider Collaborative (PC) Executive Board, reporting progress and providing assurance for delivery. Proposals for each priority area will be developed and shared with the Collaborative Executive Board for approval to begin work over the next few months.

Priority 1- Development of an All-Age West Midlands MH and LDA Strategy- The strategy will be underpinned by co-production, population health needs, review and alignment of local priorities sources across all partners and will bind organisational strategies together to make the impact greater across the West Midlands. The development of the strategy will run from Dec 2022 and will align with the new ICB strategies and the National Operating Plan publication, and be finalised in April 2023.

The data and evidence gathered during the population health analyses will support the development of subsequent strategies, such as regional bed strategy, community CAMHS approaches, as well as informing other priority programmes to co-produce at scale solutions.

Priority 2- Regional Bed Strategy- The focus will be to understand demand and capacity for locally commissioned services, to determine capacity and challenges impacting on local systems and assess opportunities for joined up approaches to address these capacity challenges, and identify areas where there is potential to improve quality and/or value for money. It is anticipated that the development of the local capacity will remain within the remit of the Lead Provider and Provider Collaborative Boards. A detailed programme proposal will be developed in February 2023 to initiate the project across all Trusts.

Priority 3- Community CAMHS Pathways Improvement- The focus will be on those services where there is an increased demand from children and young people with complex, acute and high levels of needs. The investigative stage will aim to achieve insight into why other CYP and CAMHS pathways are not effectively managing the need of these cohorts of patients, and consider future demand for adult services. This programme will run in alignment with the Regional CAMHS Tier 4 Provider Collaborative to ensure alignment between pathways. A detailed programme proposal will be developed in February 2023 to initiate the project across all Trusts.

Priority 4- Increase of Supervision Capacity for Psychological Therapies- A Hub model has been agreed for implementation across the West Midlands. Trust leads are working together to define the operating model, standards for delivery and undertaking capacity requirement exercise. Following the completion of the demand exercise, it is intended to hold a market engagement event with providers to secure additional supervision capacity to be utilised across all Trusts.

Priority 5- Clinical Support Worker Role Development Framework- The focus of the Programme is to develop a competency framework and an accompanying career progression scheme for those non-qualified staff (band 2 to 4) working in clinical environment, and a suite of training and development programmes (induction and retention) to equip support staff with softer and clinical skills. A similar Programme has been successfully trialed in East Midlands region, and an external provider has been identified as a delivery partner. The proposal outlining the delivery approach, seeking approval will be presented to the Provider Collaborative Executive Board on 9th December.

Other Developments

Regional Psychological Therapies Forum– Trusts Chief Psychological Professional Officers (CPPOs) have agreed to establish a Strategic Forum to develop consistent approaches in the planning and delivery of psychological therapies and support the development of effective workforce planning across the West Midlands. The Forum will provide steer in strategic developments and governance framework to discuss key issues with a view to formulating recommendations to be considered by the Provider Collaborative Executive Board, and subsequently for approval by each Trust.
Staff Mental Health and Wellbeing Hubs- The Trusts across the West Midlands have established mutual support arrangements, and recently shared their challenges in securing recurrent funding as the national funding of the Hubs are ending. Each Trust is reviewing demand and capacity data to engage in discussions with their ICBs to determine ongoing funding. A meeting is taking place in December amongst Trust colleagues to share local pictures and develop a consistent response and approach. A discussion is scheduled at the Provider Collaborative Executive Board in January 2023 to determine how Trusts can best support ICB discussions in securing funding, and what alternatives and options could be considered.

Regional LDA Complex Care Advisory Panel- The recent rise in complex LDA placement discussions between ICS colleagues and Trusts highlighted a gap across the region in bringing together clinical expertise to assess and agree needs and how resources can be used collectively. Discussions are underway with all West Midlands ICBs and LDA Trusts to introduce the Panel in early 2023.

NHS England Specialised Commissioning Delegation- NHS England previously shared its intention to devolve specialised mental health and learning disability and autism budgets to ICBs from 2024 onwards. The West Midlands Provider Collaborative is engaging in discussions with NHSE Regional Team and ICBs to determine any supporting role they can play in ensuring alignment between the NHS Led Specialised Mental Health and Learning Disabilities and Autism Provider Collaboratives and local pathway integration and service development.

BSoL Mental Health Provider Collaborative

Work is progressing around the development of the BSOL Mental Health Provider Collaborative, in particular:

- The Provider Collaborative partners have submitted an Integrated Delivery Plan to BSOL ICB to provide assurance on the readiness to operate from 01st April 2023. This Integrated Delivery Plan set out the collective leadership, vision and values that

underpin the collaborative and included key plans around finance, commissioning, contracting, people and quality.

- As part of preparing the Trust to have the right capacity and capability to take on the new responsibilities as a lead provider, the BSOL Mental Health commissioning team have aligned into the Trust from the 21/11/22. We welcome this team who bring with them a wealth of knowledge and experience around service design and transformation.
- Work continues on the development of a Partnership Agreement, Risk Share and Data Sharing Agreements.
- Engagement continues with the third sector to understand and develop a future approach to commissioning and contracting that ensures that we continue to support the development of a sustainable third sector.
- It is anticipated that the outcome of the assurance process and approval to proceed will be announced in mid-January 2023.

QUALITY

CQC Focused Inspection

As the Board is aware the CQC made a series of unannounced inspection to services in November and we will have our Well led inspection later in December. .

NATIONAL ISSUES

NHS Providers Operating framework

On 12 October, NHS England (NHSE) published its new operating framework. The document sets out how the NHS will operate in the new statutory framework created by the Health and Care Act 2022, and reflects the formal establishment of integrated care systems (ICSs) and NHSE's expanding remit. The framework defines NHSE's purpose, its areas of added value, and sets out the roles and accountabilities of providers, integrated care boards and NHSE's national and regional teams. This briefing summarises the content of the guidance and includes NHS Providers' view.

https://www.england.nhs.uk/publication/operating-framework/

Secretary of State for Health and Social Care

Mr Steve Barclay was appointed Secretary of State for Health and Social Care on 25 October 2022. He previously held the same role between 5 July 2022 and 6 September 2022.

He was previously appointed Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office between 15 September 2021 and July 2022.

He was previously Chief Secretary to the Treasury from 13 February 2020 to 15 September 2021 and Secretary of State for Exiting the European Union from 16 November 2018 to 31 January 2020 and Minister of State for the Department of Health and Social Care from January to November 2018. Steve was also Economic Secretary to the Treasury from June 2017 to January 2018.

He served as a Government Whip (Lord Commissioner of HM Treasury) from July 2016 to June 2017. He was elected Conservative MP for North East Cambridgeshire in May 2010.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Board Overview: Trust Values

7. QUALITY

7.1. QPES Chair’s Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE**
Date	7 December 2022
Author	Dr L Cullen, Non-Executive Director, Chair
Executive sponsor	Mr S Forsyth – Executive Director of Quality and Safety (Chief Nurse)

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

The Quality Patient Experience & Safety committee met on the 19 October 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board of Directors. The committee received several assurance reports in relation to quality and patient safety. The committee requested that actions raised during the meeting were transferred across to the action log for assurance that issues raised were resolved.

Reason for consideration

To demonstrate the effectiveness of the assurance process for the Trust's Quality and Safety Agenda and to escalate any key issues to the Board.

Strategic objectives

Quality

- Delivering the highest quality services in as safe inclusive environment where our service users, their families, carers, and staff have positive experiences, working together to continually improve

Financial implications

Significant costs associated with delivery of high-quality services and addressing quality related risks.

Strategic Risks

- QSC1- The Trust fails to co-produce with people who uses its services
- QSC2 – The Trust fails to focus on reduction and prevention of patient harm
- QS2 – The Trust fails to be a self-learning organization that embeds patient safety culture
- QS4 – The Trust fails to be a self-learning organisation that embeds quality assurance
- QS5 – The Trust fails to lead and take accountability for the development of system wide approaches to care
- QS6 – The Trust fails to prevent and contain a public health outbreak
- QS7 – The Trust fails to take account of service users' holistic needs

Equality impact

Number of reports received by the committee analyses services along the lines of protected characteristics. The notes of the meeting reflect an increasing understanding of the equality/ inequality of services. One of the items include a discussion on how the committee addresses Health inequality

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 CQC Update

The Committee received an update on the activities related.

The salient points were noted as follows:

- With the exception of Caffra, all en-suite doors have now been installed in Acute Care however the final connection to the Staff Assist System is still underway through lifecycle PFI works across Oleaster and Zinnia for the wards.
- A total of 433 Safety Huddles were completed out of a possible 444 for the period.
- In terms of safer staffing, we will be working with Birmingham City University to recruit return to practise (RTP) nurses. We also hope to have 30 additional nurses through the international recruitment process by the end of the year.
- There are now 2 Band 7 clinicians supporting decision making during out of hours
- Following the focused inspection on Meadowcroft on June 13th and 14th, we have submitted our agreed action plan to the CQC along with a letter acknowledging the final report. The action plan will be overseen at local CGCs and at QPES.
- The monthly audits of MDT standards in Acute Care continue to take place and for this submission, we have seen either consistency or an improvement in nearly all measures for the reporting period.
- The Clinical Educators have been involved in a range of activities on the wards but primarily supporting newly qualified staff as part of their induction programme. They are also continuing with their work of benchmarking standards across the Acute and Urgent Care pathway.
- The overall numbers of incidents of actual self-harm have increased for the reporting period. There has however been a decrease in the numbers of no anchor point incidents for the period.
- We reported two anchor point incidents for the period (both involving the en-suite door), on Larimar. The door monitoring alarm system worked as expected for both incidents. The service users and staff were provided with the relevant support.
- The team has continued with its programme of Assurance testing and peer reviews for service areas and sharing the findings from these.
- The CQC commenced an unannounced core inspection this week and at the point of writing the report had visited most wards in Acute Care, Steps to Recovery wards and Home Treatment teams.

The committee noted the CQC have been on a range of sites this week and initial feedback has been very positive from both staff and service users.

The committee were informed the CQC had witnessed restraints and were impressed with the de-escalation processes.

Chair's assurance comments:

We were appraised of the high level verbal feedback received from the current CQC inspectors which has highlighted concerns in relation to medications, cleanliness and IPC standards as well as lack of staff leadership/ visibility

Committee were assured all concerns raised are being addressed

We were pleased to hear that inspectors noted that staff were kind to patients , engage well and are holistic in their approach and that they have seen notable changes on Meadowcroft ward .

1.2 Serious Incident Report

The Committee received the Serious Incidents and Learning report and noted the salient points:

- 6 serious incidents have been reported to Commissioners during August 2022, which is just below the median of 7. Of these 6 incidents, 2 occurred during August with 4 occurring in July.
- In terms of incident types, 2 of these incidents related to the death of our service users in the community with 1 death in custody, 1 serious self harm incident and 2 ward closures due to covid outbreaks.
- In terms of completed reviews, 2 reports were submitted to our commissioners for consideration of closure
- The themes arising from Serious Incidents include record keeping, working in a trauma informed way and interfaces with internally and externally.
- There are 39 incidents in the review process, excluding infection control reviews.
- The governance arrangements are being worked through for the new contract with HMP Birmingham.
- 'Think family' remains a key focus with work continuing to engage families and carers inline with the 'Just Culture' within which the Trust operates.

Chair's assurance comments:

Committed noted the comprehensive report

1.3 Quality Metrics

The committee received the detailed report highlighting the following:

- There are 16 identified quality metrics
- During the month of August we have seen a second consecutive increase in the reporting of incidents. Majority of these incidents resulted in no harm. Generally incident reporting has increased within the areas of:
    - Medication,
    - Physical assault
    - Workforce issues.
- 4 of the 16 metrics reported numbers above the mean, these being:
    - Suspected suicide
    - Inpatient assaults
    - Ligature without anchor points
- 4 of the 16 metrics reported improvement, these being:
    - Serious incidents
    - Physical restraint
    - Absconsion
    - Ligature without anchor point

The committee were assured the report for November 2022 will include the diversity population data for review.

The committee were pleased to note the increase in incidents reported with a low level of harm.

No concerns were escalated.

Chair's assurance comments:

The committee were pleased to note the increase in incidents reported with a low level of harm.

Committee noted that there is more work to do to involve and engage with carers through 'Think family' perspective and carers will be invited to collaborate on frameworks and policies.

The committee agreed to have a dedicated deep dive in six months on 'Think Family'.

The committee were assured the report for November 2022 will include the diversity population data for review.

1.4 Integrated Performance Report

The Committee received the Integrated Performance Report and noted the salient points:

- FPP
  - CPA with formal review in last 12 months
  - IAPT seen within 6 and 18 weeks
  - Out of area bed days
  - Referrals over 3 months with no contact
  - Monthly agency expenditure
- People
  - Bank and agency fill rate
  - Fundamental training
  - Sickness absence
  - Vacancies
- QPES
  - None identified

The committee noted the report is being reviewed to address the themes and issues and allow further understanding of how each of the service areas are delivering against the key themes.

Chair's assurance comments:

Committee will have more detail at next committee on quality metrics which are been developed in partnership with individual teams to reflect the diversity and impact in terms of care pathways and patient journeys.

There were continued concerns in relation to staffing pressures and committee asked that that this is escalated to Board.

There was a detailed discussion in relation to zero tolerance for staff assaults and we were pleased to hear that staff are being supported through the process with support from the Police Liaison.

There will be a deep dive on assaults in December 2022.

1.5 Trust Strategy Clinical Services Strategy Priority 2021/2022 achievement and 2022/2023 goals April- Q1

The committee noted work continues to identify the priorities and a full report will be bought to the November 2022 committee meeting.

Chair's assurance comments:
A full report will be bought to the November 2022 committee meeting.

1.6 Quality and Safety of services

Following the BBC Panorama programme which showed patients being abused while in the care of an NHS Trust and the Dispatch programme of another the Trust is taking issues raised very seriously to ensure that we are doing everything possible to identify, eradicate and prevent this kind of abuse happening within this organisation**.**

The committee noted the letter received from NHS England that outlines key areas to review and were assured that processes are in place to mitigate risks and ensure the quality of patient safety is compliant.

Chair's assurance comments:
Committee commended the team on the level of detail in the report

All incidents are being reviewed with potential hot spots , via triangulation of data, and teams being identified for targeted work through a 360-degree process.

We were assured that following the ICS letter an action plan is being developed which will help develop a trigger tool that will enable continual scanning across teams and units

We were advised that safeguarding teams have increased visibility across the Trust and are offering a key point of access to support clinical services to encourage engagement. Discussions are taking place with Birmingham Safeguarding ICS to highlight challenges, culture and risks

Committee was assured that Reach Out have governance arrangements in place and are working closely with the Trust on a joint response. A full update will be provided to the November 2022 committee

1.7 National Review into Deaths of ALH & SH feedback

The committee noted the report that highlighted the overview of activities conducted by the Safeguarding Team, SOLAR, CAMHS and Street Triage on behalf of BSMHFT following the publication of the National Review.

The committee noted work with partners has increased including sharing information and receiving alerts.

Chair's assurance comments:

Committee was pleased to learn about the appointment of a new Head of

Safeguarding for the Trust, Mel Homer.
The team are working very closely with partners in the system .

Safeguarding referrals are increasing and this increased demand has led to MARAC meetings taking place daily. This activity is being actively reviewed internally

The above increase in demand is of concern and committee was pleased to hear that a business case is being developed to invest in resources to increase visibility and training opportunities.

1.8 Learning Disability Autism update and action plan

The committee noted the report and recognised the appropriate provision for people with a Learning Disability and/or Autism should be holistic and cohesive, encompassing:

- Trust-wide understanding of responsibilities (e.g. awareness of need, NICE guidelines)
- A commitment to assuring appropriate care (e.g. reporting structures, accuracy of RIO recording)
- Workforce and estates preparedness (e.g. Knowledge and experience, adaptations, recruitment).

The committee agreed that any initiatives and developments to date should be celebrated and have been met with enthusiasm and creativity by Trust departments and staff alike. There is a real commitment at all levels to improve our provision for people with a Learning Disability and/or Autism.

Chair's assurance comments:

Committee noted the excellent report and highlighted the need for an adequately resourced and skilled workforce as well as the importance of following the 'Right to be heard' code of practice to allow service users to be part of their own journey to recovery.

Work is ongoing to identify service users and ensure responsive adjustments are made. We understand that staff remain very committed, and a steering group has been developed with members from all professions to maintain focus.

Additional funding for resources has been requested from the Integrated Care Board and the committee will be appraised on progress. This is a great opportunity to review clinical area pathways to highlight the evidence of real service user pathways. It was very helpful to see the draft action plan

Our new interim Director of Nursing ,Steve Forsyth ,confirmed he is reviewing and developing a standardised action plan to be used Trust wide for a uniformed approach.

Feedback will be shared at the November 2022 committee

1.9 Escalation report from Clinical Governance Committee Report

The committee noted there were no matters for escalation. A written report will be received at future meeting to allow hot spots to be highlighted and escalated.

Chair's assurance comments: the importance of following the 'Right to be heard' code of practice to allow service users to be part of their own journey to recovery.

1.10 BAF

The committee noted the previous BAF was agreed by the Board in early 2021 and last received by Board in Committees in February 2022,

The BAF has been reviewed and refreshed it and some proposals have been developed regarding the way forward, including better linkages to strategic priorities and ongoing review processes. These were accepted by the Board and the matter referred to individual committees for discussion on the details of the risks allocated to them.

Chair's assurance comments:

Committee were advised that focus on the BAF remains a priority and is being reviewed across all committees and noted that this is a work in progress

Work is ongoing to ensure risks are appropriate and reviewed regularly through the Risk management sub committee which now meets every month and which will look at internal and external risk issues both clinical and non-clinical

We noted the report and framework and noted partial assurance.
In relation to specific issues within this committee we are planning for at least a quarterly report that focuses on issues of quality and safety which will lead to action plans.

We look forward to further support for improvement in BAF and Gill Mordain will be working closely with David Titta, Associate Director of Corporate Governance when he joins the Trust in November 2022

1.11 Minutes and Sub Committee escalations including Brooklands report

The Committee noted the update regarding quality at the Brooklands Unit. It was confirmed that we are now much clearer about the role of Reach Out and assurance processes to be used if similar cases arise in future.

The committee noted the concerns and were assured governance meetings are a priority in line with reviewing the governance processes in place.

Chair's assurance comments:
The Committee noted the update regarding quality at the Brooklands Unit. It was confirmed that we are now much clearer about the role of Reach Out and assurance processes to be used if similar cases arise in future

1.12 Hot Topics: Use of force

The committee noted the Use of Force Act and the statutory guidance issued by the Department of Health clearly set out the measures that are needed to both prevent the inappropriate use of force and ensure accountability and transparency about the use of force in mental health units.

The committee were assured work is in progress with key focus on health inequalities, quality and reducing restrictive practice.

Chair's assurance comments:

Committee were informed that the Reducing Restrictive Practice Steering Group meets monthly to review progress and will provide a report to the committee quarterly.

The committee agreed to receive the CTO report at the next committee that will include the priorities including health inequalities, cultural understanding and quality aspects.

1.13 Matters of escalation to the Board

Staffing
Concerns in relation to staffing and impact on front line colleagues

Establishment review
Training for the MHOST tool delayed until the end of the finical year.

Capital projects
Review of door alarms to be reviewed with V. Devlin and F. Aria as Executive leads. Update to next committee.

Chair's Summary

We had a very positive committee with rich discussion across the many papers presented .

Further Assurance was gained this time by an additional activity whereby all committee members were able to join a safety huddle at Ardenleigh and were impressed by the commitment of staff to manage acuity and ensure individual patient and ward safety as well as actively manage daily staff resources across wards to maintain quality of services also.

Committee plans to join safety huddles on other sites in coming months

LINDA CULLEN
NON-EXECUTIVE DIRECTOR

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE**
Date	7 December 2022
Author	Mr W Weir, Non-Executive Director, Chair
Executive sponsor	Mr S Forsyth, Interim Director of Quality and Safety (Chief Nurse)

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

The Quality Patient Experience & Safety committee met on the 23 November 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board of Directors.

The committee received several assurance reports in relation to quality and patient safety. The key updates were as follows:

- Ongoing correspondence with the Care Quality Commission (CQC)
- Quality Metrics Report / Integrated Performance Report
- Serious Incidents Report
- NHSE visits for Infection Prevention and control
- Lay Managers Report (community treatment orders)
- Trust Strategy Clinical Services Strategy achievements in Q12022/2023
- Progress with Capital projects
- Sub committee reports from Reach Out Collaborative and local Clinical Governance Committees

The committee wishes to draw to the Board's attention the CQC issuance of Section 29A warning notice in respect of staffing levels.

Reason for consideration

To assure the Board on the policies, processes, performance and monitoring for the Trust's Quality and Patient Safety and to escalate any key issues of concern to the Board.

Strategic objectives

QualityQuality

- Delivering the highest quality services in as safe inclusive environment where our service users, their families, carers, and staff have positive experiences, working together to continually improve

Financial implications

Significant costs associated with delivery of high-quality services and addressing quality related risks.

Strategic Risks

- QSC1- The Trust fails to co-produce with people who uses its services
- QSC2 – The Trust fails to focus on reduction and prevention of patient harm
- QS2 – The Trust fails to be a self-learning organization that embeds patient safety culture
- QS4 – The Trust fails to be a self-learning organisation that embeds quality assurance
- QS5 – The Trust fails to lead and take accountability for the development of system wide approaches to care
- QS6 – The Trust fails to prevent and contain a public health outbreak

- QS7 – The Trust fails to take account of service users' holistic needs

Equality impact

Number of reports received by the committee analyses services along the lines of protected characteristics. The notes of the meeting reflect an increasing understanding of the equality/ inequality of services. One of the items include a discussion on how the committee addresses Health inequality

Our values

CommittedCommitted
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 CQC Update

The Committee received an update on the activities related.

The salient points were noted as follows:

- The door monitoring alarm system has now been installed in all en-suites in Acute Care. However final connectivity it still taking place for the doors at Zinnia and the Oleaster, with expected completion by mid-November.
- In Acute Care, a total of 437 Safety Huddles were completed out of a possible 444 for the period.
- In terms of safer staffing, we continue to recruit to our vacancies and the Safer Staffing Lead is attending recruitment events when possible. International recruitment continues to be successful with 16 new staff recruited to date, and we will be putting a bid in for the next financial so we can continue our project.
- Following the focused inspection on Meadowcroft on June 13th and 14th, we have submitted our agreed action plan to the CQC along with a letter acknowledging the final report. The action plan will be overseen at local CGCs and at QPES.
- The monthly audits of MDT standards in Acute Care continue to take place and for this submission, we have seen either consistency or an improvement in nearly all measures for the reporting period.
- The Clinical Educators have been involved in a range of activities on the wards but primarily supporting newly qualified staff as part of their induction programme. They are also continuing with their work of benchmarking standards across the Acute and Urgent Care pathway.
- The overall numbers of incidents of actual self-harm have largely decreased with an increase at the end of the reporting period. There has also been a decrease in the numbers of no anchor point incidents for the period.
- We reported four anchor point incidents for the period (three involving the en-suite door and one involving the bed). Three were on Larimar and one on Melissa and involved a total of 2 service users. The door monitoring alarm system worked as expected for the incidents on Larimar. The service users and staff were provided with the relevant support and the incidents were also subject to a 72-hour review.
- The team has continued with its programme of Assurance testing and peer reviews for service areas and sharing the findings from these.
- The CQC continued its unannounced core inspection of our services and to date have inspected most wards in Acute Care, Steps to Recovery wards, Home Treatment teams and our Secure Care inpatient services. We have also received the date for the Well-led aspect of the inspection, which will be December 13th to 15th 2022. We have started confirming the schedule for those staff that the CQC have requested to interview.

The committee were assured the data requests continue to come through from the CQC related to the inspection and to date we have been able to meet all deadlines.

The committee were assured the CQC interviews have been booked in line with the requests received.

Chair's assurance comments:

The committee were assured that the Trust continues to make progress in responding to CQC concerns in relation to security of services, evidenced by progress made on doors, locks and safety huddles.The committee noted the detailed monthly letter to CQC and

how much the workload of managers have increased in responding to quality patient safety ongoing issues. The committee noted that anchor point incidents are starting to decrease.

The committee are not assured that safe staffing levels are always in place and note the section 28A escalation by CQC in relation to staffing levels.

1.2 Serious Incident Report

The Committee received the Serious Incidents and Learning report and noted the salient points:

- The report outlined the number of incidents reported within the quarter and the categories.
- The protective characteristics of the people involved in a serious incident.
- The themes that have been identified through the process.
- The involvement of families in the process.
- As we continue to use the Serious Incident Framework these incidents will be investigated using these principles until we have transitioned to the Patient Safety Incident Response Framework (PSIRF) which is likely to be in place within 12 months following the release of the new framework at the end of last month. All families where details are available will be invited to participate in the review and offered the support of the Family Liaison Officer. Staff involved will be provided with literature signposting them where they access support and reminded of the 'Just Culture' within which the Trust operates.
- At the time of writing this report there are 34 incidents in the review process, excluding infection control reviews. As the 60 day review deadline has been removed nationally due to COVID there are no breaches to report. The average time for completion of a review is currently 50 days.

Chair's assurance comments:

The committee noted the Trusts continued monitoring of serious incidents and the process for analysing lessons learned back to the services concerned. The committee noted that the Trust continues to analyse these by the protected characteristics but in particular gender and race.

The committee were assured by the processes for reporting on serious incidents, their themes and the analysis of root causes of these.

1.3 Quality Metrics

The committee received the detailed report highlighting the following:

- There are 16 identified quality metrics and trend data is provided in the graphs included within this report.
- During the month of September we have seen a second consecutive increase in the reporting of incidents. Majority of these incidents resulted in no harm. Generally incident reporting has increased within the areas of:
    - Self harm behaviours
    - Physical Assault & Attempted Assault
    - Workforce & Staffing
- 0 of the 16 metrics reported numbers above the mean, these being:
- 3 of the 16 metrics reported improvement, these being:

- Physical restraint
- General incident reporting
- Harm levels

Chair's assurance comments:

The committee were assured by the content of the report and noted the increase in incident reporting in relation to self harm, physical assault and workforce staffing levels.

1.4 Integrated Performance Report

The Committee received the Integrated Performance Report and noted the salient points:

- Finance Performance
  - CPA with formal review in last 12 months
  - IAPT seen within 6 and 18 weeks
  - Out of area bed days
  - CPA 7-day follow up
  - Referrals over 3 months with no contact
  - Monthly agency expenditure
- People
  - Bank and agency fill rate
  - Sickness absence
  - Vacancies
- Quality Safety and Patient Experience
  - Patient assaults

The committee noted the report is being reviewed to address the themes and issues and allow further understanding of how each of the service areas are delivering against the key themes.

Chair's assurance comments:

The committee noted the report.

1.5 NHS England visit update

The Trust had a visit on the 24th of August 2022 from NHS England. The visit was performed by Kirsty Morgan in representation of NHSE and escorted by the IPC lead and the matrons for the areas.

A final version of the feedback letter was received on the 7th of October 2022, replacing the provisional one received on the 30st of August 2022.

The visit covered Mary Seacole 2 and Juniper Center, Sage ward.
Also, a review of IPC documentation and procedures took place.

At the moment of production of this report, feedback from the IPC documentation is still outstanding, all comments will be actioned as soon as received.

The key themes identified were:

- Staff not-bare-below the elbows, being one of them a ward manager and other a psychologist.
- Most Nursing equipment was clean but more attention to detail is advised, including the leads and the parts the staff hold.
- At one of the areas the nursing equipment stored in the clinical room was dusty.
- One of the storerooms visited had a mix of clinical and non-clinical equipment, it was noted that the staff made effort to aggregate some of this, but room needs to have a full review and consideration is needed to identify enclosed storage for the clinical items as well as full separation of the equipment.

The key points identified as needing improvement were:

- Cleaning, including post-discharge cleans and communal areas – Advised a broader discussion around cleaning across the Trust.
- Estates concerns across both areas visited, including walls not being made good post work, areas of floor not sealed together or seals splitting. Also coved skirting peeling from the walls and wooden shelving was noted – Advised to have this added to local risk registers.
- Issues with sewage and foul smell identified in one of the wards.
- Laundry in one of the areas with no clear clean and dirty flow – Recommended an SOP and a poster for the correct use of the machines in the laundry room.

Chair's assurance comments:

The committee noted the report.

1.6 Infection Prevention and Control Update

The Trust was visited by NHSE Regional IPC team on the 24th of August 2022. The visit was conducted by Kirsty Morgan, Assistant Director of IPC, in representation of NHSE and escorted by the IPC lead and the matrons for the areas.
This review visit took place on Mary Seacole Ward 2 and Juniper Centre, Sage ward.

Detailed verbal feedback was received during the visit and a formal feedback letter received on the 7th October 2022 outlining the findings.

There will be a full documentation review, including the Trust IPC BAF, this remains ongoing and we are still awaiting formal receipt of the documentation review feedback.

The key themes identified were:

- Staff not bare below the elbows, one of them being a ward manager and other a psychologist.
- Most Nursing equipment was clean but more attention to detail is advised, including the leads and the parts the staff hold.
- At one of the areas the nursing equipment stored in the clinical room was dusty.
- One of the storerooms visited had a mix of clinical and non-clinical equipment, it was noted that the staff made effort to aggregate some of this, but room needs to have a full review and consideration is needed to identify enclosed storage for the clinical items as well as full separation of the equipment.

Chair's assurance comments:

The committee noted the report and that an action plan would be developed in response to the findings from NHSE.

1.7 Trust Strategy Clinical Services Strategy Priority 2021/2022 achievement and 2022/2023 goals April- Q1

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

- Clinical Services
- Sustainability
- People
- Quality

The Clinical Services Strategic Priority has a total 44 goals spread across 6 strategic aims, 30 of which have been prioritised as level 1 or 2.

This report summarises performance against these 30 goals in the first half of 2022/23.

There are 44 goals in total for Clinical Services. This has reduced from 52 at the beginning of the year, as during the mid year review it was clear that some separate goals connected to a specific theme should be merged under one goal, and some removed due to duplication in other areas.

There are 30 goals prioritised as Level 1 or Level 2 in the Clinical Services Strategic Priority. The detail and current status for each these are listed in an Appendix which is in the Reading Room. A summary of the overall status at the mid year point is shown below and the following slides provide an overview of achievements, focus areas for the remainder of 2022/23 and risks for each of the six strategic aims for Clinical Services.

The committee noted it is encouraging that 50% of these goals are rated 'Green' which means they are where we expected them to be in relation to their milestone plans at this point in the year.

Chair's assurance comments:

The committee were assured of the progress being made against Business Plan objectives particularly in light of the post pandemic situation and staff vacancies.

1.8 Community Treatment Order evaluation

Community treatment orders (CTOs) were introduced into legislation for England and Wales by the Mental Health Act (MHA) 2007. CTOs are typically indicated for psychiatric patients, usually with a diagnosis of psychosis, presenting with a 'revolving door' pattern of admissions secondary to poor treatment adherence and poor engagement with psychiatric services. Although the main aim of CTOs is to reduce readmissions by preventing relapse and protecting the liberty of the patient in the long term, another motivation might be to attempt to improve quality of life for patients and their carers.

BSMHFT has twice the number of CTOs as a proportion to its total population when compared to the England average. The latest Government MHA statistics for England show that 'black or black British' people are nearly 8 times more likely to be given a CTO than white people. A black patient on section 3 is twice as likely to be placed on a CTO as a white patient on discharge. BSMHFT data has also confirmed a similar picture in Birmingham and Solihull area, though this inequality is further increased in BSMHFT due to higher rates of CTOs. Inequality in detentions is further magnified whilst patients remain under the care of BSMHFT where the main Decision Makers are BSMHFT staff.

It is anticipated that a combination of review of records and comparing the process

against the standards set out in the Mental Health Act and its Code of Practise will establish the quality of the CTO process and its adherences to the stands of the code of practice. Areas of non-adherence will form the basis of a continuous improvement programme.

Focus groups with patients, AMHPs, RCs and service users who have access to the above data will enable constructive feedback and suggestions on how quality of the CTO process can be improved and will be incorporated into the continuous improvement programme.

Chair's assurance comments:

The committee noted the CTO report and noted that the reasons for high incidence of CTOs given to patients were multi-factoral but needed to be understood.

1.9 Lay Managers update

The Committee received the Lay Managers update and noted the salient points:

- In Quarter 2, there were an average of 922 people under detention of the Mental Health Act (MHA) per month of the quarter (955 Q1): and an average of 230 people on a Community Treatment Order (CTO) per month during Q2 (239 Q1).
- The average number takes into account that 1 patient may have been detained on more than one section.
- In addition, there were 248 referrals into the place of safety, of which only 42 resulted in detention under the MHA. These trends and data are discussed in the Joint Strategic Operational Group (JSOG) which is multi-agency attendance.
- Quarter 2 saw 372 MHA hearings (357 Q1), 152 of which were Lay Manager hearings.
- There are rules within the MHA which determine when a patient is eligible to appeal against their detention to the Lay Managers and to the Tribunal; and Lay Managers must hold a review hearing each time a section is renewed. This helps to explain the reason for the difference between the number of detentions versus the number of hearings.
- There were 90 MHA related incidents reported in Q2, an increase of 17 from Q1 with the most reported category of incident remaining in relation to AMHP (Approved Metal Health Professional) related issues (43).
- This quarter saw an increase in unlawful detentions (15) compared to Q1 due to paperwork issues. 8 of these 15 were due to errors reported on Joint Medical Recommendations which cannot be rectified under section 15 of the MHA. The MHLSC recommend that use of joint medical recommendations is discouraged for this reason. This was supported by Medical Advisory Committee (MAC) when presented in October, although we acknowledge as a statutory form we cannot "ban" it's use and there are benefits from using it when completed correctly.
- There were 3 unannounced Care Quality Commission (CQC) MHA visits in Q2, and 1 report received for a Q1 visit to:
- Citrine, Meadowcroft, Caffra and Juniper. The overarching themes running across all visits were around seclusion practice, care planning and quality of capacity assessments. There were no MHA specific issues to address which is positive.
- No MHA complaints were received this quarter.

Chair's assurance comments:

The committee were assured that we continue to meet our legislative requirements.

1.12 Capital projects

Circa 300 schemes have been costed in order to respond to Trust requests for Major, Minor and Risk (Security, Fire, Ligature and Environment) based Capital Schemes plus Statutory Standards and Backlog Maintenance (SSBM) projects.

The Estates element of the overall Capital Programme is normally between £6.5 and £7.0m. BSol ICS have not yet confirmed the budget allowance for 23/24 onwards but it is expected to be in this sort of order.

SSL have begun a prioritisation exercise on the SSBM project estimate of £3,749,784 aiming to reduce that to between £1.7 and 1.9m. The Executive Directors are examining the costed 23/24 capital proposals to prioritise all Major and Minor/Risk Projects project allocations for 23/24, 24/25 and onwards.

Chair's assurance comments:

The committee noted the progress in delivery of the capital projects.

1.13 Escalation report from Clinical Governance Committee Report

The committee noted there were no matters for escalation.

Chair's assurance comments:

The committee noted that there were no Clinical Governance matters for escalation to it nor therefore to the Board of Directors.

Chair's Summary and escalations to Board of Directors

The committee received a number of items pertaining to Quality and Patient Safety.

The committee wishes to draw to the Board's attention the CQC issuance of Section 29A warning notice in respect of staffing levels.

WINSTON WEIR
NON-EXECUTIVE DIRECTOR
29th November 2022

8. PEOPLE

8.1. People Committee Chair’s Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**8.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**
Date	7th December 2022
Author	P. Gayle. Non-Executive Director (Chair of Committee)
Executive sponsor	P. Nyarumbu, Executive Director of Strategy, People & Partnerships

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary
The People Committee met on the 19th October 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's sustainability agenda and to escalate any key issues to the Board of Directors
Strategic objectives/ priorities
Sustainability
Financial implications
Detailed within the report
Risks
Equality impact
Non specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Deep Dive: Bringing our values to life in our day-to-day experiences

At the meeting on the 19th October 2022, the Committee had a deep dive discussion on the Trust values and received a discussion paper to suggest the next steps regarding how the Trust would actively shape the organisational culture. With the aim to create a place where staff feel they belong and to embed the Trust's values and behaviours into the fabric of the day-to-day experience of staff, service users, carers, and our partners.

Chair's Assurance Comment:
The committee welcomed the paper presented that supported the discussion on bringing our values to life. The committee recognised the importance of amplifying the message of the importance of living our values through the behavioral framework with the emphasis of this being driven by our leadership team and cascaded down to all. Different initiatives are clearly seen within the organisation which is positive and encouraging to see. However, the committee agreed there is further work to do as we would like to see our values fully embedded in the organisation. Yet, our staff surveys continue to highlight bullying, harassment and discrimination which remains a significant concern for the Trust. The committee recognised that significant work had already taken place with our values and strategy being coproduced over a period. We need to continue to implement our strategy and embed and bring assurance of the improvements made to the committee, in both a quantitative and qualitive way and through soft intelligence such as walkabouts etc.

1.2 Quarterly Key Performance Indicators

At the meeting on the 19th October 2022, the quarterly KPI report provided the detail regarding the performance indicators relating to the vacancy position, employee turnover, bank and agency fill rates, fundamental training, appraisals, sickness absence. The challenge of recruitment was reported with the paper outlining the actions being taken. The Trust was continuing to maintain the target and tracking the number of people leaving the organisation each month. In September there was a slight increase in people leaving which had predominately been administrative staff. In terms of nursing colleagues, 6 out of the 52 members of staff who had left were registered nurses but from different directorates. In terms of bank and agency fill rate, this continued to be challenging with an increase in spend for bank usage with the Trust continuing to struggle to fill all shifts requested. It was reported that there was an increase in acuity which put pressure on filling shifts**.**

Chair's Assurance Comment:
The committee were informed that the Trust was continuing to work through the appraisal process with a slight decrease in performance and it was noted that the new appraisal process had been launched. The committee is hoping in future reports the launch of the 'new' appraisal process will increase performance. In respect of fundamental training, there was an increase over the past few months which was encouraging to note and in relation to bank staff there had been a significant increase in the uptake of fundamental training with the current performance at 75% which is a slow upward trend.

We were informed the sickness rate was reducing with a decrease in long term sickness. However, with the winter approaching there were several initiatives in place to manage staff sickness. As discussed at our last Board meeting, we have yet to establish an appropriate optimum mix of assurance which is not solely transactionally driven. This discussion is scheduled to take place this month.

1.3 Safer Staffing and E-Rostering

The October report detailed the work and outputs of the October 2022 Safer Sub Staffing Sub Committee. It was reported that the meeting was positive with discussions taking place regarding the RMN fill rates and reviewing the hot spots with specific challenges.

The subcommittee was keen for the report to be expanded further and it was suggested that different themes were explored each month and to continue to include positive facts within the report regarding recruitment data and complimentary feedback from service users, families, and carer's**.**

The current vacancies were explored across the trust along with the plans in place and the Trust would be attending recruitment events and have plans in place during the next 12 months. The Trust would be advertising three posts for registered mental health nurses, registered learning disability nurses and Nurse Associates. Data was presented regarding the number of clinical vacancies and able to implement actions to address vacancies which were not yet in the system. It was agreed that the fill rates would be included within future safer staffing reports.

The staffing establishment review has been delayed due to a directive from NHS England and the Trust was not able to use the MHost descriptor tool due to not enough staff being trained to use the tool. A plan was being put in place to train staff which would take place during the next two months with a full staff establishment review to be completed by the end of February and a paper to the Committee in March.

An update was provided on the e-rostering project and it was reported that the review was completed with a paper being submitted to the Transformation Board regarding how e-rostering could be taken forward. Engagement work with ward managers and clinical nurse managers has been undertaken. The work would continue in a different guise and would be a quality priority from a safer staffing viewpoint.

Chair's Assurance Comment:
The committee were informed in relation to ensuring the Trust was satisfying itself on the services which were short of staff in relation to patients being kept safe they felt assured that daily safety huddles were taking place where the challenges of staff shortages and mitigations were discussed which gave a level of assurance to the committee. Work was also underway with matrons to ensure plans were in place and "harm free" days were being reviewed which would be included within future reports. The committee were disappointed the staffing establishment review had been delayed but received assurance that once undertaken, and a paper submitted to the People Committee in March this would be a through process providing clear assurance for the committee to review.

The committee noted that they look forward to receiving the review paper so we can give assurance on effectiveness of the system and to report back to the audit committee where this was previously raised as a concern.

1.4 Medical Directorate Update

In October the Medical Director presented the directorate quarterly report to update and provide assurance on the work in relation to medical appraisal, revalidation and job planning. The 2022/2023 job plans have now been closed and it was intended to undertake a focus on job plans as of September this year to cover the 2023/2024 financial year. The Medical Directorate were anticipating that this would help to maintain momentum.

Learning would be taken from the last round to determine a prospective timetable for the 2023/2024 round. To aid this learning, questionnaires were circulated to current and former Clinical Leads and Clinical Directors which was followed by Focus Group meetings. The meetings were held to explore ways via a QI approach to make the 2023/2024 round more successful and meaningful.

It has been agreed that Clinical Leads and Clinical Directors would complete their own job plans in the first instance, so that they can gain a greater understanding of the process and system in order for them to be able to better support members of their team with the process.

Chair's Assurance Comment:
The committee noted that as part of the job planning process we must reflect some of the new priorities that we have in our colleagues' job plans and take out some things which may be lower in importance as we move forward to refresh peoples activities in terms of delivering our strategy.

1.5 Development of the Board Assurance Framework (BAF)

In October, the Committee received a report on the BAF which had recently been reviewed and refreshed and proposals have been developed regarding the way forward, including better linkages to strategic priorities and ongoing review processes.

The Committees would have ownership of specific risks and the Committee was informed that there would be a risk management group established to review and challenges the risks. The new Associate Director of Corporate Governance would be taking the lead on the Board Assurance Framework. It was reported that this was an ongoing process with a live document.

Chair's Assurance Comment:
The committee were informed of the purpose of the review of the BAF to strengthen the alignment of the risk with our Trust priorities and for the People Committee to have ownership of the People risks. The Committee agreed the risks allocated to the People Committee in relation to clinical service and people risks along with the current scores and confirmed the risk appetite statements.

1.6 Terms of Reference

The Committee reviewed the terms of reference and are presented to the Board of Directors for formal approval in line with being reviewed on an annual basis. *(Attached)*

Chair's Assurance Comment:
The committee approved the terms of reference and no amendments were made.

1.7 Hot Topics

Staff survey launched and there appears to be a good uptake at 29% which is encouraging but good progress.

Health Inequalities

Fabida stated she had a few meetings with Jaz EDI lead and they are thinking are doing some deep dive with medic colleagues. B. Currie took the learning for the OD paper which could ensure links were clear regarding the benefit of engaged staff would have an impact on patient safety and quality.

Chair's Assurance Comment

The committee acknowledged that although there was reference in some papers, but we could do more and be more explicit when having conversations at the committee meetings. In the work around safer staffing there were also issues to be addressed but not as explicit within the paper.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**8.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**
Date	7 December 2022
Author	A. Baines, Non-Executive Director (Interim Chair of Committee)
Executive sponsor	P. Nyarumbu, Executive Director of Strategy, People & Partnerships

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary
The People Committee met on the 23 November 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's People agenda and to escalate any key issues to the Board of Directors
Strategic objectives/ priorities
People Creating the best place to work and ensuring that we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.
Financial implications
People are the Trust's largest area of expenditure. The committee did not make any key decisions of a financial commitment
Risks
The key risk discussed with the Committee related to safer staffing and the shortage of registered nurses across the Trust.
Equality impact
Non specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Quarterly Performance Indicators

The Committee was presented with a report to provide assurance on actions being taken to address concerns around People KPIs aligned to the Shaping our Future Workforce and Transforming Our Culture Strategic Aims under the Trust's People Strategic Priority.

- Recruitment Team are looking at reviewing their processes and flow charts for the end of end process. The proposal is to measure from date of advert to date of offer, as the Trust has full control on the pace of these activities. (The Trust has no control on notice periods which currently influence the data reported. The main delays are with Occupational Health clearance and some delays to the authorisation process (in June it was an average 6.5 working days for approval).
- Current end to end time to hire is 85 days. However, the team have experienced some staffing challenges over this quarter and assurance is given that KPI can be achieved in next two quarters. They are currently appointing a new band 5 Team Leader
- 18 nursing posts have been offered via the international recruitment programme. We anticipate 2 to start in Dec 22 and 6 in Jan 23. We are proposing to have a corporate target for 60 additional nurses for 22/23.
- The Trust will be working with local universities to attract second and third year students to consider the Trust as future employer. The Trust will be participating in 'BSol Love Our Learners' event that is planned for December 2022. This an event that will be targeting second year students to consider BSol as a choice arear to work when they complete their degree. This event is being actively planned and the Trust will be playing a prominent part in this event.
- The Trust is planning a jobs fair for North wards on 17th November to address these specific wards which have as many as 41 band 5 vacancies.
- Work on the retention plans for Occupational Therapy and Psychologists is ongoing
- Flexible working programme is also developing.
- The work to improve our organisational culture, opportunities for career development for all staff, and staff experience can help improve performance.
- Current rate is below the KPI target.
- Despite increases to TSS team and number of initiatives and incentives being offered, no assurance can currently be offered that the KPI of 95% will be achieved within the next quarter
- The annual clinical supervision compliance rate at the end of September 2022 was 44.9% - that figure is for staff current at 30 September who had the training competency (traffic light) assigned to their primary role
- 478 out of the 901 BSMHFT supervisory leaders and managers have completed the core leadership programme. This equates to 53.05% of the target audience.
- To support the new appraisal process, drop in sessions for staff have been scheduled to support within resources available on a dedicated Values Based Appraisal Connect page.
- Monthly fundamental training trajectories has been created to ensure that

Trust and Commissioners compliance targets are achieved. There were increase in compliance in most of the face-to-face subjects after recovery plans has been implemented by FT team at the end of the Q2 compare to Q1.

- At the end of Q2, TSS is reporting a 13.1% significant uplift in compliance from 62.7% to 75.8%. We have reached the Commissioners Targets however, we are still below Trust Target.
- Clinical and operational areas who are in low in compliance will be communicated to ensure that team managers have sight of areas of concern.
- Data with Dignity underway – 2 directorates have completed the Data with Dignity Session and have implementation place to reduce inequality within their area.
- 95% of new starters reported recruitment process as excellent or very good. Assurance provided.
- Sickness absence is still seen as a huge priority for People Team
- Sickness action plans are being work through with the service areas
- The team are supporting individuals who are off with long Covid after the changes to NHS covid came in during this quarter
- New sickness absence policy is being consulted on
- Health and Wellbeing packages and initiatives being communicated with colleagues

Chair's Assurance Comments:

The Committee acknowledged deteriorating situations in terns of vacancies, bank and agency fill rates and sickness levels. We were concerned to hear that the data quality for some of the data source (ESR) was felt to be incomplete and that a piece of work was planned to engage with colleagues to ensure improved completion and/or transfer of data from other sources. Although it was reassuring to hear those other sources of data reflected a better positon in these areas, ESR is the source of Board Assurance. It was agreed that the communication piece with colleagues take place quickly to ensure ESR reflects the actual performance data.

The Committee was assured that a number of initiatives to reduce vacancies were underway and being successful, however the rate continued to be high and members queried what further could be done. The contribution of pathway transformation and new workforce approaches was highlighted. The Committee requested that a clear plan and trajectory and outline of the various schemes and initiatives over the next few years be developed to provide assurance that the work in place added up to the shortfall, showing the contribution of each scheme. This would give greater visibility and assurance that schemes are on track or need enhancing as appropriate.

1.2 Integrated Performance Report

The Committee received the integrated performance report with the main headlines which included the out of area placements with the pressures on wards and closures on beds. The Committee were informed most of the key points had been discussed in the quarterly indicators report presented by P. Nyarumbu.

We were informed regarding People there is an overspend with a significant spike in agency spend in this month and we are veering significantly above NHS England benchmark in terms of reducing our trends. However, the

committee were informed the majority is agency spend is on medics.

Chair's Assurance Comments:

Committee feedback within the quarterly report was referred to.

1.3 Trust Strategy Update: People Priorities

The People Strategy Implementation plan has been developed to ensure we have a robust process in place to monitor its delivery and provide assurance on the activities that are taking place to achieve the overall Strategic aims and goals. We hold monthly confirm and challenge meetings with the leads identified within the plan to support and provide solutions for potential blockers they may be facing. All leads provide quarterly highlight reports which are then complied into the overarching report. Quarterly reports are provided to the Transforming culture and staff experience sub-committee and Shaping our future workforce sub-committee.

Based on this prioritisation, the committee were given assurance on level 1 and level 2 goals.

Chair's Assurance Comments:

The key risk to delivery appeared to be capacity within the People directorate and the Committee were assured that recruitment was nearing completion and would be resolved. The Committee gave positive feedback on the structure and clarity of the report which provided assurance to that progress was being made and that key areas of future attention were clear.

1.4 Report from Shaping our Future Workforce Sub Committee

The People Committee noted the progress made against 3 of the workstreams within the People Strategy Implementation Plan that were reviewed at the Shaping Our Future Workforce Sub Committee meetings held on 3 October and 7 November 2022. These workstreams are:

1. Launch refreshed flexible working options
2. Increasing representation of BAME staff in Band 8A and above roles
3. New Value Based Appraisals process
4. Face to face corporate Induction Process

The committee note the salient points as follows:

- A working group involving operational managers, trade union partners and
- People Business Partners are planning the launch of our new corporate approach to flexible working
- BAME representation in Band 8a and above roles and noted there is a robust plan from Project Flourish which focuses on attraction, recruitment and retention. Recruitment practices are continuously reviewed to enhance inclusion and reduce racism and discrimination. The figures of representation of BAME staff in band 8A and above roles may take some months to reflect the work being done. The sub-committee requested for a detailed analysis of recruitment activity to come to the sub-committee in February 2023 to assess whether or not the Trust had improved on the number of BAME staff at Band 8a and above during the period July to December 2022.
- The new value based appraisal process has had a positive effect on the

Trust's compliance figures. The Learning and Development Team have developed a suit of helpful recourses such as training videos and guidance to support new users, and have arranged to provide support via divisional meetings with managers to talk colleagues through the new appraisal system. The new system requires the appraisee to initially complete the online form, and the L&D Team will develop communications to the Trust requesting that line managers arrange for IT kit to be made available to those staff who are not issued with personal IT equipment.

- The BSol International Nurses Recruitment Programme continues to move with pace. BSMHFT anticipates receiving its first 2 IR nurses in December 2022 and a further 4 in January 2023. The Trust is considering plans to embed high quality initial accommodation, mentoring, preceptorship, community engagement and pastoral care for this cohort of staff.

Chair's Assurance Comments:

The Committee took assurance from the paper presented and particularly noted the start of the improved induction and increased focus on flexible working.

1.5 Safer Staffing & E-Rostering Report

The committee was asked to note the work undertaken by the Transforming Our Culture and Staff Experience Sub-committee, with the following points of note:

- Staff side are exploring called 'get me home safely' this is to ensure our workforce can get home safely once they have finished work, this will also need to be discussed further as we are now introducing twilight shifts on our inpatient wards. It was collectively agreed that was an important agenda item, but we need to take this to Health and Safety Committee for this to be explored further.
- International Recruitment continues to remain a success. We have appointed 19 International Nurses and continue to interview each week. We have discussed that if we are successful in our next bid with the ICS we would like to recruit into AHP and community nurse posts as these are also hard to recruit to areas.

Chair's Assurance Comments:

The Committee expressed some concern that the report did not provide any assurance on the principle of safer staffing given the lack of absolute data and detail of gaps. QPES had been able to see some further data but a more detailed illustration of the gaps and key issues arising and could not feel assured.

The recommendations included were supported although some greater detail to expand the areas where benefits will be realised.

It was also felt that the wider remit of the Safer Staff Committee to cover other groups of staff could be included in future meetings.

1.6 Report from Transforming our Culture and Staff Experience

The committee was asked to note the work undertaken by the Transforming

Our Culture and Staff Experience Sub-committee, with the following points of note:

- Increasing levels of triangulation of colleague experience data across all workstreams monitored by the Sub-Committee
- Workstreams that are reporting to the Sub-committee have a fuller range of representation from across the organisation to support assurance
- A requirement of an organisational approach to the role of champions
- Consideration of the learnings from colleagues experience of organisational change processes

The committee had a focused discussion on the quarterly KPI report for Q2 July – September and the monthly sickness absence from August 2022 and noted the key points as:

- The percentage of ethnic minority staff in role at Band 8a and above had dipped to 23.57% a significant distance from the 40% target. Assurance was provided on the Data with Dignity sessions with two Clinical Divisions with identified implementation plans. Further work is also in place to support self-declaration of ethnicity on ESR given that there is both blank and unstated data being reported.
- The percentage of ethnic minority applicant successfully recruited into role has has dipped from 47% to 44% this quarter. Whereas the percentage of applicants with declared disabilities has increased to 8% from 6%. The committee discussed the impact of training positions that have not come through the main NHS jobs Trac route and therefore ethnicity data was not available. Assurance was provided on the review and relaunch of the Inclusive Recruitment training.
- The percentage of ethnic minority applicant successfully recruited into role has dipped from 47% to 44% this quarter. Whereas the percentage of applicants with declared disabilities has increased to 8% from 6%. The Sub-committee discussed the impact of training positions that have not come through the main NHS jobs Trac route and therefore ethnicity data was not available. Assurance was provided on the review and relaunch of the Inclusive Recruitment training.
- The sickness rates continue to decrease from peak of 7.7% in July 2022, to 6.4% in September 2022. As 26% of reported sickness absence is due to anxiety, stress or depression, there are further interventions from PAM-OH in place to provide counselling and psychological support services. The Sub-Committee requested further assurance on the take up of the PAM sessions as part of the quarterly report.
- The leavers survey has indicated that most colleagues left the organisation due to promotion and flexible working opportunities. It was positive to note that a greater proportion of leavers stated that they have received training and support required to progress in their career. The survey is also being considering within the organisation's flexible working processes.

Chair's Assurance Comments:

Committee received the paper outlining the assurance received by the Sub Committee. We noted that whilst following a Champions model across the

Trust in a variety of areas, a policy framework to support colleagues who wish to become champions and their managers. It was agreed that this would be progressed quickly and involve the people concerned.

1.7 Psychological Professions Workforce presentation

- This presentation was deferred to the next meeting due to time pressures

1.8 Freedom to Speak Up Report

The committee received a detailed report on activity during Quarter 2 and noted the following key points:

- Our registered nurses continue to raise the most concerns followed by colleagues that work in additional clinical services who have significant patient contact as part of their role
- Nine colleagues contacted Pull Up a Chair. Consent was provided for the themes or other aspects to be shared with the CEO and if appropriate, the wider executive team
- We are pleased that our increased activity means that more and more of our colleagues are accessing the Guardians for support and guidance including those from staff groups that have accessed FTSU for the first time. This quarter we have seen a spike in contacts from two separate areas with themes of a similar nature. We are currently unable to report on themes as cases are live
- This quarter, we have been able to focus on our strategic work. We have agreed with the Head of Governance that learning from patient safety concerns will routinely be fed back by the Guardians in local clinical governance committees leading to improvements in patient safety in addition to demonstrating the impact of speaking up
- Speak Up month in October saw the launch of the Champion network with a Champion information session delivered to our network chairs. A series of virtual lunch and learn webinars were provided throughout October but were poorly attended. We have received four expressions of interest with others pending and will meet with interested colleagues in the next month. Initial responses from our networks have been positive and our chairs will be supporting us to recruit Champions from their membership on an on-going basis as the network grows and evolves.

Chair's Assurance Comments

Committee received assurance from the report produced by the Freedom to Speak Up Team. It was requested that closure data be included in future reports to ensure that the process is progressing effectively.

It was also good to hear anecdotal information that positive feedback was being received through the Corporate Team. Committee congratulated the Team on this together with Communications who were supporting the publicity across the Trust.

1.9 Report on Staff Experience of Organisational Change Processes

The committee noted the report and salient points as follows:
25 colleagues who have recently experienced organisational change (restructuring) within our trust were asked to reflect on their experience of:

- The process of organisational change (restructuring)
- Communication throughout the process
- Support available to them
- The impact of the process on them

The committee noted the experiences varied and were not always in line with our trust values and behaviors.

The committee noted the lived experience of a small and focused group of colleagues who have recently been through, or are still going through, organisational change within BSMHFT.
The sample size reflects the decision to survey colleagues who have experienced organisational change (restructuring) post Covid. Organisational change was paused during the pandemic, so colleagues who experienced restructuring pre covid would have been asked to recall their experience after a significant period of elapsed time.

None of our colleagues that left because of the organisational change were contacted, and 11 of the remaining 25 colleagues surveyed responded. Colleagues surveyed all work in corporate functions.

The sample size does not dismiss the validity of the reflections and experiences of colleagues, it enables us to learn from colleagues that have remained at the trust. The work identifies some good practice that we can build on, our opportunities for improvement and the need to continue to build the trust values into our policies and practice.

The survey was developed in house, based on research from a range of sources undertaken post organisational change, and was reviewed by colleagues with an EDI, Engagement and Psychological lens.
The survey was conducted anonymously via survey monkey and was live for 4 weeks, with 3 reminders sent to potential respondents during that period.

The findings were reviewed by a multi-disciplinary task force committed to adaptive and agile ways of working that improve the experience of organisational change for all colleagues. Membership of the task force was on a voluntary basis and includes:

- a manager who has recently led organisational change (restructuring)
- colleagues who have been subject to organisational change (restructuring)
- staff side representative
- HR professionals
- OD professional

Chair's Assurance Comments

The Committee received and noted an update on the potential disposal of BI and impact on the affected colleagues. The process of consultation had been based on current Organisational Change Processes and had identified issues such as colleagues wanting permanent desk spaces and parking.

The second paper outlining the outcome of a survey of colleagues who had been though Organisational Change Processes was considered and raised a number of issues, some reflecting the less positive Staff Survey feedback. Committee requested that greater assurance that colleagues feel more engagement in change proposals during development and that the policy and procedure were being fully followed. It was agreed that a section be added into the quarterly report to people Committee providing this assurance.

ANNE BAINES
NON-EXECUTIVE DIRECTOR

8.1.1. People Committee Terms of Reference

Birmingham and Solihull Mental Health NHS Foundation Trust

PEOPLE COMMITTEE

TERMS OF REFERENCE

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1. Values

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future.
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Committee is constituted as a standing committee of the Board and is authorised by the Board to investigate any activity within its Term of Reference. It is authorised to seek any information it requires from any employee and contractors as directed to co-operate with any request made by the Committee or the Board.

2.2 The Committee is authorised by the Board to instruct professional advisors and require the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee is authorised to obtain internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 To ensure and provide assurance on behalf of the Board that the People Strategic Priority of the Trust's Strategy (2020) and people related issues of the Strategic Priorities of the Trust strategy (2020) is being delivered to all staff groups in line with the Trust values:

The Committee will take responsibility and delivery of aims set out within the People Strategic Priority as below:

- Shaping Our Future Workforce including
    - Attract and Retain Diverse Talent
    - High-Performing Workforce
    - Flexible &Transformative Workforce Models
- Transforming Our Culture including
    - Inclusion, Equality and diversity
    - Safety to Speak Up and Share Learning
    - Compassion and Wellbeing
- Modernising our People Practice including
    - Integrated People Practice
    - Evidence-Based People Practice
    - Digitally –Enabled Workforce

The Committee will be supported by two sub-groups to provide reports to the People Committee to this effect.

The following sub-committees will be chaired by professional leads outside of the People function:

- Shaping the Future Workforce Sub Committee
- Transforming Our Culture and Staff Experience Sub Committee

3.2 To assure focus and delivery of wellbeing and inclusion where staff are the top priority to support a happy workforce.

3.3 The People Strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care.

3.4 Processes are, and the right culture is, in place to support optimum employee performance to enable the delivery of the People Strategy and business plans aligned with the Trust's values.

3.5 To assure The Trust is meeting its legal and regulatory duties in relation to staff, volunteers and peers by experience.

3.6 To review and advise any human resource risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way.

3.6 To lead on monitoring of controls and assurance related to the 'People' sections of the Board Assurance Framework.

4. RESPONSIBILITIES AND DUTIES

4.1 Developing and advising the Board on the People Strategic Priorities including any leadership and organisational development interventions, actions to improve inclusion, equality and diversity necessary to deliver the Trust's strategy, incorporating external best practice and professional advice.

4.2 Overseeing delivery of the People Strategic Priorities on behalf of the Board against agreed plans, a range of workforce metrics, indicators and targets.

4.3 Providing appropriate reports to the Board on the above indicating assurances received, decisions made, and matters escalated that require consideration by the Board.

4.4 Monitoring the development of the future workforce, through an effective workforce plan that includes workforce supply, new roles, learning and organisational development.

4.5 Ensure the there is sufficient leadership and management capacity and capability within the Trust to deliver the Trust's strategy.

4.6 Ensuring that the voice of staff and volunteers is heard, via staff networks, staff surveys and other appropriate mechanisms, and that this acted upon in line with the strategic vision and values and to ensure compliance with requirements relating to Freedom to Speak Up and Whistleblowing.

4.7 Maintaining oversight and assure the Trust's equality, diversity and inclusion agenda is being delivered

4.8 Ensuring the Trust has a suitable policy framework and leadership development framework to deliver the People Strategic Priorities, ensuring alignment with the NHS People Plan and relevant regulatory requirements such as NHS Improvement workforce standards and CQC.

4.9 Oversee the development and implementation of initiatives to maintain the organization as an undergraduate and postgraduate learning provider.

4.10 Oversee and influence key relationships with educational partners to maximise benefit of these relationships to the Trust.

4.11 Review national and local strategies and reports from external bodies such as CQC, NHS E/NHS I, HEE & NHS Employers, identifying the implications for, and actions required by the Trust.

4.12 Ensure there are ongoing arrangements for reviewing the regulatory requirements relating to staff, such as NHSE/NHS I and CQC standards such as Well-Led. Ensure that appropriate strategies and plans are developed, implemented and sustained to meet these requirements.

4.13 Maintain oversight of its associated sub-groups through receipt of regular update reports and metrics.

4.14 The Committee will receive, for information, the minutes from the Joint Negotiation and Consultative Committee and the Joint Local Negotiation and Consultative Committee

4.15 Receive Review the People Risk Register and relevant risks from the Board Assurance Framework to review assurance on risk mitigation and controls including any gaps in control.

4.16 Assess any risks within the workforce portfolio brought to the attention of the Committee and identify those that are significant for escalating to IQC, FFP and Board as appropriate

4.17 Maintain oversight of Remuneration and Reward, ensuring and assuring alignment to relevant Employee and Worker legislation

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Chair – Non-Executive Director
- Deputy Chair - Non-Executive Director
- Non-Executive Director
- Chief Nursing Officer/Director of Quality & Safety
- Medical Director
- Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In Attendance

The following will be standing attendees of the Committee:

- Deputy Director of Nursing
- Deputy Director of Finance
- Associate Director for Allied Health Professions and Recovery
- Chief Psychologist
- Deputy Director of People and Organisational Development
- Chief Pharmacist

5.2 Other members of the Board can attend meetings if they indicate to the Chair of the People Committee, in advance, of their intention to do so.

5.3 Other members of staff may attend to present papers or to contribute to the staff story

5.4 Other parties may be invited to present papers from time to time.

5.5 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.6 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.7 Members should make every effort to be present at all Committee meetings.

5.8 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 3 Committee members, one of which must be a Non-Executive Director and one must be an Executive Director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All members must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 The meeting will be closed and not open to the public.

8.2 Meetings will be held monthly. Members will agree the meeting dates annually in advance.

8.3 The agenda of every Committee meeting will include as standing items a review of how effectively it has discharged its business and how effective the Committee has role modelled the values of the Trust through its decision making.

9. ADMINISTRATION

9.1 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.2 The Committee shall report to the Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

9.3 The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference.

9.4 The agenda for each meeting will be agreed by the Executive Director of Strategy, People & Partnerships and the People Committee Chair. The agenda, minutes and papers will be issued 5 calendar days before the meetings and any issues with the agenda must be raised with the People Committee Chair within 2 working days.

9.5 An action list and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.6 Any issues with the action list or minutes will be raised within 7 calendar days of issue.

10. REPORTING AND LINKS TO OTHER COMMITTEES

10.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance was received through papers and oral testimony.

10.2 The Committee will report to the Integrated Quality Committee on matters that are likely to affect workforce resourcing, education and learning to enable triangulation with clinical outcome and patient care indicators.

10.3 The Committee will report to Finance Productivity and Performance Committee on matters that are likely to affect expenditure on the Workforce and quarterly on the work of the Workforce Intelligence and Systems as they relate to pay.

10.4 The Committee will provide exception reports to the Audit Committee.

10.5 The Committee will provide reports as requested to the remaining committees.

10.6 Operational delivery of the Committee's work plan will be overseen by the Director of Strategy, People & Partnerships via day-to-day oversight of the HR, OD and Learning and Development functions.

10.7 The Committee will review its effectiveness on an annual basis, reporting the outcome of the review to the Board.

10.8 The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors at the next scheduled meeting.

Approved: December 2022

Review: November 2023

8.2. Quarterly Report Guardian of Safe Working

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**8.2**
PAPER TITLE	**Guardian of Safe Working Quarterly Report**
DATE	07 December 2022
AUTHOR	Dr Sajid Muzaffar, Guardian of Safe Working & Consultant Forensic Psychiatrist
EXECUTIVE SPONSOR	Dr Fabida Aria, Executive Medical Director

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

Equality & Diversity ***(all boxes MUST be completed)***	
Does this report reduce inequalities for our service users, staff and carers?	Yes
What data has been considered to understand the impact?	

Executive summary & Recommendations:

No immediate safety concerns were raised during this period.

Nine out of twelve exceptions were raised from the Forensic ST4-6 rotas. The theme of the exceptions is around the hours on a particular on-call being more than the average number of paid hours per on-call.

Two significant concerns were highlighted by the exception process. 1) a doctor being on call without having completed RIO and EPMA access. 2) A HR official closing the exceptions outside of the procedures. These issues have been escalated as detailed above.

The number of vacant shifts continues to be high. The largest proportion of the vacant shifts have been due to post vacancies. The shifts were primarily filled by internal locums.

Work is ongoing to help facilitate cultural change to support our doctors in training in raising issues.

Reason for consideration:

Quarterly reports mandated by the Terms and Conditions of Doctors in Training.

Previous consideration of report by:

Strategic priorities ***(which strategic priority is the report providing assurance on)***
PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users
Financial Implications ***(detail any financial implications)***
None
Board Assurance Framework ***(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities***
No new risks identified Exception reports and themes are discussed in Junior Doctors Fora on a regular basis.
Engagement ***(detail any engagement with staff/service users)***
Individual letters written to new doctors starting in our trust encouraging them to use the exception reporting system. Doctors in training have bi-monthly trainee council meetings. The meeting is open to all doctors in training in our Trust

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

July– September22
High level data
Number of doctors / dentists in training (total): 103
Number of doctors / dentists in training on 2016 TCS (total): 103
Amount of time available in job plan for guardian to do the role: 1 PA per week
Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports (with regard to working hours)

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
CT1-3	1	3	2	2
ST 3-6	1	9	6	4
GPVTS	0	0	0	0
Total	2	12	8	6

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
ST4-7	1	9	6	4
ST 3-6	1	3	2	2
GPVTS	0	0	0	0
Total	2	12	8	6

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	0
CT1-3	0	0	2	2
ST3-6	0	0	6	4
GPVTS	0	0	0	0
Total	0	0	8	6

b) Work schedule reviews

Status (12 exception reports - figures include 2 exceptions carried forward);

4 Reviews are pending
8 Completed
0 Request for more information
2 Unresolved
0 Waiting for Doctor Agreement
0 Miscellaneous

c) Locum bookings

Locum bookings JULY 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	24	24	215.00	215.00
Rota 2	17	17	162.00	162.00
Rota 3	18	18	175.00	175.00
Rota 4	30	30	296.00	296.00
Rota 5	30	30	294.50	294.50
Rota 6	14	14	140.00	140.00
ST4-6 North	43	41	598.00	581.00
ST4-6 Rea/Tam	7	7	120.00	120.00
ST4-6 Sol/East	13	13	240.00	240.00
ST4-6 South	18	18	251.00	251.00
Total	214	212	2491.50	2474.50
Locum bookings AUGUST 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	11	11	110.00	110.00
Rota 2	17	17	159.50	159.50
Rota 3	5	5	45.50	45.50
Rota 4	10	10	105.50	105.50
Rota 5	15	14	129.00	116.50
Rota 6	3	3	29.50	29.50
ST4-6 North	27	27	376.00	376.00
ST4-6 Rea/Tam	9	9	160.00	160.00
ST4-6 Sol/East	12	12	232.00	232.00
ST4-6 South	18	18	244.00	244.00
Total	127	126	1591.00	1578.50

Locum bookings SEPTEMBER 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	2	2	25.00	25.00
Rota 2	9	9	93.00	93.00
Rota 3	2	2	24.50	24.50

Rota 4	21	21	199.50	199.50
Rota 5	9	9	101.50	101.50
Rota 6	5	5	45.00	45.00
ST4-6 North	25	25	369.50	369.50
ST4-6 Rea/Tam	8	8	136.00	136.00
ST4-6 Sol/East	18	18	328.00	328.00
ST4-6 South	16	16	240.50	240.50
Total	115	115	1562.50	1562.50

Locum bookings JULY 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	133	133	1282.50	1282.50
ST4-6	81	79	1209.00	1192.00
Total	214	212	2491.50	2474.50

Locum bookings AUGUST 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	61	60	579.00	566.50
ST4-6	66	66	1012.00	1012.00
Total	127	126	1591.00	1578.50
Locum bookings SEPTEMBER 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	48	48	488.50	488.50
ST4-6	67	67	1074.00	1074.00
Total	115	115	1562.50	1562.50

Locum bookings JULY 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	115	114	1381.50	1369.00
Sickness	17	17	178.50	178.50
COVID 19	16	15	121.50	117.00
Off Rota	66	66	810.00	810.00
Total	214	212	2491.50	2474.50

Locum bookings AUGUST 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
New Intake	14	14	100.50	100.50
Vacancy	81	81	1077.00	1077.00
Sickness	8	7	97.00	84.50
COVID 19	3	3	48.00	48.00
Off Rota	15	15	191.00	191.00
Comp Leave	1	1	16.00	16.00
Acting Up Consultant	5	5	61.50	61.50
Total	127	126	1591.00	1578.50

Locum bookings SEPTEMBER 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	76	76	1086.00	1086.00
Sickness	9	9	98.00	98.00
COVID 19	7	7	88.00	88.00
Off Rota	21	21	281.50	281.50
Special Leave	2	2	9.00	9.00
Total	115	115	1562.50	1562.50

Qualitative information
Issues arising

A doctor was put on night shifts that stopped them from attending the induction. This meant that the doctor was on call without access to the RIO or EPMA. It is a significant clinical risk and has been escalated to the medical staffing with assurance that doctors will not be put on call without access to clinical records systems.

A significant procedural concern was identified and raised by the trainees. This was in relation to exceptions raised by Forensic ST-ST6s. The exceptions were cancelled administratively by the HR. This is not part of the procedure, and this was highlighted to the Deputy Medical Director who raised it with the staff member. I am assured that this will not be repeated.

There are 6 outstanding exceptions. Reminders are sent by the Medical Staffing Department to the supervisors and doctors related to the exceptions.

Work is in progress to support a culture change to encourage doctors in raising exceptions. A QI project is under way. The Guardian has written to the doctors highlighting the importance of exception reporting and highlighting the changes the system helped to bring. Exception reporting training is part of Trust induction for post graduate doctors in training.

Actions taken to resolve issues
See above.
Summary
No immediate safety concerns were raised during this period.
Nine out of twelve exceptions were raised from the Forensic ST4-6 rotas. The theme of the exceptions is around the hours on a particular on-call being more than the average number of paid hours per on-call. The pattern is being monitored and may require a review of the Rota to ensure that the number of average hours reflects the workload.
Two significant concerns were highlighted by the exception process. 1) a doctor being on call without having completed RIO and EPMA access. 2) A HR official closing the exceptions outside of the procedures. These issues have been escalated as detailed above.
The number of vacant shifts continues to be high. The largest proportion of the vacant shifts have been due to post vacancies. The shifts were primarily filled by internal locums.

Questions for consideration:
Support from the board in encouraging culture change in relation to use of exception reporting system and other avenues in highlighting issues. A message from directly from the Trust board would be helpful especially given the recent issues.

9. SUSTAINABILITY

9.1. Audit Committee Chair’s Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE AUDIT COMMITTEE**
Date	11th October 2022
Author	W. Weir, Non-Executive Director (*Chair of Committee)*
Executive sponsor	D. Tomlinson, Executive Director of Finance

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

The Audit Committee met on the 6th October 2022. The attached Chair's Assurance Report is provided for the attention of the Board.

- Update report from newly appointed Internal Auditors (RSM)
- Update report from newly appointed Local Counter Fraud (RSM)
- Noted Terms of Reference for Board consideration
- Confirmed External Audit strategy for 2022/23

There are no matters for escalation to the Board of Directors.

Reason for consideration

The assurance process for the Trust's Audit, Counter fraud and legal consideration. A revised Terms of Reference of the Committee is enclosed for Board consideration.

Strategic objectives/ priorities

Sustainability

Financial implications

The committee provides assurance to the board of the validity of financial statements, the internal financial controls of the organization including key policies and procedures.

Risks

The committee discussed audit/ accounts risks. In future meetings, the committee will consider the Board Assurance framework key risks.

Equality impact

There are no obvious matters for equality, diversity and inclusion.

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 External Auditors

As Chair of the Audit Committee, I presented a recommendation to the Council of Governors at their meeting in September, to endorse a recommendation from the Audit Committee for an extension by two years of the contract for the external auditors, Mazars

Chair's Assurance Comments: To note the extension of Mazars external audit contract.

1.2 Data Security and Protection Toolkit (DSPT)

The Committee received the final audit on DSPT which was undertaken by TIAA, previous internal auditors**.** The overall risk assessment across all 10 standards had received a "*substantial*" rating. The Committee was informed that this was a positive audit and all the recommendations had been completed.

It was noted that the audit was an annual requirement and would be undertaken again during the next 12 months.

Chair's Assurance Comments: 2021/22 Data Security and Protection Toolkit risk assessment is low receiving substantial assurance (i.e. positive) from internal audit for this Trust.

1.3 Committee Terms of Reference

The Terms of Reference for the Committee were presented for the annual review. These was being reviewed in conjunction with Terms of Reference for NHS England Audit Committee and it was being recommend that further detail be included regarding the element of financial reporting. The amendments would also include a section regarding reviewing compliance with Standing Financial Instructions and the Scheme of Delegation to ensure that any breaches were reported to the committee in its oversight role.

Chair's Assurance Comments: Assured that the Audit committee is covering its standing responsibilities in line with NHS England requirements. The Board is asked to approve the revised Terms of Reference.

1.4 Work Programme 2023

The Work Programme for the Committee was agreed and noted. This would be a standing item on future agendas.

1.5 Internal Auditors: RSM

Internal Audit Progress Report

The internal Audit Progress report was presented to the with the NHS news briefings being noted as welcomed by Committee Members.

Internal Recommendation Tracking
The Committee received the internal audit recommendation tracking document. The report detailed that status of 48 internal audit actions, 12 were reported as implemented with supporting evidence being provided. There were 13 actions which were due, 3 actions had yet to receive a response and there were 12 actions with revised implementation dates.

Chair's Assurance Comments: The committee were assured of a process for monitoring internal audit recommendations.

1.6 Local Counter Fraud Specialist (LCFS) Progress Report

The Committee received the Counter Fraud Progress report which included a number of appendices which included the Reactive Benchmarking report, the Local Counter Fraud Specialist Communication Strategy, Mandate Fraud report and the LCFS Newsletter for September 2022.

In relation to awareness, International Fraud Awareness Week was being held in November 2022 with information and invitations for RSMs counter fraud awareness sessions being shared with the Communications Team and Departmental Leads.

RSM hosted an Identification and Verification training session on 7th September which included practical examples of identification requirements and queries regularly seen by recruitment and HR teams. The next training session would be held in December.

The Trust was invited to take part in the Counter Fraud thematic exercise and the information had been collated and shared with the Counter Fraud Authority

Chair's Assurance Comments: The committee were assured that Local Counter fraud had commenced their work programme. The committee noted Fraud awareness Week in November 2022 and training sessions for HR teams in December 2022.

1.7 External Audit: Mazars: Audit Strategy Development

The Committee was presented with a summary initial Audit Strategy document for 2022/23 which summarised the audit approach, highlighted the initial consideration of likely significant audit risks and areas of key judgements. The final Audit Strategy Memorandum would be presented to the Committee in January 2023.

Chair's Assurance Comments: The committee noted the External Audit strategy and were assured that this was in line with NHS Requirements. The committee noted the audit risks from an external audit perspective. The committee were assured of the audit approach.

WINSTON WEIR
CHAIR OF AUDIT COMMITTEE

11th October 2022

9.1.1. Audit Committee Terms of Reference

Birmingham and Solihull Mental Health NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. VALUES

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future.
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Audit Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Board. This will include the responsibilities of the Trust in being a provider and commissioner of services.

2.2 The Committee is authorised by the Board to request the attendance of individuals and authorities from within or outside the Trust with relevant experience and expertise if it considers this necessary.

2.3 The Committee is a Non-Executive Committee of the Board of Directors, with no executive powers, other than those specifically delegated in the Terms of Reference.

3. PURPOSE

3.1 The Committee is authorised by Board to carry out any function within its terms of reference.

3.2 The Committee shall request and review reports and positive assurances from directors and managers, on the overall arrangements for governance, risk management and internal control and will provide assurance on these to the Board.

3.3 The Committee is delegated and authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- Recommend the Annual Accounts and Report (including the Quality Account and Charitable Funds Accounts) to the Board for approval

3.4 The Committee may also request specific reports from individual functions within the organisation as it may deem appropriate to provide assurance on overall governance arrangements.

3.5 The Committee will review all matters relevant to both the commissioning and provider functions within the overall Group.

3.6 Summerhill Services Limited (SSL) is a wholly-owned subsidiary of the Trust but is an independent company. As such the Board of SSL will make its own arrangements regarding audit and will account for these directly to the Board of the Trust. The financial results of SSL are consolidated within the overall accounts of the Group.

4. DUTIES

4.1 <u>Governance, Risk Management and Internal Control</u>

4.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

4.1.2 The Audit Committee will scutinise the Board Assurance Framework to provide the Board with assurance that the BAF is valid and suitable for the Trust's requirements. Specifically, the Audit Committee will:

- Ensure that there is an appropriate spread of strategic risks. This should be done once a year
- Assure itself that the process undertaken by management to populate the BAF is appropriate. This could be carried out on the Committee's behalf by the Internal Auditors to terms of reference agreed by the Committee
- Monitor the implementation of action plans that have been drawn up to cover gaps in controls, assurances, and reports to management
- Consider the audit needs of the organisation in terms of sources of assurance, and that there is a plan for these assurances to be received

- Review the results of assurances and the implications these have on the achievement of the Trust's strategic objectives

4.1.3 The Committee will review the adequacy of:

- All risks and controls related to disclosure statements (in particular the declarations of compliance with the CQC regulations and requirements for the Annual Report and Accounts and the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to approval by the Board
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the NHS Counter Fraud Authority

4.1.4 The Committee will ensure and assure on behalf of the Board that:

- The Trust has an appropriate and up-to-date Risk Policy
- The Risk Policy is being adhered to, in that risks are being identified, described, scored, managed, and addressed appropriately
- There is a transparent and effective method for the escalation of risks upwards within the Trust
- The higher scoring risks as collated into a single Corporate Risk Register, which is visible to the Board
- The Board Assurance Framework is a live document that reflects the controls and assurances needed to ensure and assure management of the risks associated with delivery of the Trust's Strategy

4.1.5 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit and other independent assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it

4.1.5 The Committee will have delegated authority from the Board to receive and approve changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation. It will also consider any breaches of these arrangements.

4.2 Financial Reporting

4.2.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal instructions bv the Regulator regarding financial performance.

4.2.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review both as to the completeness, accuracy and fitness for purpose of the information and with regard to the effectiveness of the Board's consideration of this information.

4.2.3 The Committee will review the annual report and accounts before submission to the Board, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted misstatements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the audit;
- letter of representation; and
- qualitative aspects of financial reporting.

4.3

Internal Audit

4.3.1 The Committee shall ensure that there is an effective internal audit function appointed in line with the scheme of delegation and that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation dismissal; as well as agreeing the adequacy of the procurement process
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation including those identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit

4.4 Counter Fraud

4.4.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas/

4.5 External Audit

4.5.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor in order for a recommendation to go to the Council of Governors, whose role it is to appoint the external auditors
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including receipt of the annual audit letter before submission to the Board and any work carried outside the

annual audit plan, together with the appropriateness of management responses
- Consider any non-audit work to ensure external audit retain independence

4.6 Other Assurance Functions

4.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arms-length Bodies or appropriate regulators/inspectors.

4.6.2 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee, and any Risk Management committees that are established, as well as receiving or seeking assurances as appropriate, from the other board sub committees.

4.6.3 In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

6. MEMBERSHIP AND ATTENDANCE

6.1 All members of the Committee will be independent Non-Executive Directors. At least one member will have a formally recognised accountancy qualification.

6.2 The membership of the Committee will be:
- Chair – Non-Executive Director
- Deputy Chair – Non-Executive Director
- At least two other non-Executive Directors

The membership will comprise representation (Member or Chair) from the Trust committees leading on quality, finance and people.

6.3 The following will be standing attendees of the Committee:
- Executive Director of Finance
- Company Secretary

6.4 Invitations for attendance of others will be issued by the Chair of the Committee in line with the requirements of the agenda.

6.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. Other Non-Executive Directors who are not members of the Committee may attend with the agreement of the Chair of the Committee. The Chair of the Board will not be a member of the Committee but may be in attendance at the discretion of the Committee Chair.

6.6 All members will have one vote. In the event of votes being equal the Chair of the Committee will have the casting vote.

6.7 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. At least once a year the Committee should meet privately with the External and Internal Auditors.

7. QUORACY

7.1 A quorum shall be two Non Executive Directors of the Committee.

8. DECLARATION OF INTERESTS

8.1 All members and attending officers must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

9. MEETINGS

9.1 Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may ask the Committee Chair for a meeting if they consider that one is necessary.

9.2 Meeting dates will be agreed annually in advance by the members of the Committee.

9.3 To include as a standing item on every agenda the Committee should review how effectively it has discharged its business.

10. ADMINISTRATION

10.1 The meeting will be closed and not open to the public.

10.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

10.3 An Action List and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

10.4 Any issues with the Action List or minutes will be raised within 7 calendar days of issue.

10.5 The Company Secretary will agree a draft agenda with the Committee chair and it will be circulated 7 calendar days before the meeting.

10.6 Any issues with the agenda must be raised with the Committee chair within 4 working days.

10.7 All final Committee reports must be submitted 7 calendar days before the meeting.

10.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings.

11. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

11.2 The Committee will review their effectiveness on an annual basis, reporting the outcome of the review to Trust Board.

11.3 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee.

Approved: October 2022

Renewal: October 2023

9.2. Finance, Performance & Productivity Committee Chair’s Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.2 (a)**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE & TERMS OF REFERENCE**
Date	7th December 2022
Author	R. Beale Non-Executive Director (Chair of Committee)
Executive sponsor	D. Tomlinson, Executive Director of Finance

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

The FPP Committee met on the 19th October 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board along with the Committee Terms of Reference which were reviewed and are presented for approval by the Board of Directors.

Reason for consideration

To demonstrate the effectiveness of the assurance process for the Trust's sustainability agenda and to escalate any key issues to the Board of Directors

Strategic objectives/ priorities

Sustainability

Financial implications

Detailed within the report

Risks

Equality impact

Non specific.

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Reach Out Commissioning Sub Committee

The Committee was presented with the Chair's Assurance report from the Reach Out Commissioning Sub Committee which was held on the 13th October 2022. The report from the Reach Out Mental Health Steering Group was received and the committee reported partial assurance noting all risks had been appropriately defined and reflected in the risk register. The committee understood the causes and impacts and have taken with appropriate mitigating actions. There was full assurance on contracting and quality monitoring with partial assurance on transformation/ commissioning, performance and finances. The shortfalls related to interfaces with other sectors such as local secondary mental health and prisons and the pace at which we are committing service development funding.

In relation to the Learning Disability and Autism Assurance report, a detailed update was given at the meeting regarding quality concerns at the Brooklands Unit including the improvement plans and risks.

The Committee received the risk registers noting that improvements were being made. Assurance was given that the Trust was analysing risks between provider, commissioner and partnerships. W. Weir queried the timescale for the completion of the risk register and was informed that the risk registers had been populated with further work being undertaken and would be presented on a quarterly basis to the Sub Committee

Chair's Assurance Comments:

1.2 Finance Position

The month 6 Group position was a deficit of £1.6m year to date, this was £1.6m adverse to the break-even plan as submitted to NHSE on 20/6/22. The position comprised a £1.9m deficit for the Trust, a £6k deficit for Summerhill Services Limited (SSL) and a £125k surplus position for the Reach Out Provider Collaborative. The month 6 Group deficit position was mainly driven by slippage on savings, out of area placements and staffing pressures.

The one area the Committee's attention was due to was temporary staffing spend with the current forecast being a total of £39m by the end of the year with approximately £9m on agency and £30m on bank. The Trust spend was £600k higher on bank staff than the previous year. The Trust remained above the NHS ceiling for agency relating to the new rule of aiming for a reduction of 10% and the Trust was running £3m above the ceiling. Since the last meeting, the system has had to submit an agency reduction plan which the Trust has contributed to.

In relation to cash, at month 6 the Group cash position was £68.1m and there was a significant level of cash with a deposit of £20m deposit and further discussions would be held in relation to the increase of the interest rate.

For capital, the spend was discussed by the Capital Review Group and SSL colleagues were reporting on the continued spend of capital

Chair's Assurance Comments:

1.2 Integrated Performance Report

The Committee was informed that in relation to out of area placements, there was a weekly trajectory in place and a significant financial pressure. The issue was one of quality to ensure patients were close to home. A report would be presented to the next meeting which would detail the trajectory and the work undertaken. At the end of last week, should be at 262 bed days and was under at 225 and ahead of the planned trajectory. The figure used to be 52 services users out of area which was now currently at 42.

Chair's Assurance Comments:

1.3 Establishment Review

The Committee was informed that the Trust had been working with NHS England regarding the MHost tool. Due to the work taking place at a national level, there has been a requirement for 15 people to be trained in every Trust. The Trust has a range of training booked for December onwards for staff to attend. The issue of recruitment and retention was being reviewed in conjunction with the establishment review. This was about maximizing the potential of recruitment and retaining people.

The Committee was informed that discussions were taking place regarding alignment of the recruitment and nursing strategies.

Chair's Assurance Comments:

1.4 Business Development including Partnership Update

The Committee received a report which summarised the key business development and partnership activities in Quarter 2 2022/23. Formal tender activity has continued to be significant over the past 3 months. The bid to retain the current liaison and diversion, prison leavers and mental health treatment requirements services, in the form of an Integrated Offender Healthcare service across BSOL, was successful and mobilisation will begin in mid-October.

A bid to retain veterans mental health services was submitted on 7 September. This was a national procurement exercise for all veteran's mental health services involving a single contract for each NHSE region.

The bid for the Midlands was submitted in partnership with all current providers with Lincolnshire Partnership NHSFT as lead provider. There were some significant concerns around the financial envelope which were detailed in the report.

A bid to provide IAPT Psychological Wellbeing Practitioner training for the Midlands was submitted to Health Education England on 30 September. The Trust already provides this training and HEE were looking to expand capacity through having multiple providers.

The Trust was expecting procurement for the Vulnerability Support Hubs (replacing the current Prevent In Place pilot service) by Counter Terrorism Policing Headquarters to begin in October.

The other significant area of business development activity was the provider collaborative work. Focus and priority was being given to the development of the BSOL Mental Health Service Integrator, with planning in place to meet the deliverables which was understood would be set out in the Delegation Assurance Framework.

Progress was being on the Perinatal Provider Collaborative with a project plan and team in place and clinical workshop to take place later in October, and the CAMHS provider collaborative went live on 1 October 2022.

Chair's Assurance Comments:

1.5 Development of the Board Assurance Framework

It was reported at the October Board meeting, that the previous BAF was agreed by the Board in early 2021 and last received by Board in Committees in February 2022. The BAF had recently been reviewed and refreshed and some proposals have been developed regarding the way forward. This includes better linkages to strategic priorities and ongoing review processes. This was accepted by the Board and the matter referred to individual committees for discussion on the details of the risks allocated to each Committee.

The Committee was informed of the process of reviewing risks with Deputy Directors reviewing the risk registers on a monthly basis to ensure work was progressing and to ensure risks were being closed as appropriate. The risks would be formally signed off by the Executive Team before risks were formally closed. It was also noted that a Risk Management Group was being established.

The Risk Management Policy was being reviewed and would be out for consultation in December and approved in January 2023.

The risk appetites were reviewed and agreed as:

Finance. Governance and Environment Aspirational Risk Appetite (Open): *We are willing to consider all potential delivery options and choices whilst also providing an acceptable level of reward.*

Digital and Partnerships Aspirational Risk Appetite (Seek): *We are eager to be innovative and to choose options offering higher business rewards, despite greater inherent risk.*

There would be a Board Development session arranged in the new year to review the Board Assurance Framework and the scoring for the strategic risks

Chair's Assurance Comments:

1.6 Terms of Reference Integrated Care Board Investment Committee

At the September 2022 meeting of the Chief Finance Officers, the draft Terms of Reference for the ICB Investment Committee were received with a request that these were presented at each Trust's Finance Committee.

The Committee was asked to note that that there was potentially an extra step in the process with an impact on scheme of delegation/SFIs and any changes required would be brought to the Board of Directors for approval.

The Terms of Reference were noted and it was reported that they may be subject to change.

Chair's Assurance Comments:

1.7 Annual Review of Terms of Reference

The Terms of Reference were reviewed and are presented to the Board of Directors for approval, as required on an annual basis. ***(Appendix A).***

Chair's Assurance Comments:

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.2**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	7 December 2022
Author	R. Beale Non-Executive Director (Chair of Committee)
Executive sponsor	D. Tomlinson, Executive Director of Finance

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary
The FPP Committee met on the 23 November 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's sustainability agenda and to escalate any key issues to the Board of Directors
Strategic objectives/ priorities
Sustainability
Financial implications
Detailed within the report
Risks
Equality impact
Non specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE

Reach Out
Reach Out Mental Health Steering Group Chair's Assurance Report

The committee were presented with a detailed overview of the Mental Health Steering Group highlighting the salient points as follows:

Transformation and commissioning

- Sessions now regularly held and positively received for work on partnership development. Concentrating at present on purpose, ambition and how we work/collaborate. Development programme, supported by 4OC, will support further integration with LDA part of the collaborative
- Ardenleigh Blended service now operating business as usual. Multi-agency workshop held in October to review womens pathway across inpatient and community services to inform commissioning intentions for 2023/24.
- Workforce strategy development workstream commenced with workforce data collection and structured interviews with partners

Contracting

- Contract Review meeting (CRM) Terms of Reference drafted and agreed by all partners; they will be ratified at Q2 meetings
- 21/22 subcontract for MPFT now complete
- NHSE have confirmed that revised Price Activity Matrix is being sent to Reach Out. The tariff inflator has been reduced following reversal of NI changes. The issue of PAMs to individual providers continues to be on hold
- STAH contract agreed with NHSE and prices have been uplifted by 5.15%. The Additional inflation will be funded out of the 2% growth pot
- Revised EPC costing template shared with all partners with a request to use and test for all October costings; it is expected that it will be formally agreed at November FCCG.

Performance

- Overall inpatient population increased by 6 in September to 447 and is essentially unchanged since Sep-21, although well down since introduction of Reach Out in 2017 (554). The out of area total has increased from 53 in April to 63. Discharges (10) and admissions (16) are both within normal ranges of performance
- Surge in referrals in August has subsided. Improved performance in regard to time for completed assessments in second quarter compared to first quarter.

Quality

- Regulatory Updates: CQC currently inspecting BSMHFT, including secure
- Note re. BBC Panorama: All partners reflected with constructive discussion at QAIG. Partner responses were aligned and included communications from board members, reiterating available support, Freedom to Speak Up guardians and the importance of leadership visibility and presence on the wards. Some partners written to carers and families, some are exploring how further lessons could be learned and some are reflecting on their restrictive practice. Partners advised they do not suspect, based on available insights, any of their services to exhibit culture and behaviours like those shown in the programme, this aligns with Reach Out quality surveillance with vigilance to be maintained

Finance

- Even with slight increase in inpatient population, financial performance remains good - value of under-performance has reached £4.0m or 9.4% by end of September. Largely driven by less than planned out of area
- Reserves (both from prior year and this financial year) remain unutilised and formed part of the discussion at FCCG about plans for spending

Risk Registers

Both risk registers (mental health and LDA) had been reviewed in detail prior to submission to the sub-committee and updated to reflect the current position.
The committee noted the key risks and issues reported for mental health and LDA. There was detailed discussion on some, particularly regarding provider staffing and agreement reached to moderate these to reflect risks more appropriately.

Partnership Development and Integration

There is good progress with the partnership development work and 4OC are continuing to support the work. Detailed plans are being developed for ongoing implementation.
In addition to this we are having further discussion regarding closer alignment between the mental health and learning disability and autism elements of the partnership and plan to make a number of improvements over the next six months.

Chair's assurance comments:
Report on Reach Out received – reasonable levels of assurance reported, and plans in place to improve those areas where it's not complete. Transformation funding not being spent which is a concern: reason is lack of people and time to consider the issues, but since this is a vital part of the change needed for sustainability, we remain concerned.

Finance Position

The month 7 Group position is a deficit of £0.7m year to date, this is £0.7m adverse to the break even plan as submitted to NHSE on 20/6/22. The position comprises a £1.1m deficit for the Trust, a £2k deficit for Summerhill Services Limited (SSL) and a £146k surplus position for the Reach Out Provider Collaborative. The month 7 Group deficit position is mainly driven by slippage on savings delivery and continuing out of area and staffing pressures.

Month 7 Group capital expenditure is £2m, which is £0.6m less than year to date plan but in line with the year to date revised forecast profile.

The month 7 Group cash position is £70.5m.

Bank and agency spend has increased significantly and the total forecasted spend is £41m.

BSMHFT Capital Programme update, assurance and recommendations for 2022/23 Capital Programme and 2023/24 onwards Capital programme.

Capital Programme 2022/23 – as at end October 2022

- Total Estates section of the Capital Programme sum £6,888,040 (excluding Trust ICT and Ardenleigh FCAMHS Seclusion)
- Ardenleigh FCAMHS Seclusion anticipated spend £250k in year 22/23 against total sum of £1.5m.
- Commitment as at October- total committed is £3,651,858 of the £6,888,040 programme.

Circa 300 schemes have been costed in order to respond to Trust requests for Major, Minor and Risk (Security, Fire, Ligature and Environment) based Capital Schemes plus Statutory

Standards and Backlog Maintenance (SSBM) projects.

The Estates element of the overall Capital Programme is normally between £6.5 and £7.0m. BSol ICS have not yet confirmed the budget allowance for 23/24 onwards but it is expected to be in this sort of order.

SSL have begun a prioritisation exercise on the SSBM project estimate of £3,749,784 aiming to reduce that to between £1.7 and 1.9m. The Executive Directors are examining the costed 23/24 capital proposals to prioritise all Major and Minor/Risk Projects project allocations for 23/24, 24/25 and onwards.

Chair's Assurance Comments:
Adjustments available in-year mean that we are still on track towards a neutral budget position by the end of the year, but we are concerned that the subsequent year will offer significant challenges that we are not assured of addressing.

The agency/bank spend is noted as a significant cost pressure, and we think we need to reframe the issues to address the problems: an alternative perspective is that if we were to spend and additional £40m on staffing, how would we best spend it? We have assurance that some of the schemes in place to reduce vacancies are seeing success (e.g. international recruitment is over target) though we do not have sufficient detail on the gaps remaining and what the plans are to address those, nor the timescales, and so cannot yet be assured on improvements to the staffing situation and associated costs. It was agreed that timescales for plans to address this would be circulated shortly to committee members.

Savings remain low in value compared to expectations, but we received assurance that most divisions have considered costs and identified that no savings can be made, which is more useful than not being able to comment. It seems likely that, given the historical scale of cost improvements and the position the trust is in, there is minimal scope for significant savings from trimming approaches. We all agree that the savings can be assisted through system working, and are assured that processes around collaboration are in place and are working well. However, the transformation of services is now becoming a vital part of plans to meet sustainability and financial pressures, and we have requested more visibility of what is in place and planned to address this. We are assured that there is some progress in this, but also that we need to see more detail, timings, expectations of improvements and suchlike so that we can start to give assurance that we can continue to deliver appropriate services. It was agreed to bring more detail to the committee so that we can scrutinize it and gain relevant assurances: at present, we are not sufficiently sighted to comment.

Integrated Performance Report

The Committee received the Integrated Performance Report and noted but did not discuss the salient points:

- FPP
  - CPA with formal review in last 12 months
  - IAPT seen within 6 and 18 weeks
  - Out of area bed days
  - CPA 7-day follow up
  - Referrals over 3 months with no contact
  - Monthly agency expenditure
- People

- Bank and agency fill rate
- Sickness absence
- Vacancies
- QPES
- Patient assaults

The committee noted the report is being reviewed to address the themes and issues and allow further understanding of how each of the service areas are delivering against the key themes.

Chair's Assurance Comments:
The commentary in the report is much improved: issues are identified, actions planned are given, and expected results and timescales presented, and where appropriate reported against. This gives us much more assurance on the control of the problems, and the committee noted its thanks to those involved for the improvements.

Out of Area: Trajectory Data

The committee noted the current position on in appropriate out of area placements actual versus forecast Trajectories:

- BSMHFT- Acute and PICU
- FTB Acute and PICU
- Combined datasets (Acute and PICU)
- Concluding remarks

Acute Beds

- Underlying demand remains at high of 13 beds used until end of September
- Assume no new in-area beds will be available
- We manage to avoid further inappropriate OOA admissions after September due to new active operational management measures
- Discharges of the existing 13 patients proceed steadily, supported by new transfer beds and OOA discharge coordinator, however slowly because of prioritisation of OOA PICU patients
- Reduction in inappropriate OOA bed usage is linear, reaching zero by start of June
- Proactive management of patients in out of area beds via the discharge coordinators to enable repatriation/discharge as appropriate.

PICU Beds

- Underlying demand remains at high of 22 beds used going forward
- Assume no new in-area beds will be available
- Impact of new transfer beds and OOA discharge coordinator prioritising PICU reduces OOA beds needed by 2 each month from November, with cumulative impact of 10 beds by March
- Demand still outstrips supply by around 12 beds at 1/4/2023

The committee noted the OOA project team is working alongside Operational service leads and Clinicians to select and assess potential improvement opportunities in workshops this week. The aim is to produce a robust implementation plan by the end of November.

The committee were assured the work being undertaken will then feed into a revised OOA trajectory and the FPP will continue to be provided with updates on this work.

Chair's Assurance Comments:

Congratulations to Vanessa and her team on this – BSMHFT's data shows a clear and persistent trend downwards, ahead of expectations, giving us strong assurance that the processes put in place are working, and we can continue to expect improvements. FTB are less experienced at both the modelling and addressing the issues and we are providing them with support – their trajectory is less good but is improving.

Trust Strategy Updates
Sustainability

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

- Clinical Services
- Sustainability
- People
- Quality

There are 23 goals in total for Sustainability, a reduction of 1 from the start of the year due to removal of a duplicated goal.

9 of these goals are prioritised as Level 1 or Level 2 and are reported in this report to FPP Committee.

It is encouraging that 78% of these goals are rated 'Green' or 'Amber' which means they are where we expected them to be at this point in the year or have only minor issues impacting delivery which are being managed, in relation to their milestone plans at this point in the year. 2 goals are rated 'Red':

- Develop clinically led digital roadmap (level 1 priority) – discussions have taken place about how to take forwards but there is not yet a concrete plan in place to progress, this will be developed in Q3/4.
- Develop delivery plans and timescales for efficiency schemes (level 1 priority) - due to the risk around identifying and delivering savings schemes impacting on financial balance.

Chair's Assurance Comments: Both strategic updates taken together – see below for comments.

Trust Strategy Updates
Clinical Services

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

- Clinical Services
- Sustainability
- People
- Quality

The Clinical Services Strategic Priority has a total 44 goals spread across 6 strategic aims, 30 of which have been prioritised as level 1 or 2.

This report summarises performance against these 30 goals in the first half of 2022/23.

There are 44 goals in total for Clinical Services. This has reduced from 52 at the beginning of the year, as during the mid year review it was clear that some separate goals connected to a specific theme should be merged under one goal, and some removed due to duplication in other areas.

There are 30 goals prioritised as Level 1 or Level 2 in the Clinical Services Strategic Priority. The detail and current status for each these are listed in an Appendix which is in the Reading Room. A summary of the overall status at the mid year point is shown below and the following slides provide an overview of achievements, focus areas for the remainder of 2022/23 and risks for each of the six strategic aims for Clinical Services.

The committee noted it is encouraging that 50% of these goals are rated 'Green' which means they are where we expected them to be in relation to their milestone plans at this point in the year.

Chair's Assurance Comments:
A comprehensive and visual approach to presenting multifaceted data, giving us a clear picture of progress. Much to celebrate here in terms of progress. We are assured that the strategic programs are, in the main, on track. We did request a little more information on the blocks to those rated red, and the plans in place to address the issues, as we do not currently have any clarity on whether these can progress or not.

RUSSELL BEALE
CHAIR OF FINANCE, PERFORMANCE AND PRODUCTIVITY

9.2.1. Finance, Performance & Productivity Committee Terms of Reference

Birmingham and Solihull Mental Health NHS Foundation Trust

FINANCE, PERFORMANCE AND PRODUCTIVITY COMMITTEE

TERMS OF REFERENCE

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1. VALUES

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Finance, Performance and Productivity Committee is constituted as a Standing Committee of the Board of Directors. Its constitution and terms of reference are as set out below, subject to amendment by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise as it considers necessary.

2.3 The Committee is authorised to carry out any function within its terms of reference.

3. PURPOSE

3.1 The primary purpose of the Committee is to provide assurance on finance, performance and productivity systems and processes and to approve any business cases in line with the SFI's and scheme of delegation.

3.2 To seek any and all explanations and information it requires from any employee or contractor of the Trust to achieve the Committee's purpose

3.3 To ensure and assure on behalf of the Board that the Sustainability stream of the Trust's Strategy (2020) is being delivered:

- Balancing the books
- Transforming with digital
- Caring for the environment
- Good governance
- Changing through partnerships

3.4 To lead on monitoring of controls and assurance related to the "Sustainability" sections of the Board Assurance Framework.

3.5 To receive assurance reports from the Reach Out Commissioning Sub-Committee. The Committee will ensure and assure on behalf of the Board the finance and contracting aspects of the Adult Secure Care and Learning Disability & Autism Secure Care Provider Collaborative.

4. DUTIES

4.1 To receive assurance regarding the Trust's medium- and long-term financial strategy and financial health, including consideration and endorsement of financial plans and budgets for approval by the Board.

4.2 To receive assurance regarding the Reach Out Provider Collaborative's medium- and long-term financial strategy and financial health, including consideration and endorsement of financial plans and budgets for approval by the Board as the Lead Provider.

4.3 To approve business cases in line with authority limits defined by the scheme of delegation or to make a recommendation to the Board for matters reserved to Board. The Committee will expect assurance that there has been full and proper consideration of the quality implications of any business case coming to the Committee for approval or review.

4.4 To consider savings targets and plans and endorse them for approval by the Board, including assurance of progress against the cost improvement programme.

4.5 To consider the Trust's approach to tax.

4.6 To approve and keep under review the Trust's investment strategy and policy.

4.7 To receive regular reports and insights regarding organisational performance in a form determined by the Committee, including external benchmark information as an aid to improving overall performance and productivity of the Trust.

4.8 To review relevant high-level risks and escalate to Integrated Quality Committee (IQC) and Audit Committee as appropriate in order to ensure these are properly reflected in the Board Assurance Framework.

4.9 To scrutinise and challenge financial information and service redesign plans and ensure that any potential impact on quality is fed back to Q&S.

4.10 To seek assurance regarding the strategic direction and operational delivery of the digital agenda, its impact on users and plans for sustaining it.

4.11 Where there are any concerns regarding finance, planning, performance and productivity, the committee is authorised to seek assurance that the concerns have been investigated, corrective action taken and lessons learnt.

4.12 To review and advise on the Trust's strategic business development and planning approach, including strategic intentions. This includes consideration of any relevant, significant business development proposals.

4.13 To approve policies appropriate to the work of the Committee, as defined by the Policy for Management of Policies.

4.14 To review and discuss the R & D strategy prior to approval by the Board.

4.15 To oversee, promote and provide assurance that the research and innovation work of the Trust is positively impacting on services.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

Chair - Non-Executive Director

- Deputy Chair - Non-Executive Director
- Non-Executive Director
- Executive Director of Finance
- Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In attendance

5.2 The following will be standing attendees of the Committee

- Deputy Director of Finance
- Company Secretary

5.3 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.4 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.5 Other members of the Board can attend meetings if they indicate to the Chair of Committee, in advance, of their intention to do so.

5.6 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.7 Members are expected to make every effort to be present at all Committee meetings.

5.8 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 3 Committee members, including one non-executive director and one executive director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 Meetings will be held at least 8 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 The Executive Director of Finance will be responsible for updating the Committee's cycle of business, with input from the Executive Director of Operations, for agreement with the Chair of the Committee.

9.4 The Executive Director of Finance will agree a draft agenda with the Committee Chair and it will be circulated 7 calendar days before the meeting.

9.5 Any issues with the agenda must be raised with the Committee chair within 4 working days.

9.6 All reports and papers must be submitted 7 calendar days before the meeting.

9.7 The agenda, minutes and papers will be issued 6 calendar days before the meetings.

9.8 An action list and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.9 Any issues with the action list or minutes will be raised within 7 calendar days of issue

10. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

10.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

10.2 The Committee will receive regular reports from the Research and Innovation Committee which will formally report into it and will receive regular exception reports from OMT covering issues emerging which are relevant to the remit of SC, including development of tenders and business cases.

10.3 The Committee will provide exception reports to the Audit Committee as the lead committee for governance.

10.4 The Committee will receive exception reports from Q&S on concerns which have been raised about potential impact on quality of financial plans. Conversely, exception reports will be reported to Q&S on issues the committee needs to draw to its attention about the impact on quality from issues emerging from discussions.

10.5 Overlap between Q&S, PC and SC business will be provided through an attendee at Q&S meetings providing a verbal update to SC. Attendees at Q&S, PC and SC will ensure the need for an integrated approach so that impact issues are not lost, and papers to committees will need to indicate where there is a potential impact on quality or the people agenda.

10.6 The Committee will review their effectiveness on an annual basis, reporting the outcome of the review to the Board of Directors.

10.7 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee. The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors at the next scheduled meeting.

Date Reviewed: October 2022

Approved by the Board:

Date of Review: October 2023

9.3. Integrated Performance Report - Front sheet

Enclosure 1: Integrated Performance Report

Enclosure 2: Overall October 2022 data

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.3**
Paper title	**Integrated Performance Report**
Date	7/12/2022
Author	Richard Sollars, Deputy Director of Finance Gill Mordain, Associate Director of Clinical Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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

- FPP
  - CPA with formal review in last 12 months
  - IAPT seen within 6 and 18 weeks
  - Out of area bed days
  - CPA 7-day follow up
  - Referrals over 3 months with no contact
  - Monthly agency expenditure
- People
  - Bank and agency fill rate
  - Sickness absence
  - Vacancies
- QPES – Patient assaults

Reason for consideration:

To assure the Committee of Trust delivery against its key performance indicators and priorities and seek support for recommended improvements.

Previous consideration of report by:

Executive Team and Performance Delivery Group

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

Clinical Services, Quality, People and Sustainability

Financial Implications *(detail any financial implications)*
None
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
N/A
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Ongoing performance monitoring via Performance Delivery Group

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: Out of Area is improving. IAPT remain key problems

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

October 2022

Performance

CPA 7 day FU	88.3% ↓
CPA with Formal Review last 12 mths	87.0% ↓
Data Quality Maturity Index (DQMI)	97.9% ↑
Delayed Transfer Bed Days	715 ↑
Delayed Transfer, percent of bed days	4.5% ↑
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	46.6%
IAPT seen in 18 weeks	70.3% ↓
IAPT seen in 6 weeks	38.9% ↓
Out of Area Bed Days	894
Referrals over 3 mths with no contact	3263 ↓

People

Bank & Agency Fill Rate	84.5% ↓
Fundamental Training	93.4% ↓
Rolling 12m Turnover	10.9% ↑
Staff Appraisals	82.0%
Staff Sickness	7.0% ↓
Staff Vacancies	14.2% ↓

Quality

Absconsions from inpatient units	7
Commissioner reportable incidents	6
Community confirmed suicides	0
Community suspected suicides	1
Failure to return	21
Incidents of self harm	141
Incidents resulting in harm (other)	15.8% ↑
Incidents resulting in harm (patients)	12.5% ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	40
Ligature with anchor point	3
Patient assaults	76 ↘
Patient assaults / 1000 OBD	4.0 ↓

Sustainability

CAP Ex	£378k
Cash	£70,497k ↑
CIP	£655k
Info Governance	92.4%
Monthly Agency	£769k
Operating Surplus	-£840k
SOF rating	3 ↑

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

compassionate inclusive committed

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: Out of Area is improving. IAPT remain key problems

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

October 2022

Performance

CPA 7 day FU	88.3% ↓
CPA with Formal Review last 12 mths	87.0% ↓
Data Quality Maturity Index (DQMI)	97.9% ↑
Delayed Transfer Bed Days	715 ↑
Delayed Transfer, percent of bed days	4.5% ↑
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Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	46.6%
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Out of Area Bed Days	894
Referrals over 3 mths with no contact	3263 ↓

People

Bank & Agency Fill Rate	84.5% ↓
Fundamental Training	93.4% ↓
Rolling 12m Turnover	10.9% ↑
Staff Appraisals	82.0%
Staff Sickness	7.0% ↓
Staff Vacancies	14.2% ↓

Quality

Incidents resulting in harm (patients)	12.5% ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	40
Ligature with anchor point	3
Patient assaults	76 ↘
Patient ssaults / 1000 OBD	4.0 ↓
Physical restraints	228
Physical restraints/ 1000 OBD	12.1
Prone restraints	66
Prone restraints/ 1000 OBD	3.5
Reported incidents	2298 ↑
Staff assaults	118
Staff assaults / 1000 OBD	6.2

Sustainability

CAP Ex	£378k
Cash	£70,497k ↑
CIP	£655k
Info Governance	92.4%
Monthly Agency	£769k
Operating Surplus	-£840k
SOF rating	3 ↑

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

compassionate inclusive committed

Integrated Performance Dashboard

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
CPA 7 day FU	95.00	91.0%	94.4%	92.1%	94.6%	91.8%	88.3% ↓
CPA with Formal Review last 12 mths	95.00	84.9%	84.3%	84.4%	84.6%	85.5%	87.0% ↓
Data Quality Maturity Index (DQMI)	95.00	97.1%	94.2%	96.9%	97.9%	94.7%	97.9% ↑
Delayed Transfer Bed Days		1161	984	823	783	720	715 ↑
Delayed Transfer, percent of bed days		7.3%	6.4%	5.2%	4.9%	4.8%	4.5% ↑
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Eating disorders urgent	95.00	100.0%		100.0%	100.0%	100.0%	100.0%
First episode psychosis	60.00		100.0%	100.0%	100.0%	100.0%	100.0% ↑
IAPT into recovery	50.00	47.5%	47.0%	48.8%	52.6%	48.8%	46.6%
IAPT seen in 18 weeks	95.00	65.3%	60.7%	64.3%	64.2%	65.7%	70.3% ↓
IAPT seen in 6 weeks	75.00	30.1%	29.2%	32.9%	34.0%	34.9%	38.9% ↓
Out of Area Bed Days	1,159.00	520	570	731	814	998	894
Referrals over 3 mths with no contact		2636	2789	2817	2955	3076	3263 ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* Out of Area is improving
* IAPT
* CPA 12-month review
* New referrals not seen in 3 months

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Staff Vacancies		11.0 %	14.3%	14.2%	14.9%	14.7%	14.2% ↓
Staff Sickness	4.28	6.1%	6.2%	7.7%	6.7%	6.4%	7.0% ↓
Staff Appraisals	90.00	84.8 %	84.5%	83.3%	83.2%	84.0%	82.0%
Rolling 12m Turnover		10.4 %	10.5%	11.0%	10.8%	10.9%	10.9% ↑
Fundamental Training	95.00	92.9 %	93.3%	93.5%	93.4%	93.1%	93.4% ↓
Bank & Agency Fill Rate		83.2 %	84.5%	76.2%	85.2%	82.9%	84.5% ↓

Top Line Commentary (Trust level)

KEY CONCERNS

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

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

Integrated Performance Dashboard

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Absconsions from inpatient units		8	2	3	3	10	7
Commissioner reportable incidents		3	6	8	6	5	6
Community confirmed suicides		0	0	0	0	0	0
Community suspected suicides		0	4	1	1	2	1
Failure to return		16	6	14	21	14	21
Incidents of self harm		167	181	158	182	157	141
Incidents resulting in harm (other)		12.0%	11.7%	16.4%	15.1%	14.8%	15.8% ↑
Incidents resulting in harm (patients)		13.4%	14.4%	14.6%	12.6%	15.3%	12.5% ↑
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		31	20	31	50	27	40
Ligature with anchor point		0	0	2	0	3	3
Patient assaults		51	38	32	48	55	76 ↘
Patient ssaults / 1000 OBD		2.7	2.1	1.7	2.6	3.1	4.0 ↓
Physical restraints		339	305	176	241	181	228
Physical restraints / 1000 OBD		18.1	16.6	9.4	12.8	10.1	12.1

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Incidents of self harm		167	181	158	182	157	141
Incidents resulting in harm (other)		12.0%	11.7%	16.4%	15.1%	14.8%	15.8% ↑
Incidents resulting in harm (patients)		13.4%	14.4%	14.6%	12.6%	15.3%	12.5% ↑
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		31	20	31	50	27	40
Ligature with anchor point		0	0	2	0	3	3
Patient assaults		51	38	32	48	55	76 ↘
Patient ssaults / 1000 OBD		2.7	2.1	1.7	2.6	3.1	4.0 ↓
Physical restraints		339	305	176	241	181	228
Physical restraints/ 1000 OBD		18.1	16.6	9.4	12.8	10.1	12.1
Prone restraints		43	44	42	83	60	66
Prone restraints/ 1000 OBD		2.3	2.4	2.2	4.4	3.3	3.5
Reported incidents		2446	2378	2323	2360	1988	2298 ↑
Staff assaults		103	87	105	103	106	118
Staff assaults / 1000 OBD		5.5	4.7	5.6	5.5	5.9	6.2

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	
CAP Ex		£59k	£94k	£63k	£139k	£1,200k	£378k	
Cash		£55,444k	£59,698k	£68,000k	£69,584k	£68,089k	£70,497k	↑
CIP		£1,144k	£572k	£823k	£738k	£656k	£655k	
Info Governance		81.1%	92.6%	93.3%	89.8%	90.8%	92.4%	
Monthly Agency		£689k	£576k	£650k	£1,095k	£670k	£769k	
Operating Surplus		£632k	£598k	-£341k	£235k	£279k	-£840k	
Property		98.5%	98.5%					
SOF rating		3	3	3	3	3	3	↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

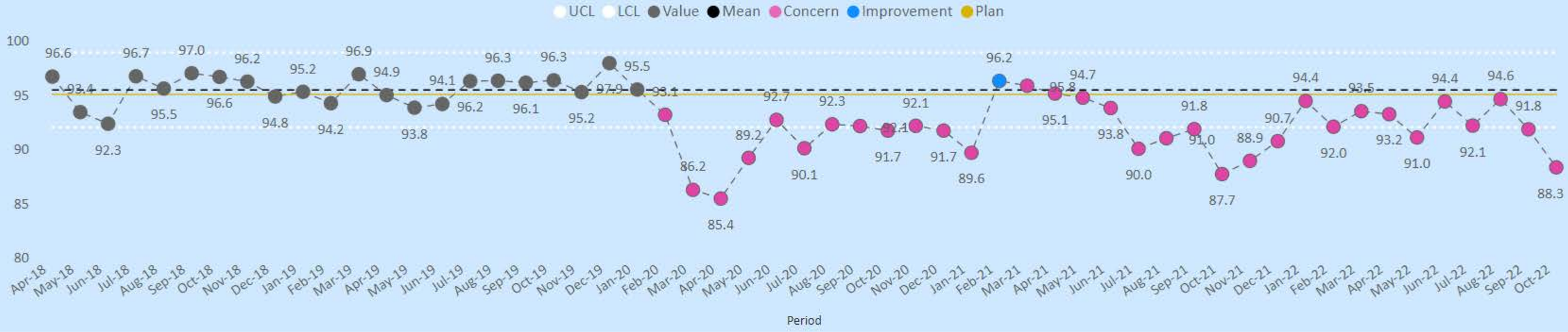
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	91.0%	94.4%	92.1%	94.6%	91.8%	88.3%
B: Acute and Urgent Care	98.0%	97.3%	60.0%	80.0%	81.1%	62.1%
C: ICCR	91.7%	75.0%	55.6%	75.0%	0.0%	57.1%
D: Secure Serv & Offender Health	57.1%	87.5%	66.7%	66.7%	80.0%	66.7%
E: Specialties	78.6%	100.0%	33.3%	75.0%	83.3%	75.0%

Commentary

National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 91.75% for September 2022. However there are two of passes, and if data entry was completed would bring it up to 92.5%

September 2022 performance is just below the target of 95%. This relates to 11 outstanding follow ups from 134 discharges in September of which, 3 patients were discharged to the care of FTB, 1 patient was discharged to a care home and contact was with staff only, 1 patient was discharged to an acute hospital and contact was with staff only, attempts were made to contact 1 patient without success, 2 patients were seen outside 7 days and 2 will be a passes when data entry has been completed. Of the 11 exceptions 8 were adult acute, 1, From ICCR, 1 from older adults and 1 in specialties

CPA 7 day FU

October- 2022

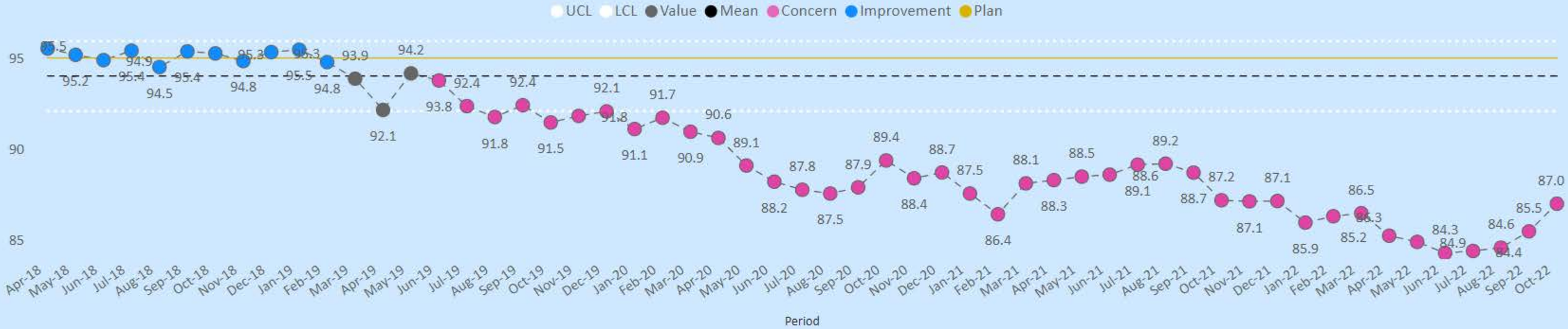
Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 91.75% for September 2022. However there are two of passes, and if data entry was completed would bring it up to 92.5% September 2022 performance is just below the target of 95%. This relates to 11 outstanding follow ups from 134 discharges in September of which, 3 patients were discharged to the care of FTB, 1 patient was discharged to a care home and contact was with staff only, 1 patient was discharged to an acute hospital and contact was with staff only, attempts were made to contact 1 patient without success, 2 patients were seen outside 7 days and 2 will be a passes when data entry has been completed. Of the 11 exceptions 8 were adult acute, 1, From ICCR, 1 from older adults and 1 in specialties
B: Why has it happened?	Impact of COVID, operational pressures, staff sickness levels have impacted on this measure including ability to access care homes during the COVID period. Where service users have been discharged to other mental health services to undertake the follow up, this requires BSMHFT to check with them to see if this has taken place. Recording has been challenging this month as a number of staff have undertaken bank shifts with teams they do not normally work in and therfore were not set up to record contacts. Teams have had additionally support to rectify where this has occured.
C: What are the implications and consequences?	Early follow up of patients post discharge prioritised by HTT in line with evidence based practise to reduce the risk of suicide or self harm. Service users are at a higher risk of suicide or self harm within the first 3-7 days of discharge and follow up is important to minimise this risk.
D: What are we doing about it?	Daily notifications of discharges are sent to the responsible team to alert them to plan follow up and this is monitored by the CSM for Home Treatment. Teams continue to require support from the information team regarding data entry on RIO. The addition of FTB data to the shared care record will also enable staff to check if patients have been followed up.
E: What do we expect to happen?	We expect 7 day follow up standard of 95% to be maintained with HTTs acting on the daily discharge notification received.
F: How will we know when we have addressed issues?	Standard is being maintained with minimal or no input required from the information team to review data entry.

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	84.9%	84.3%	84.4%	84.6%	85.5%	87.0%
B: Acute and Urgent Care	10.0%	11.1%	30.8%	44.4%	18.2%	18.2%
C: ICCR	83.5%	84.1%	81.9%	81.9%	82.0%	83.1%
D: Secure Serv & Offender Health	97.3%	97.6%	97.9%	97.4%	97.9%	97.9%
E: Specialties	69.0%	74.1%	73.3%	72.8%	70.1%	69.5%

Commentary

The number of reviews taking place has consistently declined over the last year and has been outside control limits since July 2019. The rate was maintained at an average of 89% from April 2021 until October and then declined to 87%. There have been periods of a slow decline followed by periods of stability. April – June declined to 84% which has then been sustained for July and August with an increase in September to 85.28%. Within divisions there is variation in performance with between 0-42 reviews outstanding. . Adult CMHTs have a total of 306 exceptions for September with 7 CMHTs having more than 30 reviews outstanding. Older Adult CMHTs have a total of 35 oustanding with the maority (21) in Solihull HUB. Adult CMHT account for 52%, older adult CMHT for 4%, Secure for 15% and AOT for 23%.

CPA with Formal Review last 12 mths

October- 2022

Question	Answers
A: What has happened?	The number of reviews taking place has consistently declined over the last year and has been outside control limits since July 2019. The rate was maintained at an average of 89% from April 2021 until October and then declined to 87%. There have been periods of a slow decline followed by periods of stability. April – June declined to 84% which has then been sustained for July and August with an increase in September to 85.28%. Within divisions there is variation in performance with between 0-42 reviews outstanding. . Adult CMHTs have a total of 306 exceptions for September with 7 CMHTs having more than 30 reviews outstanding. Older Adult CMHTs have a total of 35 oustanding with the maority (21) in Solihull HUB. Adult CMHT account for 52%, older adult CMHT for 4%, Secure for 15% and AOT for 23%.
B: Why has it happened?	During the COVID period face to face contacts have reduced with staff using digital solutions such as AccuRx and telephone calls to conduct appointments. Meetings with multiple people remains challenging at the moment. There is a reluctance for some older adults to attend face to face. ICCR: The AD has advised that there is variation within Adult CMHTs, and deep dives into the data, have highlighted inconsistencies in teams recording and outcoming CPA reviews and in the application of the CPA review criteria. Each team has been given a timeline of 3 months to bring their CPA review recording above 90%. AOT & EIS are consistently meeting the target with only one AO team having an issue which can be connected to staff shortages. Specialties: Face to face contacts are increasing, however, caseloads of care coordinators are currently very high (some CPNs have 50+ against an ideal maximum of 35) it is felt that the scheduling and recording of formal CPA reviews has not been as robust as it should be. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There has been no consistent Team Manager in the Solihull Team for the past 6 months due to the prevous recruited staff not staying in post, this has now been recruited to andthe new postholder has commenced.
C: What are the implications and consequences?	Carrying out as a minimum an annual CPA reviews is key to ensuring that the service user's care plan is updated to reflect changes in service users' needs, care and support requirements.
D: What are we doing about it?	Exception reports outlining service users coming up for their annual CPA review are available to all teams to enable proactive action in advance of the 12 months expiring. Work has taken place to address data quality issues in HTT, specialties and secure care. A plan to strategically review the CPA process including care plans has commenced with plans to introduce a new care plan in line with changes outlined in national guidance. Changes to the process in the community will be based on clinical models developed as part of the transformation work and in line with the NHSE statement on CPA. ICCR are reviewing the processes in place to ensure that they have a sustainable approach to completing CPA reviews and have undertaken an audit to identify any CPA reviews have not been recorded in the correct way. Each team who is below the target has been given a timeline of 3 months to bring their CPA review recording above 90% Specialties: Within older Adult CMHTs, a senior administrative lead has been tasked with following up with individual clinicians to ensure that formal CPAs are booked in and completed by end of September 2022. The new Team Manager is now in post in Solihull and is robustly following up caseload management for individuals including prompting appropriate discharging of patients. Within perinatal and Deaf services all Team Managers have been tasked with ensuring CPA reviews have taken place by end of September 22.
E: What do we expect to happen?	ICCR have set a trajectory to reach 90% over the next three months, with the aim of all teams being above 95% within 6 months

CPA with Formal Review last 12 mths

October- 2022

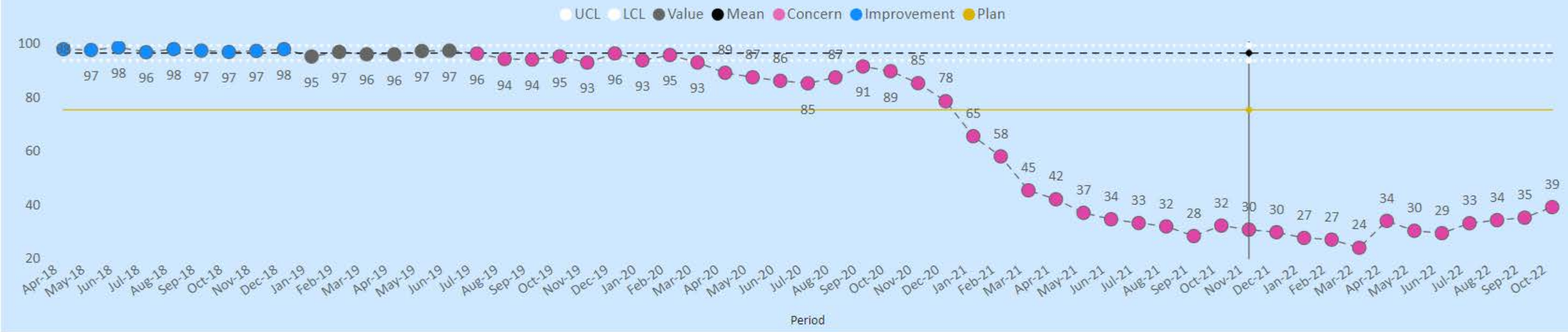
Question	Answers
	sustained for July and August with an increase in September to 85.28%. Within divisions there is variation in performance with between 0-42 reviews outstanding. . Adult CMHTs have a total of 306 exceptions for September with 7 CMHTs having more than 30 reviews outstanding. Older Adult CMHTs have a total of 35 oustanding with the maority (21) in Solihull HUB. Adult CMHT account for 52%, older adult CMHT for 4%, Secure for 15% and AOT for 23%.
B: Why has it happened?	During the COVID period face to face contacts have reduced with staff using digital solutions such as AccuRx and telephone calls to conduct appointments. Meetings with multiple people remains challenging at the moment. There is a reluctance for some older adults to attend face to face. ICCR: The AD has advised that there is variation within Adult CMHTs, and deep dives into the data, have highlighted inconsistencies in teams recording and outcoming CPA reviews and in the application of the CPA review criteria. Each team has been given a timeline of 3 months to bring their CPA review recording above 90%. AOT & EIS are consistently meeting the target with only one AO team having an issue which can be connected to staff shortages. Specialties: Face to face contacts are increasing, however, caseloads of care coordinators are currently very high (some CPNs have 50+ against an ideal maximum of 35) it is felt that the scheduling and recording of formal CPA reviews has not been as robust as it should be. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There has been no consistent Team Manager in the Solihull Team for the past 6 months due to the prevous recruited staff not staying in post, this has now been recruited to andthe new postholder has commenced.
C: What are the implications and consequences?	Carrying out as a minimum an annual CPA reviews is key to ensuring that the service user's care plan is updated to reflect changes in service users' needs, care and support requirements.
D: What are we doing about it?	Exception reports outlining service users coming up for their annual CPA review are available to all teams to enable proactive action in advance of the 12 months expiring. Work has taken place to address data quality issues in HTT, specialties and secure care. A plan to strategically review the CPA process including care plans has commenced with plans to introduce a new care plan in line with changes outlined in national guidance. Changes to the process in the community will be based on clinical models developed as part of the transformation work and in line with the NHSE statement on CPA. ICCR are reviewing the processes in place to ensure that they have a sustainable approach to completing CPA reviews and have undertaken an audit to identify any CPA reviews have not been recorded in the correct way. Each team who is below the target has been given a timeline of 3 months to bring their CPA review recording above 90% Specialties: Within older Adult CMHTs, a senior administrative lead has been tasked with following up with individual clinicians to ensure that formal CPAs are booked in and completed by end of September 2022. The new Team Manager is now in post in Solihull and is robustly following up caseload management for individuals including prompting appropriate discharging of patients. Within perinatal and Deaf services all Team Managers have been tasked with ensuring CPA reviews have taken place by end of September 22.
E: What do we expect to happen?	ICCR have set a trajectory to reach 90% over the next three months, with the aim of all teams being above 95% within 6 months
F: How will we know when we have addressed issues?	When reviews are undertaken in a systematic way and performance increases and is maintained although it is noted that the system will change and is part of a wider strategic review

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	30.1%	29.2%	32.9%	34.0%	34.9%	38.9%
E: Specialties	30.1%	29.2%	32.9%	34.0%	34.9%	38.9%

Commentary

Performance has been on a reducing trend since March 2020 below the 75% target. April 2022 increased by 10% to 33.7% which has then fluctuated with August at 34%. There have been small increases in July and August 2022.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 18 weeks

Divisions

Statistical Process Control (SPC)

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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	65.3%	60.7%	64.3%	64.2%	65.7%	70.3%
E: Specialties	65.3%	60.7%	64.3%	64.2%	65.7%	70.3%

Commentary

Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 11 months. Levels have been sustained in April and May at 65%. June figures dipped to 60.7% but have increased again in July to 64.2%, which has been sustained in August.

IAPT seen in 6 weeks

October- 2022

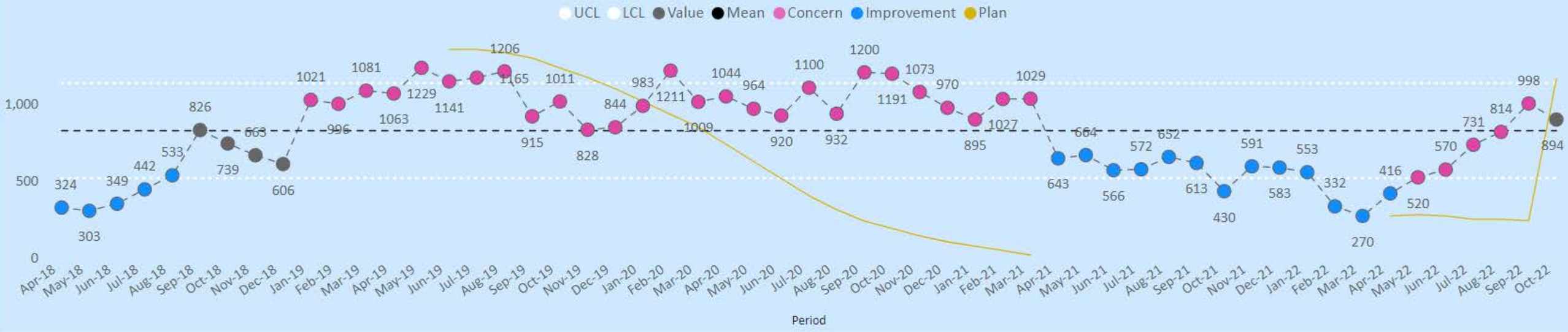
Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 below the 75% target. April 2022 increased by 10% to 33.7% which has then fluctuated with August at 34%. There have been small increases in July and August 2022.
B: Why has it happened?	The ability to see patients face to face was impacted by Covid as access to GP surgeries and access to community facilities stopped. Face to face groups also stopped and, whilst these have now increased in BHM premises since easing of restrictions, they have needed to be undertaken in a COVID secure way and capacity is therefore reduced in the number of participants per group. The iAPT model relies on large group interventions to see the majority of patients at Step 2, with smaller numbers then requiring Step 3 - 1:1 intervention. The service also has a large number of vacancies following staff retirements and leavers. Over the past 5 years significant challenges have been faced around retention of staff who have left to take up further training, work outside of the NHS or move to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees.
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. Internally: funding agreed to offer all High Intensity therapist at Band 7 bringing in line with other Trusts. This has already had an impact whereby the service has recently retained 10 of the 11 trainees, who will start in October. A communications strategy and social media campaign has commenced to support the rolling adverts for both qualified and future trainee posts. A review has taken place of clinical space in order to increase group capacity and GP premises have reopened to BHM. The removal of masks and social distancing from 12th September will allow a further increase in group participants. Online groups are also well established, which show lower numbers of DNAs. An additional quality oversight managerial role is being recruited to free up clinicians from management duties and increase clinical contact hours. A team mamanagr post has also been recruited to. Allocation of trainee places for 'new to IAPT' posts have been agreed and plans are in place to recruit to these, for both CBT and non-CBT modalities. Drop in sessions have been reinstated.
E: What do we expect to happen?	The service expects to see a containing in the reversal of the downward trend against this KPI and significant improvement against the target by March 2023. The service expects to be back above the 75% target by March 2024, following a further 3 intakes of trainees and the successful retention of these staff on completion of their training.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 75% target.

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	520	570	731	814	998	894
B: Acute and Urgent Care	520	570	731	814	998	894

Commentary

Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January 2022 at 575 bed days. Numbers started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease continued in March 2022 to 270 OOA bed days. April onwards has seen a significant increase with September at 998 days with 14 admissions to PICU beds and 4 to acute beds, taking the full month's number to 47 OOA placements. An initial trajectory was agreed with commissioners for 2022/23 to reach 186 bed days by March 2023. September 2022 performance is above the target of 240 OOA bed days and there is continued pressure on adult PICU beds. A revised trajectory has been agreed with commissioners from October 2022 to July 2023 to reach 372 bed days by July 2023, which will focus on removing acute out of area placements and reducing PICU usage.

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

October- 2022

Question	Answers
A: What has happened?	Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January 2022 at 575 bed days. Numbers started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease continued in March 2022 to 270 OOA bed days. April onwards has seen a significant increase with September at 998 days with 14 admissions to PICU beds and 4 to acute beds, taking the full month's number to 47 OOA placements. An initial trajectory was agreed with commissioners for 2022/23 to reach 186 bed days by March 2023. September 2022 performance is above the target of 240 OOA bed days and there is continued pressure on adult PICU beds. A revised trajectory has been agreed with commissioners from October 2022 to July 2023 to reach 372 bed days by July 2023, which will focus on removing acute out of area placements and reducing PICU usage. From the 1st October 2021 NHSE have agreed a Standard Operating Protocol (SOP) with the Trust to enable 10 Priory acute beds based in Willenhall to be classified as 'appropriate placements' for 6 months until 31st March 2022 in addition to the same classification for the MERIT beds. Internal reporting and commissioner reporting from 1st October 2021 has been amended to reflect this change. It has also been agreed by NHSE that any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements' from the 1st January 2022. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHS Digital currently does not recognise the bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The increases over the last 5 months are a combination of a number of issues and risks. Taking into account the procurement of 22 additional beds with the Priory, for 12 PICU and 10 acute beds, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has also increased with high acuity and high levels of observations required. It is also noted that all of the admissions are on an emergency basis. Staffing has also remained a challenge in terms in recruiting to vacancies and sickness and a number of acute beds remaining closed. DTOCS accounted for 338 lost bed days and remains an issue.
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 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 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 receive national and commissioner scrutiny which will increase if the Trust is unable to demonstrate continuing progress.
D: What are we doing about it?	The Performance Delivery Group deep dive took place in August and outlined the pressures and actions being taken to try and reduce OOA activity, in addition to those steps already in place. A task and finish group will be established to identify issues and solutions which will help reduce the current high levels of out of area placements. Actions currently include:

Out of Area Bed Days

October- 2022

Question	Answers
	bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The increases over the last 5 months are a combination of a number of issues and risks. Taking into account the procurement of 22 additional beds with the Priory, for 12 PICU and 10 acute beds, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has also increased with high acuity and high levels of observations required. It is also noted that all of the admissions are on an emergency basis. Staffing has also remained a challenge in terms in recruiting to vacancies and sickness and a number of acute beds remaining closed. DTOCS accounted for 338 lost bed days and remains an issue.
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 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 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 receive national and commissioner scrutiny which will increase if the Trust is unable to demonstrate continuing progress.
D: What are we doing about it?	The Performance Delivery Group deep dive took place in August and outlined the pressures and actions being taken to try and reduce OOA activity, in addition to those steps already in place. A task and finish group will be established to identify issues and solutions which will help reduce the current high levels of out of area placements. Actions currently include: Length of stay- To try and address the outlier length of stays for those patients placed out of area to be supported by a dedicated discharge manager whose focus will be on managing the needs of out of area patients with a view to supporting transfers back to their home localities where possible. Additional bed capacity- Active Care Group are opening 20 beds in King's Norton Birmingham- this presents an opportunity to bring patients closer to home which also leads to a shorter length of stay. Use of these local beds would also be subject to being classified as 'in area'. Longer term options include the potential for a capital build solution which is at an exploratory stage. A revised trajectory has been agreed with commissioners from October 2022 to July 2023 to reach 372 bed days by July 2023, which will focus on removing acute out of area placements and reducing PICU usage.
E: What do we expect to happen?	Monthly use of Out of area beds is expected to continue but reducing as the range of actions get implemented and embedded and more recently as a result of the SOP agreed with NHSE. However, it should be noted that the service is currently facing Covid-19 pressures in terms of outbreaks on wards and impact on staff sickness absence levels.
F: How will we know when we have addressed issues?	When the numbers of OOA bed days reduce in line with the trajectory submitted in the action plan. Operational meetings have continued to take place to maintain the implementation of the actions required to support the actions on a sustainable basis. Stabilisation in terms of inpatient capacity and the Trust's plan to review new ways of working will further assist in taking forward this workstream.

Detailed Commentary

Referrals over 3 mths with no contact

October- 2022

Question	Answers
A: What has happened?	The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular. The number of patients who have not been seen after 3 months of referral in April 2021 was 2227 with the trend since then showing a reduction to July. August onwards has shown a steep increase reaching 2578 in October 2021 which then fell slightly in November. March 2022 onwards has shown a continued increase with September 2022 at 3076. The number of referrals not seen within 3 months of referral have increased in all services with the exception of SOLAR and CAMHS Primary mental health which have fallen. Neuropsychiatry service accounts for23.5% and Adult CMHTs 32% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts have reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. Based on available research, it is expected that the backlog of service users not seen or choosing not to access services during the Covid period together with new demand arising as a result of the impact from Covid -19 will result in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. This indicator also relies on teams outcoming appointments on Rio and work is being undertaken with services on an ongoing basis to reduce the number outstanding. ICCR: have undertaken a deep dive of those with longer waits and have identified that there are a number with future appointments in place. Where there were no appointments a number themes were highlighted which has shown that a number are transfers from another BSMHFT/FTB team so are still actively under these teams, a number are recurrent DNAs and the last themes that actions are from MDT not followed through e.g. discharging patients Specialties: We currently have an aging population and better awareness of mental health concerns within the population and at primary care level. This has led to a consistent increase in number of referrals to our Older Adult CMHT, particularly for patient with dementia, but has not been accompanied with any increase in the Older Adult CMHT workforce. Caseloads of care coordinators are currently high (some CPNs have 50+ against an ideal maximum of 35) reducing CPN capcity to see new assessments and take new patients on. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. This is particularly significant in Solihull where there has not been a consistent manager in post for the past 6 months. There are discrepancies in medical workforce numbers between the teams causing higher waits for medical outpatient clinics in some teams. There is also a significant number of patients in care homes where, due to pandemic restrictions, our service was unable to see or communicate with directly however, through carers were able to provide consultation and commence treatment, however these have reamined on the waiting list. For all service it is important to note that where patients DNA, they are likely to have been provided with an appointment within 3 months - this is a particular issue for perinatal patients where due to having an infant patients frequently cancel or DNA appointments prior to eventually being seen. In bi-polar service, patients will already be under a CMHT in order to access their service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred.
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service

Detailed Commentary

Referrals over 3 mths with no contact

October- 2022

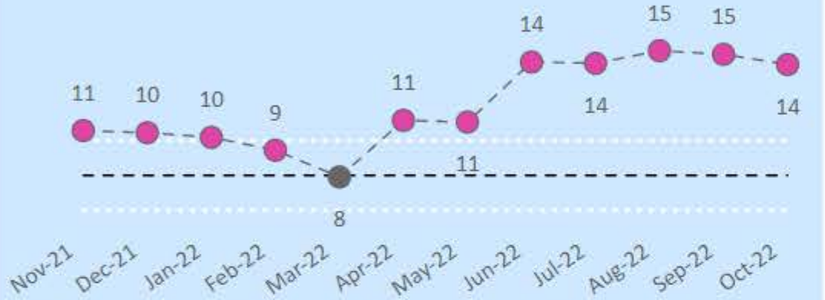
Question	Answers
	service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred.
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service
D: What are we doing about it?	ICCR: Reviewing patient flow and activities as part of strategic management of demand and capacity informed by service user need and staffing levels/skill mix to support. New ways of working and alternative methods of contact are being taken into account to manage the demand and services are drawing up plans to agree the appropriate level of face to face contact for each service. Face to face activity has continued to increase over the past few months. Adult CMHTs have set up some Saturday clinics to help address backlog, however this relies on clinicians to support these. As Primary Care Liaison teams grow suitable patients will be moved from Secondary to primary care teams with eventual GP only care – This will generate capacity in CMHT to manage SMI. Solar are introducing additional group work initiative's to manage capacity where appropriate and have introduced peer volunteer support counselling roles which have been positively evaluated. Specialties: The Team Manager is now in place in Solihull Older Adult CMHT. A caseload audit is currently being undertaken picking up patients who have been waiting longer than 3 months. Regular contact (every 2 weeks) is being made with these patients by the duty clinician, offering telephone support and prioritising appointments if there has been a deterioration in presentation. Regular management supervision is focussing on care coordinator capacity, looking at where patients could be stepped down from care coordination to free staff up to do new assessments. Admin lead supporting the management of care support patients using Rio to identify where patients do not have follow up appointments (where they have missed the appointment) and booking these in through med secs. A new role of Clinical Development Lead is being recruited to provide a focus on sustaining improvement and performance and provide support to hotspot areas, improve the quality of care and develop the pathway for Older People. A small proportion of new referrals will be rerouted to primary care hub via the establishment of Community Transformation Primary Care hubs (only for Serious Mental Illness, not Dementia patients) and current caseloads will be referred to primary care teams where possible through reconcilliation audits.
E: What do we expect to happen?	For Adult CMHTS we would expect to see changes over the next 24 months as community transformation develops and is embedded across all BSOl Primary care Networks. Within older adult CMHTs we expect there to be some improvement in waiting lists, particularly in Solihull over the next 3 months following this focussed piece of work. The service however expects this improvement to be limited across the service due to the small number of patients suitable for community transformation development and the rising demand for dementia care in secondary services, with no additional funding in this area. It is unlikely that Neuropsychiatry waiting times will be improved.
F: How will we know when we have addressed issues?	Where national access standards are in place e.g. Eating Disorders, First episode psychosis, these are consistently met by services. For adult and older adult community services success will be meeting the national 4 week target which has yet to be formally introduced. The delivery of this standard is part of the community services transformation work plan and planned revised pathways to support service users.

Birmingham and Solihull Mental Health NHS Foundation Trust

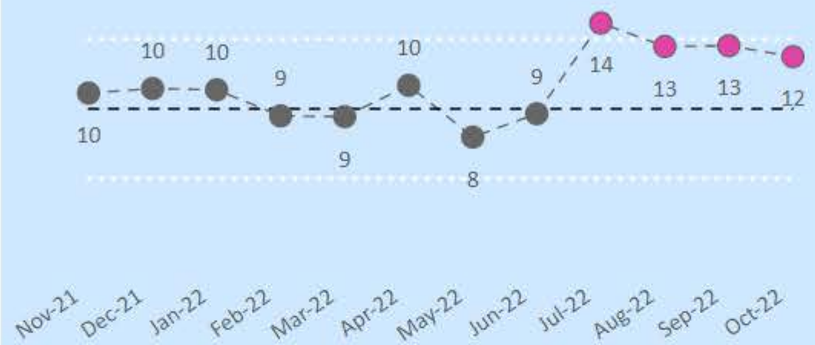
Staff Vacancies

Trust level

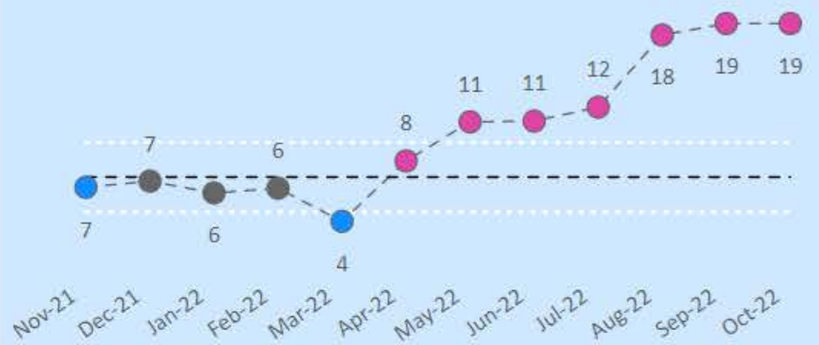
A: All



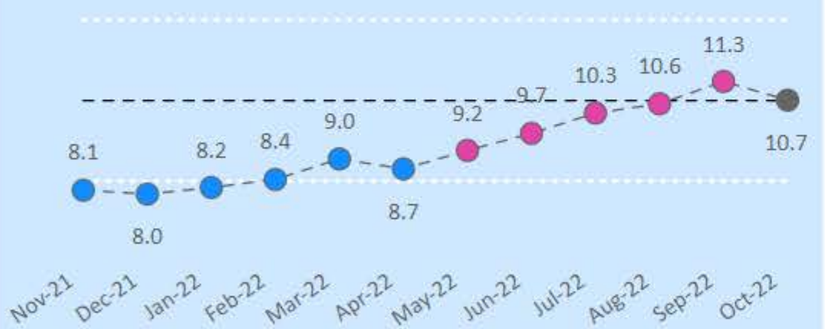
B: Acute and Urgent Care



C: ICCR



D: Secure Serv & Offender Health



E: Specialties

F: Corporate

Key

UCL LCL Value Mean Concern Improvement

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

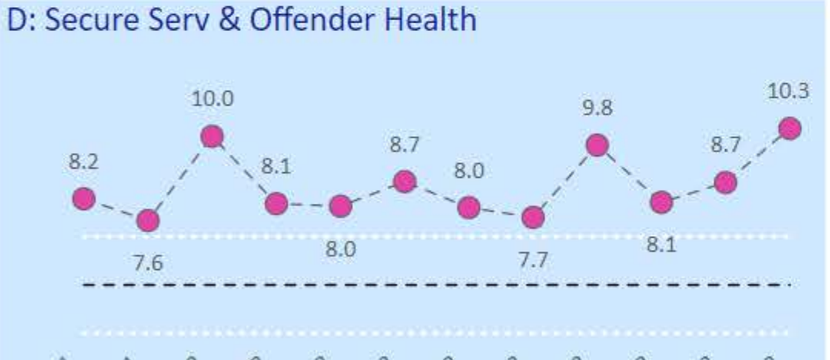
Trust level

A: All

B: Acute and Urgent Care

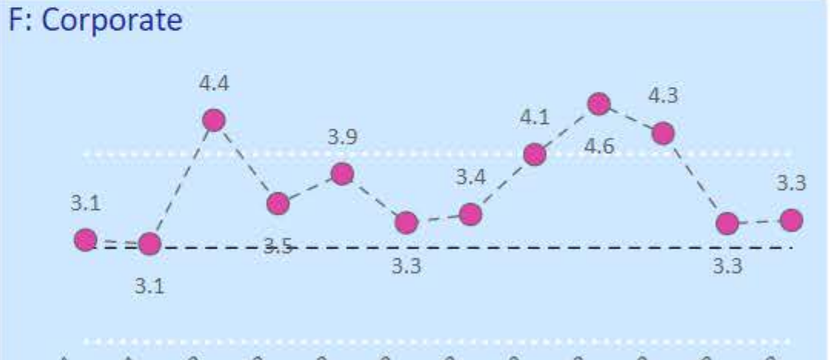
C: ICCR

D: Secure Serv & Offender Health



E: Specialties

F: Corporate



Key

UCL LCL Value Mean Concern Improvement

compassionate inclusive committed

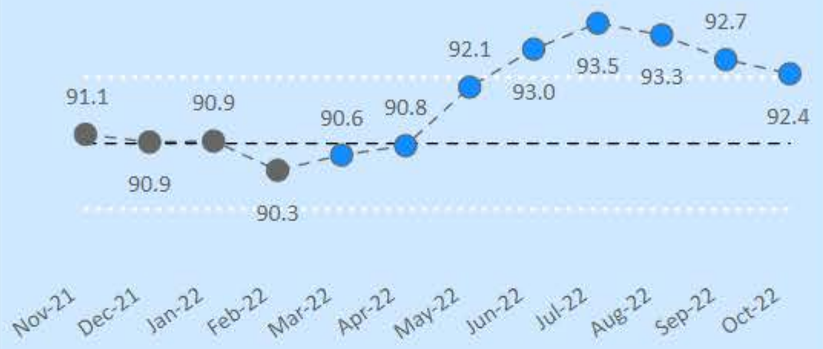
Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

Trust level

A: All

B: Acute and Urgent Care



C: ICCR

D: Secure Serv & Offender Health

E: Specialties

F: Corporate

Key

UCL LCL Value Mean Concern Improvement

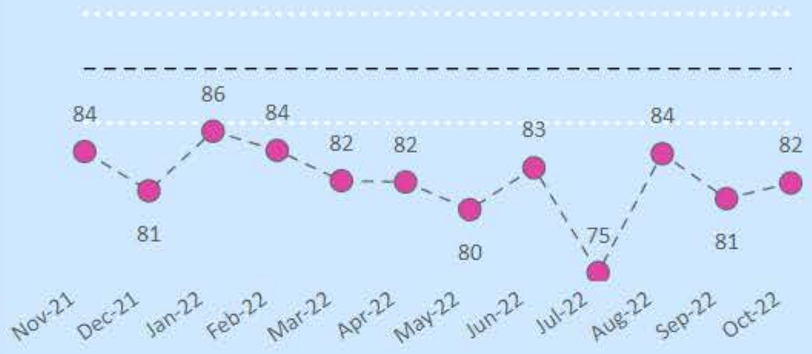
Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

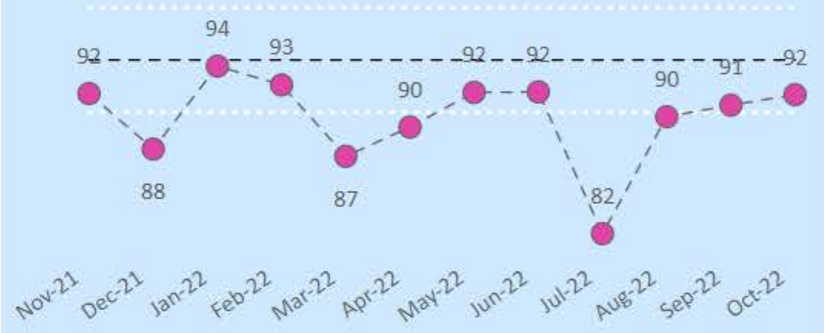
Trust level

A: All

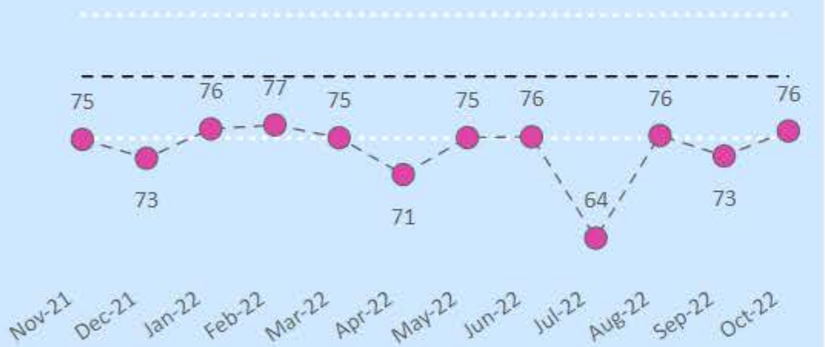
B: Acute and Urgent Care



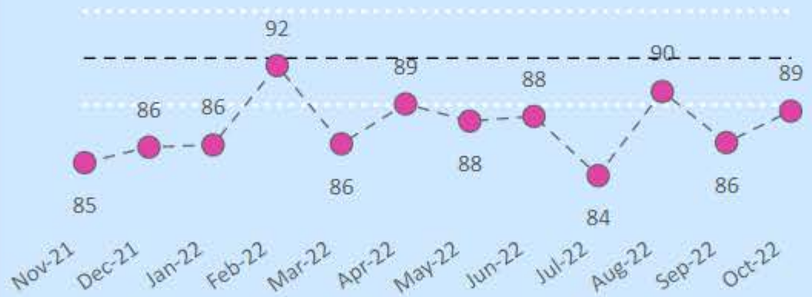
C: ICCR



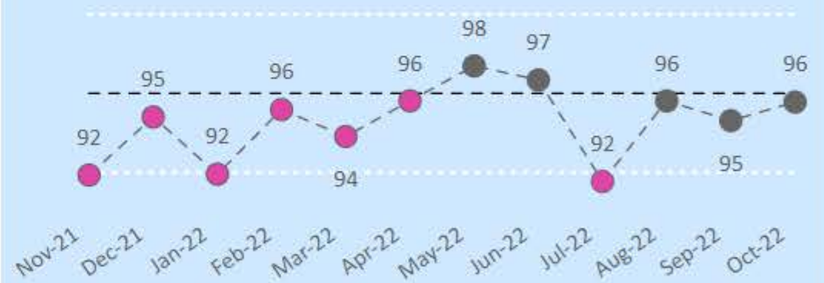
D: Secure Serv & Offender Health



E: Specialties



F: Corporate



Key

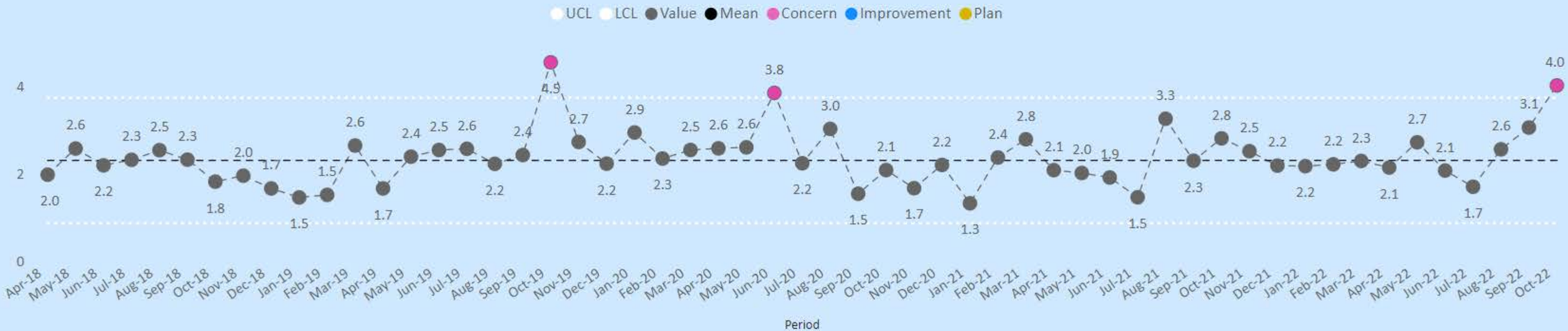
UCL LCL Value Mean Concern Improvement

Birmingham and Solihull Mental Health NHS Foundation Trust

Patient ssaults / 1000 OBD

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	2.7	2.1	1.7	2.6	3.1	4.0
B: Acute and Urgent Care	5.8	4.0	2.6	5.0	6.7	9.4
C: ICCR		0.4		1.1		
D: Secure Serv & Offender Health	1.0	1.0	1.3	0.4	0.2	0.1
E: Specialties	2.0	1.6	1.9	3.0	4.3	4.1

Commentary

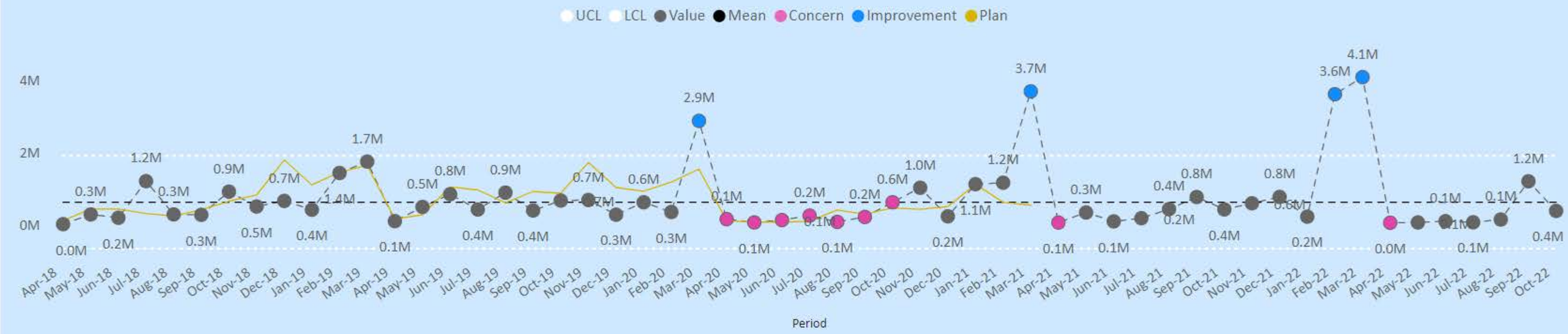
(Blank)

Birmingham and Solihull Mental Health NHS Foundation Trust

CAP Ex

Divisions

Statistical Process Control (SPC)



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

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
A: All	£59k	£94k	£63k	£139k	£1,200k	£378k

Commentary

Monthly capital expenditure is now starting to increase as programme starts moving forward in earnest. Spend of £1.2m in month. Still behind plan, but will meet expected annual plan

Integrated Performance Report

Context

All SPC-related charts and detailed commentaries can be accessed if you are on 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

Performance in October 2022

The key performance issues facing us as a Trust have changed little over the last twelve months:

- **Out of Area Bed Use** – Some process improvements have helped us address underlying issues, but the impact of COVID-19 and the closure of beds ha29significantly impaired our ability to eliminate use of out of area beds. October's figure is 33 patients
- **IAPT** – As discussed at FPP, there is a range of issues which require a system approach to resolve and additional investment
- **New referrals not seen** – As discussed at FPP, there are a range of issues here, including the level of Neuropsychiatry waits
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. This has deteriorated as a result of COVID, but the overall divergence between individual teams has long been a concern:
- **YTD financial position** is a deficit of £0.7m against a planned breakeven, chiefly because pressures on temporary staffing and out of area beds. We expect to achieve breakeven for the year as a whole

Quality

- Ligature incidents with no anchor point are back up to 40 after falling from 50 to 27 In September – with anchor point unchanged at 3 (all in Acute and Urgent Care
- Patient assaults on patients have increased from 3.1 to 4.0 per 1,000 OBDs, the highest since Oct-19
- Incidents reported up to 2298 from 1988 in September, which was the lowest figure since Sep--21. High levels of reporting are considered a positive
- **Key concerns: Patient assaults**

Performance

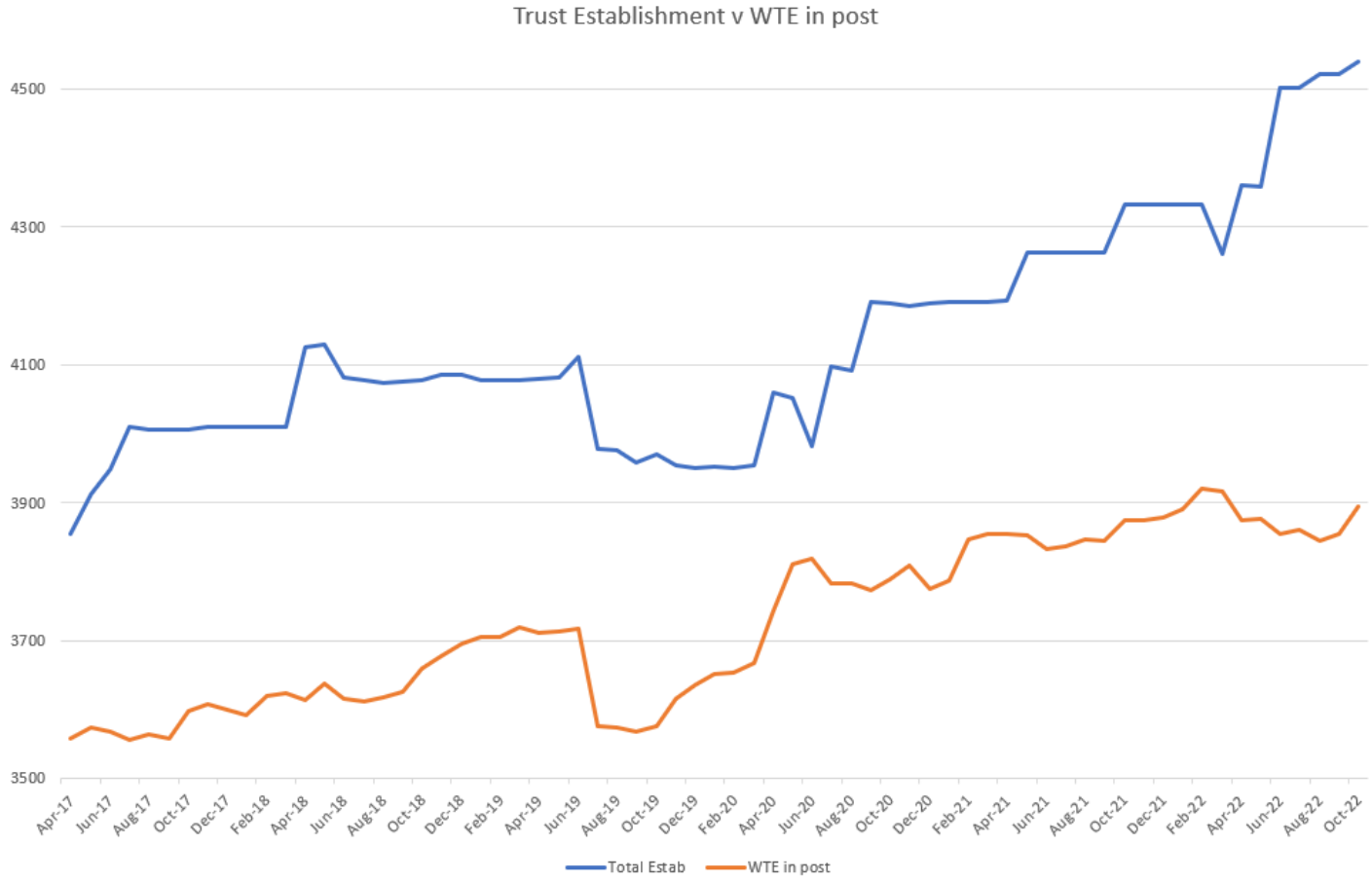
- The level of Out of Area Patients remains a concern. The figure for September is down substantially in October (from 998 down to 894 – down from 33.3 patients to 28.9), but it remains up from April 416 OBD (13.9). The elimination of acute bed days is anticipated in the next month or so, though PICU Out of Area stays will remain problematic
- CPA 7-day follow up is down from 91.8% to 88.3%, the lowest figure since Oct-21
- CPA with formal review in last 12 months up to 87.0%, highest level since Dec-21 and the fourth successive improvement
- IAPT patients seen within 6 weeks of referral has improved to 38.9%, the highest figure since Apr-21 and the fourth successive improvement. This is being discussed across BSol to

identify how to address underperformance. Performance for within 18 weeks is up to 70.3%. the highest figure since Mar-21

- New referrals not seen within 3 months are of concern and up to 3,763, the highest figure in four years. Of this, Neuropsychiatry represents the most significant issue
- **Key concerns: Out of Area, CPA 7-day follow up, IAPT waiting times, CPA 12-month review and new referrals not seen in 3 months**

People

- The People domain continues to show the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Scores are of concern across the board
- Vacancy levels at 14.2% are of concern. Staff in post are up by 41 WTE in month but little changed since Oct-21 (up by 20 WTE)



- Rolling 12-month sickness levels up to 7.0%, second highest since Jan-22
- Fundamental training up from 93.1% to 93.4% and IG training by temporary staff starting to fall
- Bank and Agency fill up from 82.9% to 84.5%
- **Key concerns: Vacancies, bank and agency fill rate, sickness**

Sustainability

- Financial position for the first seven months is a deficit of £0.7m against a planned breakeven, chiefly because pressures on temporary staffing and out of area beds. We expect to achieve breakeven for the year as a whole
- Capital expenditure for the first seven months is £2.0m, £0.6m less than plan. This mainly relates to the phasing of the plan being fixed with NHSE before the Trust agreed priorities for the year. A more representative monthly cash flow is being finalised

- Although we are able to generate some technical efficiencies to achieve required cost improvement plan for the year, there is no pipeline of savings schemes and difficulties are anticipated in 2023/24
- Monthly agency expenditure is up to £769k in October but remains significantly higher than NHSE target
- **Key concerns: CIP, agency expenditure**

9.4. Finance Report

Enclosure 1: Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**9.4**
PAPER TITLE	**Month 7 2022/23 Finance Report**
DATE	7/12/2022
AUTHOR	Emma Ellis, Head of Finance & Contracts
EXECUTIVE SPONSOR	David Tomlinson, Executive Director of Finance

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

Equality & Diversity ***(all boxes MUST be completed)***	
Does this report reduce inequalities for our service users, staff and carers?	No
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

Revenue position

The month 7 Group position is a deficit of £0.7m year to date, this is £0.7m adverse to the breakeven plan as submitted to NHSE on 20/6/22. The position comprises a £1.1m deficit for the Trust, a £2k deficit for Summerhill Services Limited (SSL) and a £146k surplus position for the Reach Out Provider Collaborative. The month 7 Group deficit position is mainly driven by slippage on savings delivery and continuing out of area and staffing pressures.

Capital position

Month 7 Group capital expenditure is £2m, which is £0.6m less than year to date plan but in line with the year to date revised forecast profile.

Cash position

The month 7 Group cash position is £70.5m.

Reason for consideration:

Update on month 7 financial position.

Previous consideration of report by:
Regular briefing on financial position with FPP chair.
Strategic priorities ***(which strategic priority is the report providing assurance on)***
SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population
Financial Implications ***(detail any financial implications)***
Group financial position
Board Assurance Framework ***(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities***
FPP OVERALL RISK - There is a risk that the Trust fails to make best use of its resources
Engagement ***(detail any engagement with staff/service users)***
Ongoing financial briefings via Operational Management Team and Sustainability Board.

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2022 to 31st October 2022

Month 7
Group financial position

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Healthcare Income	295,830	172,568	172,696	129
Other Income	107,927	62,958	66,735	3,777
Total Income	**403,758**	**235,525**	**239,431**	**3,906**
Expenditure				
Pay	(237,321)	(138,438)	(141,398)	(2,960)
Other Non Pay Expenditure	(130,284)	(75,998)	(78,000)	(2,001)
Drugs	(5,956)	(3,474)	(3,795)	(321)
Clinical Supplies	(871)	(509)	(385)	123
PFI	(11,130)	(6,493)	(6,334)	158
EBITDA	**18,195**	**10,614**	**9,519**	**(1,095)**
Capital Financing				
Depreciation	(9,983)	(5,823)	(5,774)	49
PDC Dividend	(1,930)	(1,126)	(1,123)	3
Finance Lease	(4,845)	(2,826)	(2,835)	(9)
Loan Interest Payable	(1,154)	(662)	(688)	(26)
Loan Interest Receivable	97	45	427	382
Surplus / (Deficit) before taxation	**380**	**222**	**(474)**	**(696)**
Profit/ (Loss) on Disposal	-	-	(32)	(32)
Taxation	(380)	(222)	(224)	(2)
Surplus / (Deficit)	**(0)**	**0**	**(730)**	**(730)**

Month 7 2022/23 Group Financial Position

The month 7 consolidated Group position is a deficit of £0.7m year to date. This is £0.7m adverse to the break even plan as submitted to NHSE on 20/6/22.

The Group position is mainly driven by the Trust month 7 deficit of £1.1m year to date. Key pressures contributing to the deficit position are slippage on savings delivery, out of area pressures and staffing pressures, particularly in Acute and Urgent Care, leading to a high level of temporary staffing expenditure. These are partly offset by vacancies across the Trust and slippage relating to Service Development Fund (SDF) investment, some SDF income has been deferred in relation to this. There has been an improvement in run rate in month 7 in line with planned release of deferred income.

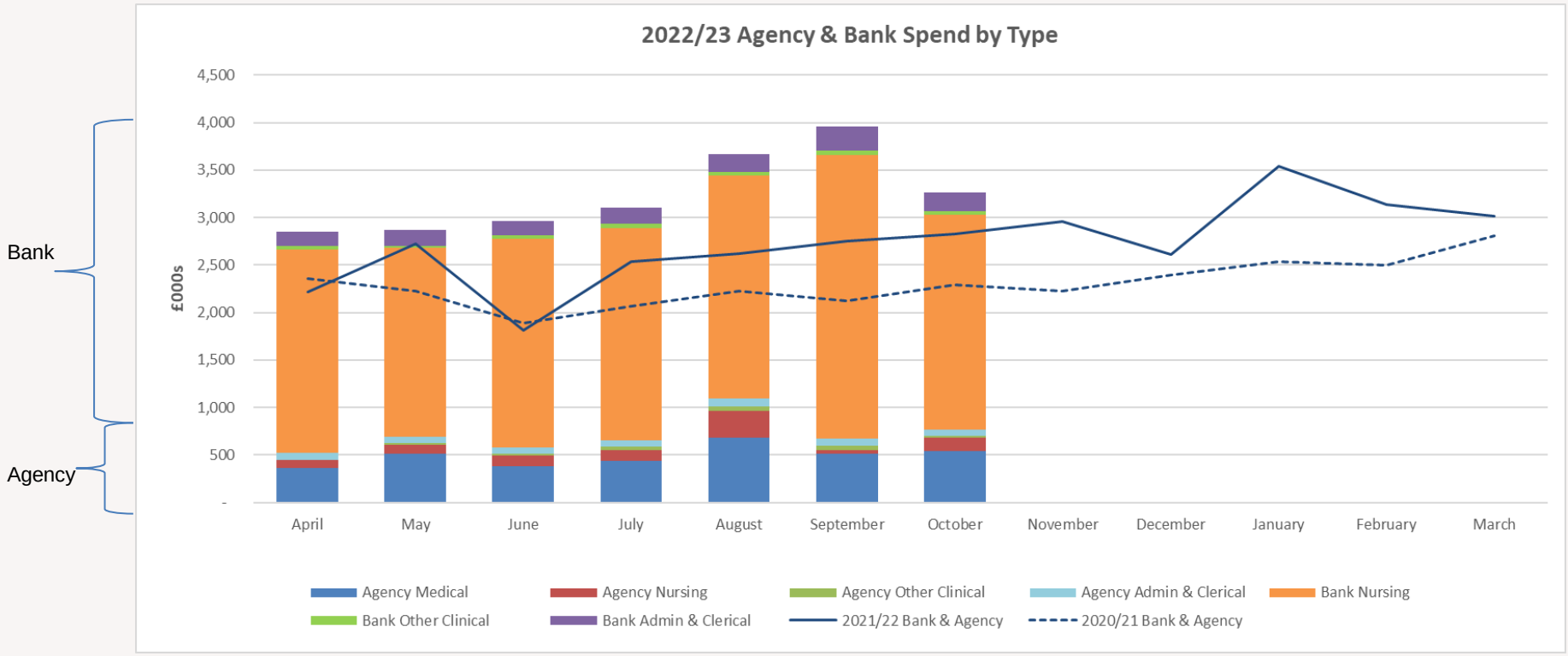
The Group position includes a £2k surplus for our wholly owned subsidiary, Summerhill Services Limited (SSL) and a £146k surplus position for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads year to date. For a segmental breakdown of the Group position, please see page 3.

Month 7 Group position
Segmental summary

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Trust	SSL	Reach Out	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000
Income					
Healthcare Income	172,696	-	-	-	172,696
Other Income	17,040	15,826	81,607	(47,739)	66,735
Total Income	**189,736**	**15,826**	**81,607**	**(47,739)**	**239,431**
Expenditure					
Pay	(134,873)	(5,986)	(700)	161	(141,398)
Other Non Pay Expenditure	(38,162)	(4,489)	(80,761)	45,412	(78,000)
Drugs	(4,002)	(1,720)	-	1,927	(3,795)
Clinical Supplies	(385)	-	-	-	(385)
PFI	(6,334)	-	-	-	(6,334)
EBITDA	**5,980**	**3,632**	**146**	**(239)**	**9,519**
Capital Financing					
Depreciation	(4,116)	(1,946)	-	288	(5,774)
PDC Dividend	(1,123)	-	-	-	(1,123)
Finance Lease	(2,835)	(221)	-	221	(2,835)
Loan Interest Payable	(688)	(1,239)	-	1,239	(688)
Loan Interest Receivable	1,666	0	-	(1,239)	427
Surplus / (Deficit) before Taxation	**(1,116)**	**226**	**146**	**270**	**(474)**
Profit/ (Loss) on Disposal	(32)	-			(32)
Taxation	-	(224)	-	-	(224)
Surplus / (Deficit)	**(1,148)**	**2**	**146**	**270**	**(730)**

Temporary staffing expenditure



The month 7 year to date temporary staffing expenditure is £22.7m. The graph above shows a breakdown of the temporary staffing expenditure by type.

Bank expenditure £17.7m (78%) – the majority of bank expenditure relates to nursing bank shifts - £16.2m.

Bank expenditure has decreased by £0.8m in October compared to September mainly due to the spike in September driven by payment of the back dated pay award for April to September.

Agency expenditure £5m (22%) – the majority of agency expenditure relates to medical agency - £3.4m.

For further analysis on bank and agency expenditure, see page 5.

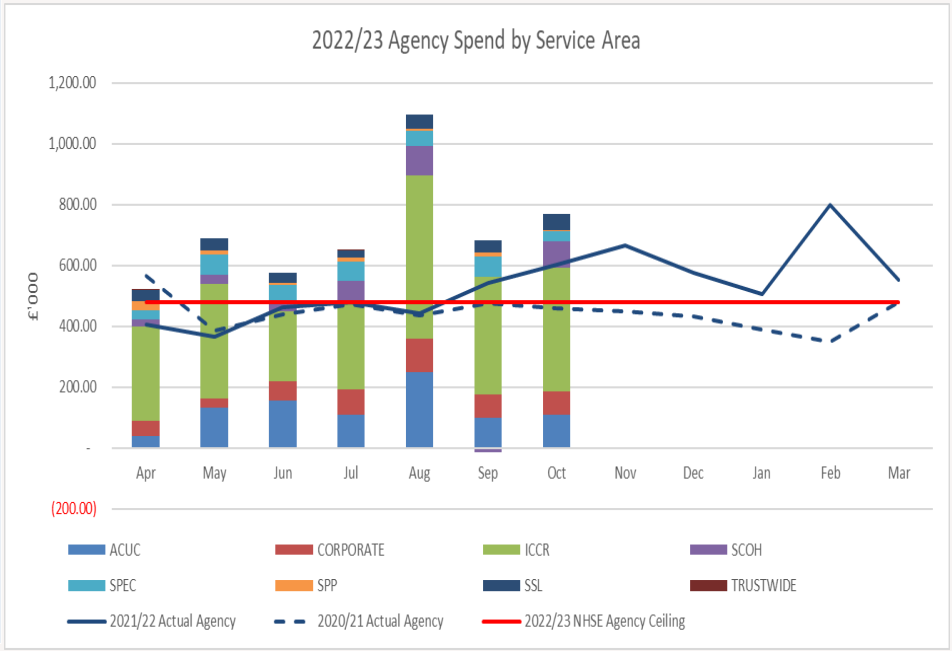
Agency and Bank expenditure analysis

Agency expenditure

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	2022/23 YTD
Agency Spend (£'000)	520	689	576	650	1,095	670	769	**4,967**
NHSE Ceiling (£'000)	479	479	479	479	479	479	479	**3,350**
Variance to NHSE ceiling	(41)	(210)	(97)	(171)	(616)	(191)	(290)	**(1,617)**
Agency Medical	358	515	378	433	677	510	542	3,412
Agency Nursing	86	87	113	117	285	43	136	867
Agency Other Clinical	(1)	20	20	40	45	46	25	195
Agency Admin & Clerical	77	67	66	61	88	71	65	494
Agency Spend (£000s)	**520**	**689**	**576**	**650**	**1,095**	**670**	**769**	**4,967**

Total year to date agency expenditure is £5m. This has predominantly been incurred within the following service areas: ICCR £2.5m, Acute & Urgent Care £0.9m, Specialties £0.4m and Corporate £0.5m.

October expenditure is £99k above the September spend, mainly driven by qualified nursing agency in Secure and Offender Health. The year to date average monthly agency spend is £0.7m. This is £0.2m above the 2021/22 monthly average and £0.3m above the 2020/21 average. Year to date spend is £1.6m above the NHSE ceiling which has been set at 90% of 2021/22 spend.



Bank expenditure

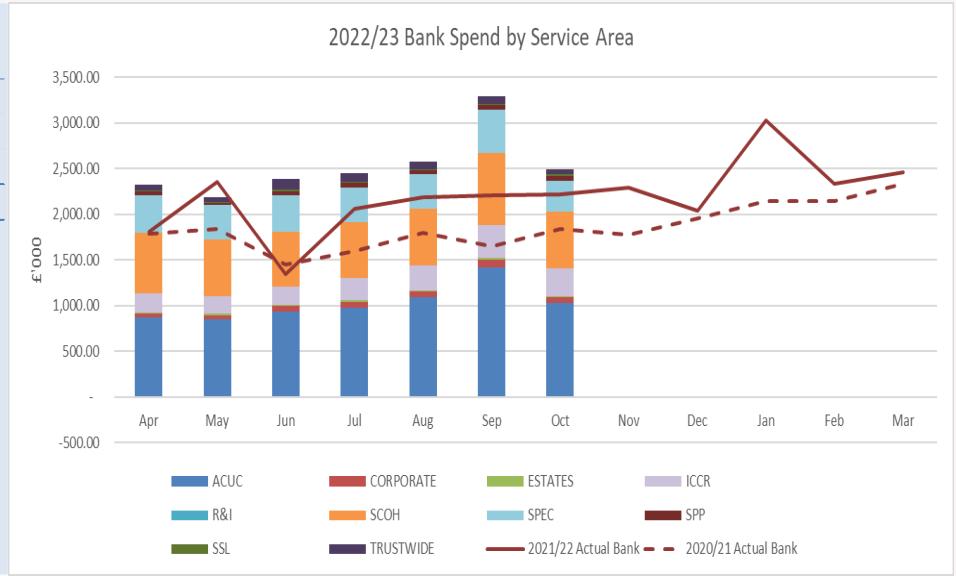
Type	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	YTD
Bank Nursing	2,140	1,991	2,196	2,241	2,348	2,991	2,260	16,165
Bank Other Clinical	42	20	39	40	34	45	35	255
Bank Admin & Clerical	145	172	155	171	193	253	197	1,286
Grand Total	**2,326**	**2,183**	**2,390**	**2,452**	**2,575**	**3,289**	**2,492**	**17,707**

Total year to date bank expenditure at month 7 is £17.7m. This has predominantly been incurred within the following service areas:
Acute & Urgent Care £7.2m, Secure and Offender Health £4.5m, Specialities £2.8m and ICCR £1.8m.

Total bank spend has decreased by £797k in October compared to September due to payment of the back dated pay award in September.

The average monthly bank expenditure is £2.5m year to date, this is £0.3m above the 2021/22 monthly average and £0.6m above the 2020/21 average.

For further detail on service area pay positions, see page 10.



Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - Audited 31-Mar-22 £m's	NHSI Plan YTD 31-Oct-22 £m's	Actual YTD 31-Oct-22 £m's	NHSI Plan Forecast 31-Mar-23 £m's
Non-Current Assets				
Property, plant and equipment	186.5	201.4	200.4	201.9
Prepayments PFI	1.6	1.3	2.0	1.3
Finance Lease Receivable	-	-	(0.0)	-
Finance Lease Assets	-	-	0.0	-
Deferred Tax Asset	0.1	0.1	0.1	0.1
Total Non-Current Assets	188.1	202.8	202.5	203.3
Current assets				
Inventories	0.4	0.4	0.4	0.4
Trade and Other Receivables	9.7	11.1	12.4	11.1
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	53.2	70.5	49.9
Total Curent Assets	38.9	64.8	83.3	61.5
Current liabilities				
Trade and other payables	(29.4)	(46.4)	(55.6)	(46.2)
Tax payable	(4.4)	(4.8)	(5.1)	(4.8)
Loan and Borrowings	(2.7)	(2.7)	(2.4)	(2.7)
Finance Lease, current	-	(1.0)	(1.0)	(1.0)
Provisions	(1.2)	(1.2)	(1.5)	(1.2)
Deferred income	(13.2)	(25.3)	(34.0)	(25.3)
Total Current Liabilities	(50.9)	(81.3)	(99.6)	(81.2)
Non-current liabilities				
Loan and Borrowings	(29.5)	(25.5)	(25.5)	(25.1)
PFI lease	(49.3)	(46.6)	(46.6)	(45.8)
Finance Lease, non current	-	(6.0)	(6.0)	(5.6)
Provisions	(2.4)	(4.3)	(3.5)	(4.3)
Total non-current liabilities	(81.3)	(82.5)	(81.6)	(80.9)
Total assets employed	94.9	103.8	104.7	102.7
Financed by (taxpayers' equity)				
Public Dividend Capital	110.5	113.0	113.0	113.0
Revaluation reserve	27.5	36.8	36.8	36.8
Income and expenditure reserve	(43.1)	(46.0)	(45.1)	(47.1)
Total taxpayers' equity	94.9	103.8	104.7	102.7

SOFP Highlights

The Group cash position at the end of October 2022 is £70.5m (this includes Reach Out).

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 7 to 8.

Current Assets & Current Liabilities

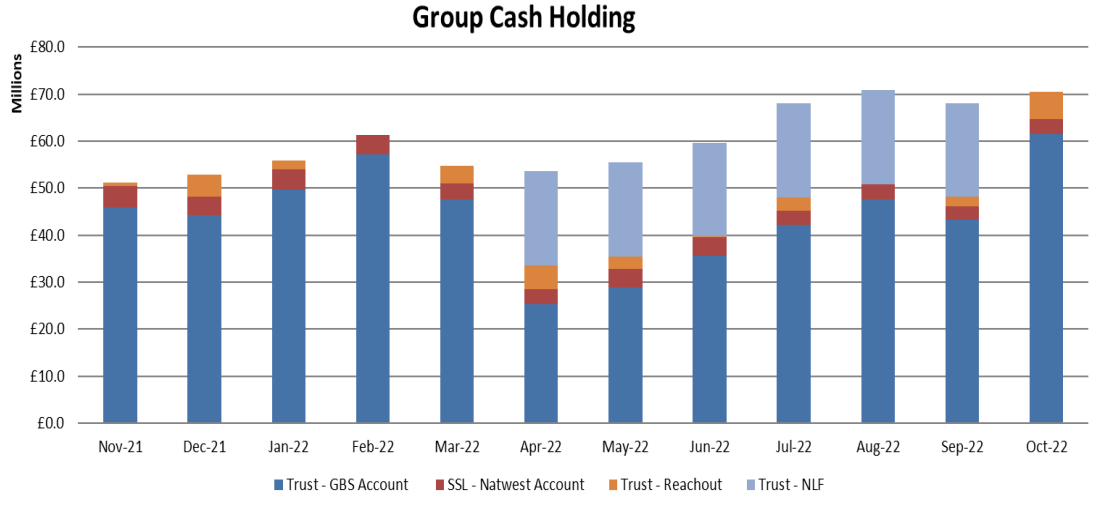
Ratios

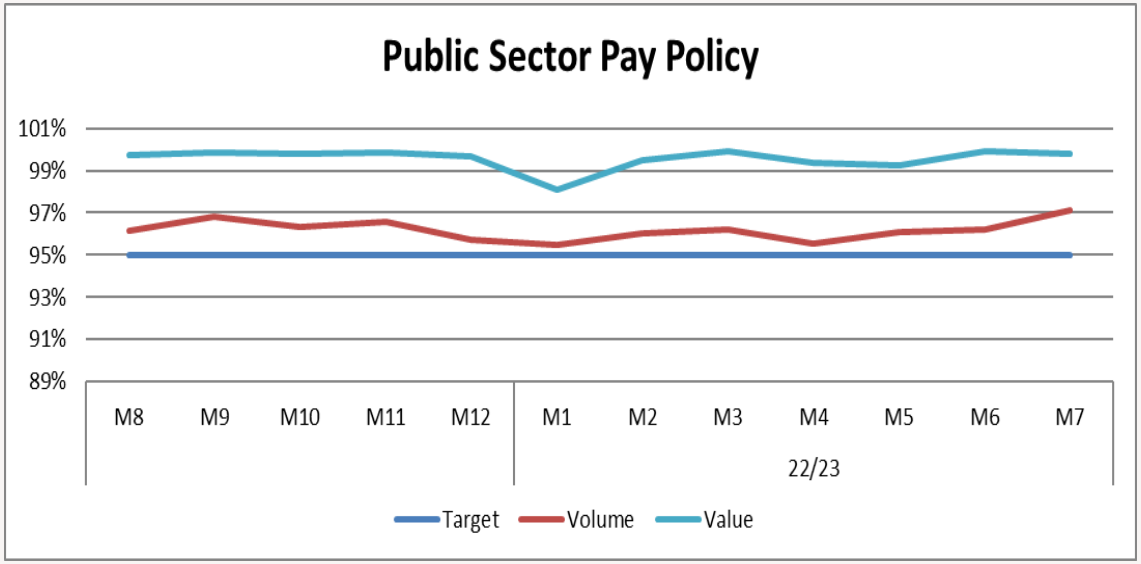
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	83.3
Current Liabilities	-99.6
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 October 2022 is £70.5m.

In April 2022 we deposited £20m with the National Loan Fund (NLF) for 6 months, this yielded a return of £116k based on the interest rate at the time of placing the deposit. This was returned to the Trust in October 2022.

With the recent announcement of interest rate increases we are reviewing our investments to ensure we are maximising our interest receivable potential.

Better Payments

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

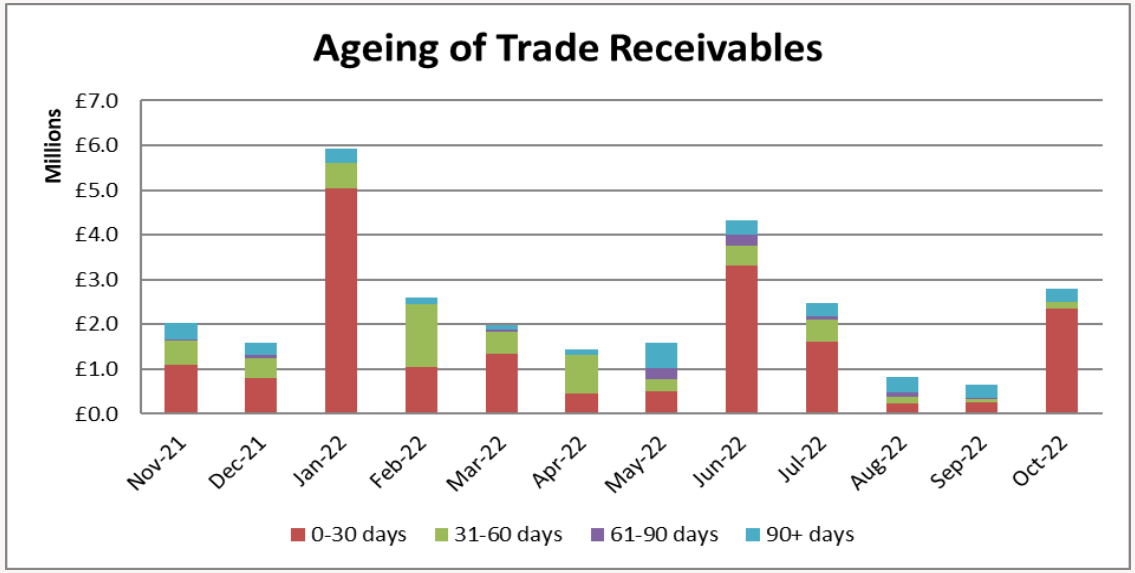
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

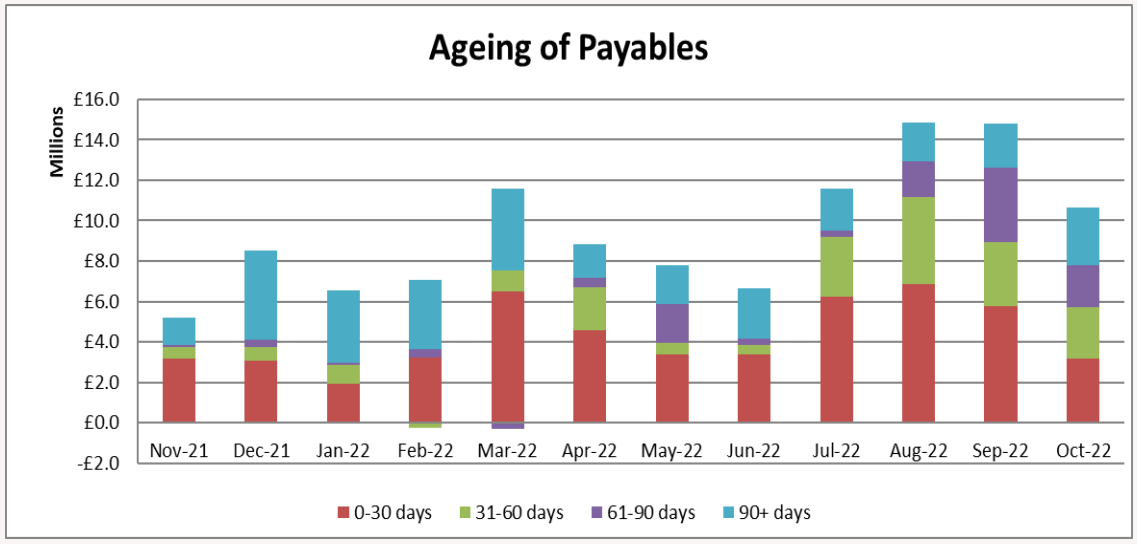
Better Payment Practice Code :

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

Trust Receivables and Payables

Birmingham and Solihull Mental Health NHS Foundation Trust





Trade Receivables

There is continued focus to maintain control over the receivables position and escalate to management, system and other partners where necessary for urgent and prompt resolution.

Receivables :

- **0-30 days-** new invoices raised in the period with no known disputes at present and staff overpayments (on payment plans)
- **31-60 days-** increase of balance mainly NHS monthly charges of £101k outstanding-slow processing of payments, £6k NHSE in query with no other known issues at present, staff overpayments (on payment plans)
- **61-90 days –** mainly staff overpayments (on payment plans)
- **Over 90 days -** balance comprises DOH £114k further delay of obtaining final signature to release payment, staff overpayments (on payment plans).

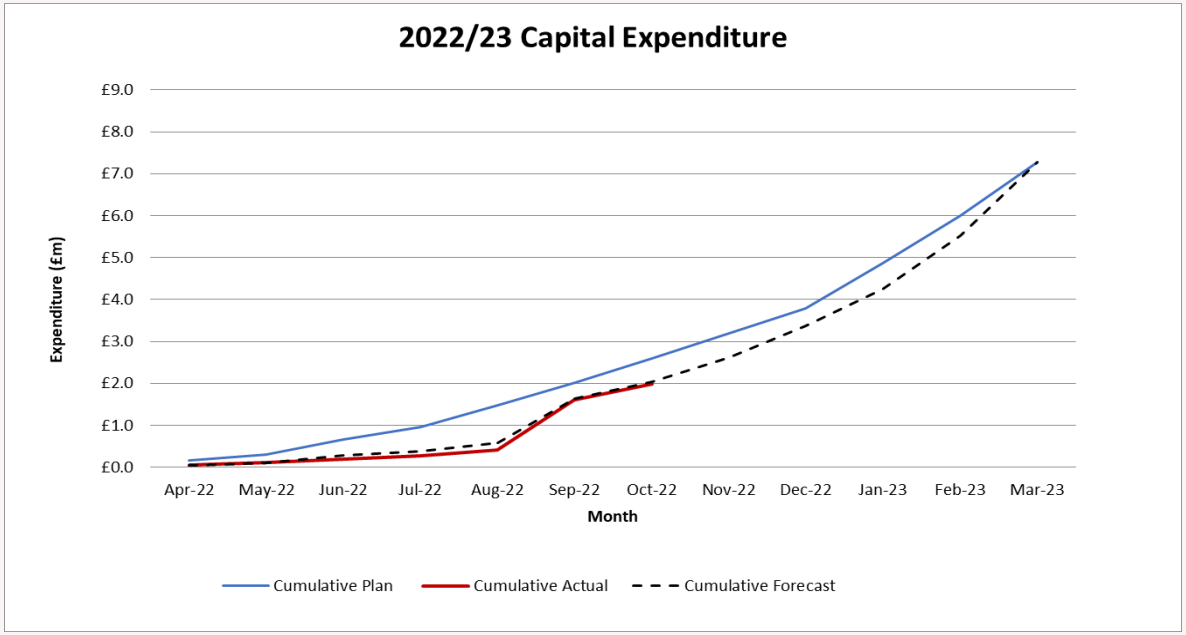
Trade Payables:

Over 90 days -

- NHS Property Services £570k– progress has been made in the past month regarding the lease agreement being finalised to enable payment. Estates colleagues are working with NHS Property Services to resolve this matter (DoF is aware of the position)
- Oxford NHS £525k Reach Out in query, BWCH £216k – passed for payment in Nov 22, SWBH £102k-awaiting supporting information to facilitate payment.
- Non-NHS Suppliers (43) £1.3m – mainly bed fees invoices in query, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in November 22.

Capital Expenditure

Capital schemes	Annual Plan	Annual Forecast	YTD Plan	YTD Forecast	YTD Total Actual	YTD Variance to plan	YTD Variance to forecast
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Approved Schemes:							
Major Projects (inc Carry-Forward)	1.2	1.3	0.8	0.2	0.1	-0.7	-0.1
SSBM Works	1.7	1.7	0.4	0.7	0.7	0.4	0.1
ICT Projects	0.8	0.8	0.3	0.3	0.2	-0.1	-0.1
Risk Assessment Works	3.6	3.6	1.1	0.9	0.9	-0.2	0.0
Total	7.3	7.3	2.6	2.0	2.0	-0.6	0.0



Month 7 Group Capital Expenditure

As at month 7, Group capital expenditure is £2m year to date. This is £0.6m behind the original plan but in line with the year to date revised forecast profile. It is forecast that the full capital programme will be spent by year end.

9.5. Trust Strategy Mid-Year Update

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**9.5**
PAPER TITLE	**TRUST FIVE YEAR STRATEGY MID YEAR UPDATE**
DATE	7 DECEMBER 2022
AUTHOR	Abi Broderick Head of Strategy, Business Development and Planning
EXECUTIVE SPONSOR	Patrick Nyarumbu Executive Director of Strategy, People and Partnerships

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

Equality & Diversity *(all boxes MUST be completed)*	
Does this report reduce inequalities for our service users, staff and carers?	Yes
What data has been considered to understand the impact?	Reducing inequalities is a theme that runs throughout our Trust Strategy.

Executive summary & Recommendations:

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

- Clinical Services
- Sustainability
- People
- Quality

Each year we agree goals for each strategic priority. The goals for 2022/23 were taken through Committees and Board at the beginning of the financial year.

Following Trust Board in May, we agreed that a prioritisation exercise would be carried out on the Trust goals for each of the four strategic priorities and that goals prioritised as level 1 would be reported to Trust Board, with level 1 and level 2 goals reported to Board committees.

There are a total of 99 goals spread across the four strategic priorities, 28 of which have been prioritised as level 1.

This report summarises performance against these 28 goals in the first half of 2022/23.

The Board is asked to note:

- The contents of this report.
- The progress made in quarters 1 and 2 against the goals, including RAG rating.
- The key actions for quarters 3 and 4.
- The risks identified for the remainder of the year.
- The timeline for end of year reporting and business planning for 2023/24.

Reason for consideration:

To provide assurance to the Board on the progress against the goals agreed for 2022/23 at the mid-year point, highlighting any risks relating to delivery of the goals.

Previous consideration of report by:

N/A

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

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.

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

QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve

SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population

Financial Implications ***(detail any financial implications)***

Any goals with financial implications have costed plans/budgets.

Board Assurance Framework
(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities

The BAF is aligned to our four strategic priorities and we have used the BAF as one of the drivers for prioritising the goals. Delivery of our annual goals should contribute as assurance or mitigations towards risks included on the BAF.

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

Subject leads and teams were involved in developing the goals for 2022/23 and leads have provided the updates for this report.

Our Trust Five Year Strategy

Mid Year Review

Trust Board

7 December 2022

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1. Introduction: our Trust Five Year Strategy

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners.

The Strategy comprises four strategic priorities – Clinical services, People, Quality and Sustainability – each of which is underpinned by a number of strategic aims.

In order to achieve these aims, each year we agree annual goals. The goals for 2022/23, the second year of the strategy, were taken through Board at the beginning of the financial year.

Specific reports relating to each strategic priority have been/will be taken by the leads for each priority to the relevant Board sub-committees as follows:

Clinical services:	FPP and QPES Committees, 23 November
People:	People Committee, 23 November
Quality:	QPES Committee, 21 December
Sustainability:	FPP Committee, 23 November

The purpose of this report is to provide a summary to Board on progress against year 2 goals at the mid-year point.

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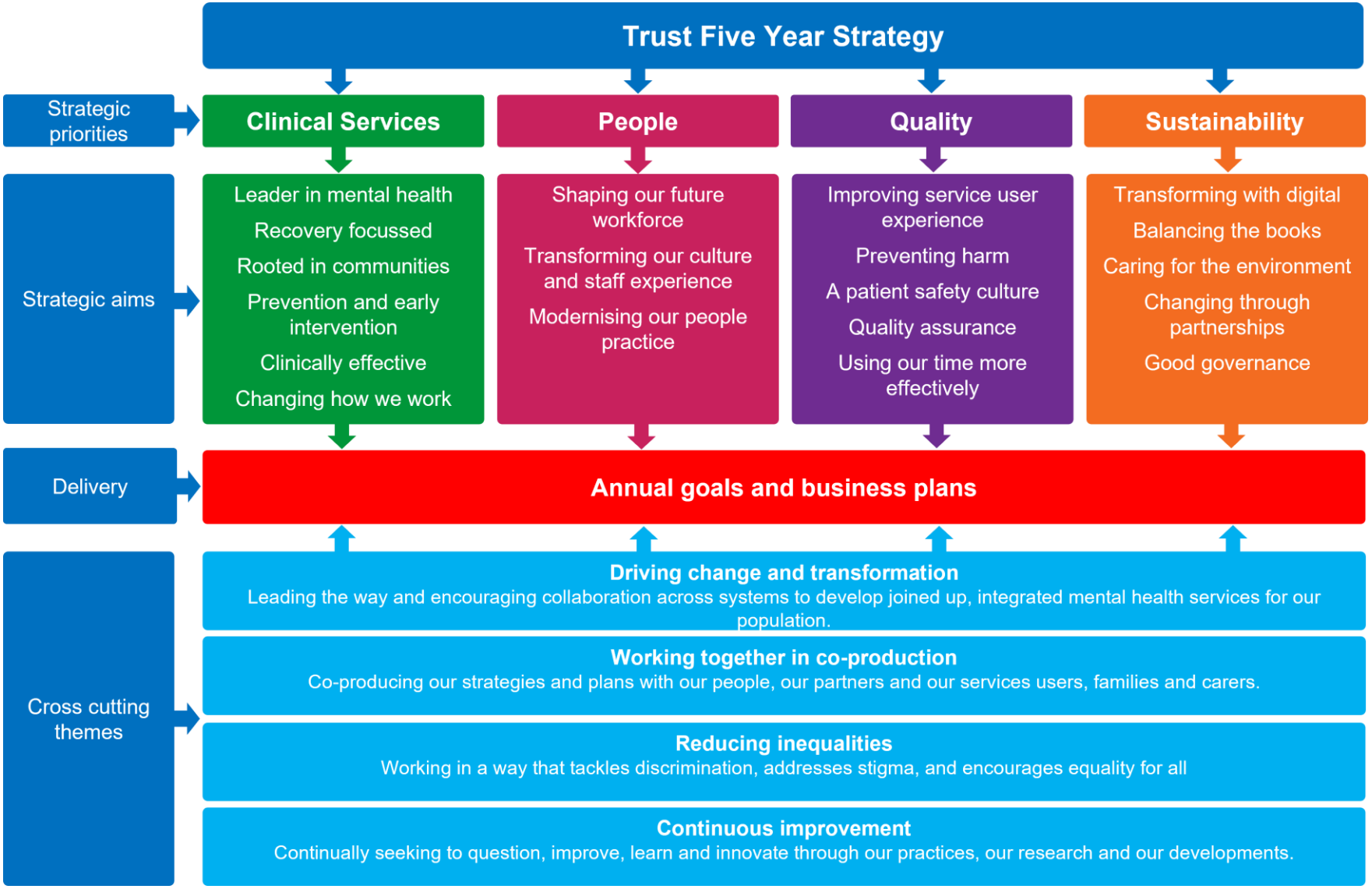
2. Strategy and planning at a glance

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



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3. Prioritisation of 2022/23 goals

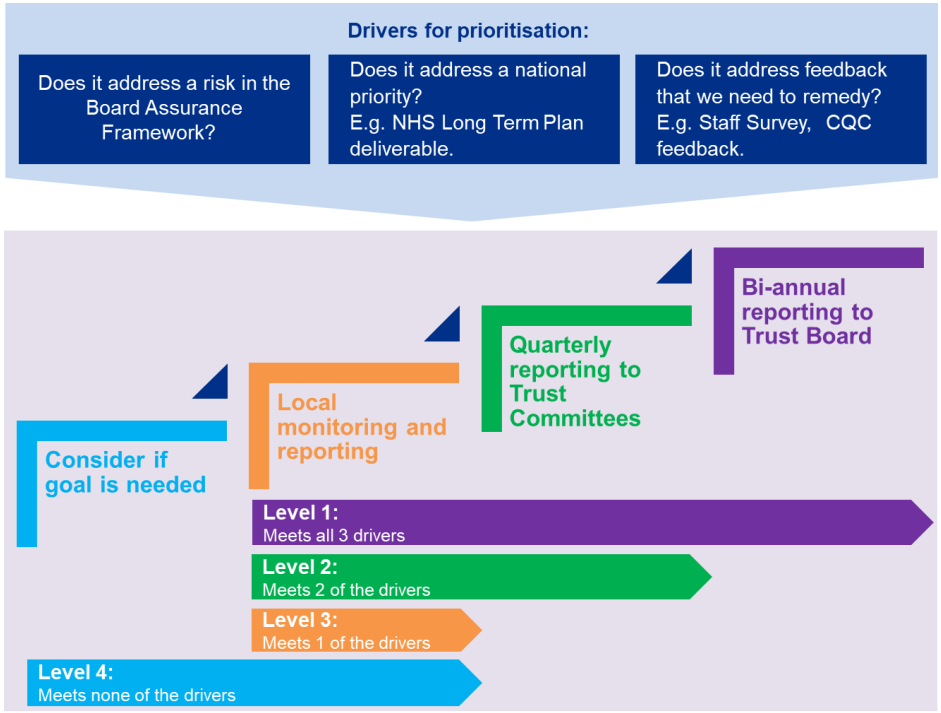
Birmingham and Solihull Mental Health NHS Foundation Trust

- We have an ambitious Trust strategy with a number of aims across our four strategic priorities: clinical services, people, quality, and sustainability.

- This has resulted in a large number of Trust goals set for 2022/23. Following Trust Board in May we agreed that a prioritisation exercise would be carried out on the Trust goals for each of the four strategic priorities. This helps:
  - Inform what the most important priorities are.
  - Define what is reported to Board and Committees for monitoring and assurance.
  - Make decisions about use of resources.
  - Identify whether any goals can be moved to subsequent years of the strategy.

- A common prioritisation framework has been used to assess each goal, to ensure consistency of decision making. This uses three drivers to assess the priority level of each goal:
  - Does it address a risk in the Board Assurance Framework?
  - Does it address a national priority? E.g. NHS Long Term Plan deliverable.
  - Does it address feedback that we need to remedy? E.g. staff survey, CQC feedback.

- Based on this prioritisation, level 1 and level 2 goals are reported to committees and the purpose of this report is to provide assurance on **level 1 goals**.



4. Level 1 goals

Birmingham and Solihull Mental Health NHS Foundation Trust

Clinical Services

- Community transformation programme
- Transformation of rehabilitation services
- Urgent care transformation programme
- Out of area placement reduction
- BSOL wide IAPT offer
- Transformation plans for CYP in Solihull
- Effective interfaces between our services
- Family and carer pathway – review and refresh
- Using inclusion/inequalities data and positive practice
- Partnerships with local communities to reduce inequalities
- Reaside re-provision and Highcroft redevelopment

People

- Anti racist and anti-discriminatory organisation
- LGBTQ staff aren't bullied or harassed
- BAME staff aren't bullied or harassed
- BAME staff have equality for their careers
- Improved staff survey
- HR processes are free from bias
- Supporting staff to speak up

Quality

- Ligature alarm systems on acute wards
- Physical health monitoring
- Service user involvement in care planning
- Carer involvement
- Patient Safety Partner role
- Safety culture and incident reporting/learning from incidents

Sustainability

- BSOL Mental Health Provider Collaborative
- Delivery plans for efficiency schemes
- Medium term revenue and capital plans
- Five-year clinically led ICT/digital map and strategy

*** Inequalities goals highlighted in blue text ***

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5. Trust goals: an overview

There are **99 Trust goals in total** for 2022/23. This has reduced by 9 since the beginning of the year, as during the mid-year review it was clear that some separate goals connected to a specific theme should be merged under one goal, and some removed due to duplication in across areas.

There are **28 goals prioritised as Level 1**. A summary of the overall status at the mid-year point is shown on the next page and the following slides provide an overview of achievements, focus areas for the remainder of 2022/23 and risks to delivery.

It is encouraging that **89% of these goals are rated 'Green' or 'Amber** which means they are exactly where we expected them to be in relation to their milestone plans at this point in the year or have only minor issues impacting delivery that are being addressed to bring them on track. **Three goals are rated 'Red',** two because we are concerned that they aren't where we want them to be, and the third due to the potential impact if the goal is not delivered. The three red goals are:

- Progress with the developments for Reaside re-provision and Highcroft redevelopment. This is outside of our control.
- Bring together clinicians, ICT, service users and carers to develop a clear strategy and five-year roadmap for how digital and technology will enable clinical services, quality and people transformations and developments.
- Develop delivery plans and timescales for efficiency schemes following development of the Project Initiation Documents and Clinical Quality Equality Impact Assessments (CQEIAs) for these.

For Amber and Red goals the focus areas for Q3 and Q4 outlined for each describe actions to bring the goals on track where this is within our control.

We are closely monitoring areas where although progress has been made we are not achieving performance trajectories, e.g. IAPT, out of area placements, and recovery plans are in place.

Our end of year report will triangulate performance against milestones with performance against key performance metrics and qualitative measures of success where relevant, to measure the impact of the goals.

It should be noted that the current position has been achieved against a backdrop of significant pressures on services, which is a testament to the **commitment** of our teams to provide high quality, **compassionate** and **inclusive** care through driving improvement and transformation.

6. Trust goals: RAG summary

Strategic aim	Red	Amber	Green	Total
Clinical Services	1	6	4	11
People	0	7	0	7
Quality	0	2	4	6
Sustainability	2	2	0	4
Total	**3 11%**	**17 61%**	**8 28%**	**28**

RAG definitions:

Red = not started / major issues / seriously behind;

Amber = partially met / minor issues;

Green = fully met / fully on track

7. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Build a library of local inclusion and equalities data and positive practice to influence Trust and ICS data quality, reducing inequalities and transformation plans.

Leader in mental health

Key achievements:

- ✓ Data with Dignity sessions delivered across divisional meetings, socialising current inclusion and equalities data available and initiating dialogue, case studies and resources about good practice.
- ✓ Case studies and resources are being collated ready for an online platform to be launched, which is in development.

Focus areas for Q3 and Q4:

- Continuation of Data with Dignity sessions at service level to enhance local ownership and consideration of holistic data to inform and challenge blind spots in delivery of equitable services.

Risks:

- Service level engagement in inclusion work due to workforce pressures is a risk to delivery of the goal.

Goal: Make sure we have effective interfaces between our services, for example community services and acute/urgent care services, and secondary care and forensic services.

Leader in mental health

Key achievements:

- ✓ In ICCR each Clinical Service Manager has interface meetings with other areas to improve pathways.
- ✓ Separate interface meeting established between ICCR and Secure Care.
- ✓ Home Treatment interface meetings established with ICCR.
- ✓ Meetings take place between acute and CMHT psychology to ensure effective transitions.
- ✓ Interfaces between specialties and ICCR through the community transformation programme.

Focus areas for Q3 and Q4:

- Working group of senior leaders to look at integration between service areas.

Risks:

- Delivery of the goal requires ensuring effective engagement.

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

Recovery focussed

Key achievements:

- ✓ Review and refresh of family and carer pathway has been scoped and approach agreed.
- ✓ Agreed to hold a stakeholder event.
- ✓ Question: Where is the family and carer pathway applicable and where do we need a different approach to recording our interaction with carers?

Focus areas for Q3 and Q4:

- Complete stakeholder review and agree the plan going forward.
- Hold stakeholder engagement events and defining next steps to develop the family and carer pathway.

Risks:

- Difficulty in engaging staff due to shortages and proportion of temporary staff as well as lack of capacity for leads for this work in service areas may hinder delivery of the goal.

8. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Transformation of rehabilitation services.
Part a: Creation of intensive complex recovery community service with access to local supported tenancies
Part b: HDU provision, secure appropriate accommodation flow and gender specific complex care services

Rooted in communities

Key achievements:

- ✓ Rehabilitation Project Group launched.
- ✓ Recruiting to key roles in Intensive Community Rehab Team (ICRT): leadership recruited to start post January and recruitment for the rest of the team is under way.
- ✓ Creation of gender specific complex care services at Knowle site completed.

Focus areas for Q3 and Q4:

- ICRT operational by early February and gradual build of caseloads.
- Develop social accommodation offer for BSOL.
- Establish links between ICRT and Community Mental Health and Wellbeing Service.

Risks:

- Recruitment to posts and sourcing appropriate accommodation are risks to delivering this goal.

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

Rooted in communities

Key achievements:

- ✓ New trajectory developed and an OOA (Out of Area) System Oversight Group stood up.
- ✓ Demand and capacity modelling.
- ✓ Grant Thornton supporting Out of Area (OOA) project with set up, developing the plan and implementation support working with Trust and system stakeholders.

Focus areas for Q3 and Q4:

- Develop and implement the plan.
- Plan to utilise Psychiatric Decisions Unit more effectively.
- Embed crisis house provision.
- Designated discharge manager.
- Single urgent care pathway and harmonise FTB/BSMHFT bed management.

Risks:

- Risks if this goal is not achieved include impact on patient experience and finances and increased ICB and NHSE scrutiny.

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

Rooted in communities

Key achievements:

- ✓ PCREF– 10 competencies identified from engagement work and community collaborative partnership agreement developed.
- ✓ We continue to meet our Synergi pledges through our range of inclusion work and a number of research studies into access to and experience of services for ethnic minorities.

Focus areas for Q3 and Q4:

- Community collaborative to be further developed.
- PCREF – development of products and resources to test with teams to see if they influence practice and reduce inequalities.

Risks:

- Service level engagement and ownership of inequalities programmes due to workforce pressures are risks to achieving this goal.

9. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Roll out community transformation across all geographical areas within the BSOL footprint, across young people, adult and older adult services.

Rooted in communities

Key achievements:

- ✓ Community Mental Health and Wellbeing Service live across Birmingham and Solihull.
- ✓ Developing Mental Health Primary Care Teams.
- ✓ Multi Agency Team meetings established in all areas.
- ✓ ARR roles recruited (Additional Roles Reimbursement Scheme).
- ✓ Links established with VCSE colleagues.
- ✓ Developed comprehensive training package.
- ✓ Recruited Experts by Experience (EBE) lead and have EBEs in all key meetings.
- ✓ EBE Co-Production Strategic Group and project groups for comms, training and language established.
- ✓ Older adults are an integral part of the Community Transformation with older adult representation at all levels of the programme.

Focus areas for Q3 and Q4:

- Launch of promotional materials and online hub.
- Eating Disorders recruitment to new roles and offer to include training, consultation and support to primary care teams.
- Personality Disorder pathway development.
- Clinical validation for service users identified primary care ready.

Risks:

- Risks to delivery of this goal include:
  - Recruitment challenges.
  - Engagement of all Primary Care Networks (PCNs) and GPs to ensure equity of access across PCNs and a full model of care.
  - Future funding and continued roll our of ARR roles is not certain.

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

Prevention and early intervention

Key achievements:

- ✓ Funding for substantive staff for mental health hub at Heartlands and continuation of front door service at City Hospital.
- ✓ Discussions with Queen Elizabeth Hospital to implement front door service and additional clinicians to focus on the Medical Assessment Unit.
- ✓ Place of Safety - agreement to staff the third room in the urgent care centre. Adverts out for substantive staff.
- ✓ Launch of crisis house.
- ✓ Psychiatric Decisions Unit (PDU) model changes agreed to enable patients to come straight from A&E for assessment.

Focus areas for Q3 and Q4:

- Launch front door service in the Queen Elizabeth Hospital and increase Liaison Psychiatry nursing establishment.
- Additional staffing for PDU and Place of Safety to operate fully 24/7.
- Embed and further integrate crisis house provision.

Risks:

- Risks to delivery of this goal include:
  - Limitations on physical space in ED and PDU
  - Recruiting of substantive staff (even bank and agency difficult and not sustainable due to cost).
  - Effective communication and engagement with acute trusts regarding using our pathways etc.

10. Strategic priority: Clinical services

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Goal: Deliver transformation plans for children and young people in Solihull, e.g.,18-25 service, Learning Disability and Autism (LDA) needs, mental health teams in schools, primary care liaison and eating disorder pathways.

Prevention and early intervention

Key achievements:

- ✓ Transition workers established in Solar for those reaching 18.
- ✓ Mental health teams in schools, all vacancies recruited to.
- ✓ Primary care liaison - all groups re-established, and a range of webinars delivered.

Focus areas for Q3 and Q4:

- Transformation worker roles to be duplicated in CMHTs.
- Eating Disorders: working with colleagues in Birmingham, FREED Champion roles advertised.

Risks:

- Recruitment challenges, including bank and agency, are a risk to delivery of this goal.
- Pressure nationally on children and young people's services is also reflected in Solihull.

Goal: Development of a clear BSOL wide IAPT offer (including use of digital) of which Birmingham Healthy Minds plays an integral part.

Prevention and early intervention

Key achievements:

- ✓ Move towards meeting targets – current off track.
- ✓ Programme to uplift Band 6 posts to Band 7 has improved recruitment and retention.
- ✓ Recruitment action plan including social media, rolling adverts and engagement with universities.
- ✓ Significant trainee places support agreed in 22/23 to increase capacity.

Focus areas for Q3 and Q4:

- Develop collaborative 3 year plan to achieve the national access target.
- Performance and recovery plans continue to be monitored for all providers at BSOL IAPT Forum and contract meetings.

Risks:

- Risks to delivering this goal include financial risk to a due to low activity and recruitment risks.

Goal: Progress with the developments for Reaside re-provision and Highcroft redevelopment.

Changing how we work

Key achievements:

- ✓ Reaside re-provision: strategic outline case (SOC) completed, approved internally and commented on externally.
- ✓ Highcroft redevelopment: Case for reducing length of stay strengthened and model developed further to include the impact of the community transformation programme.
- ✓ Worked to further develop the SOC for Highcroft.

Focus areas for Q3 and Q4:

- Highcroft SOC completion and approval.
- Both SOCs to be submitted externally.
- Obtaining clarity on DHSC funding.

Risks:

- We will not be able to achieve this goal if the schemes are not awarded funding. Latest information is that a decision on the schemes will now be made in December 2022.
- Potential for financial constraints to have an impact on delivering the clinical model for Highcroft.

11. Strategic priority: People

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Goal: The Trust is an Anti-racist and Anti-discriminatory organisation.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Road map to becoming an anti-racist, anti-discriminatory organisation published.
- ✓ Take the pledge campaign launched with over 1200 colleagues signed up.
- ✓ Senior leaders have undertaken anti-racism training.
- ✓ Launched Enough is Enough Campaign.
- ✓ Data with Dignity Roadshows undertaken
- ✓ WRES reporting now containing staff voice.
- ✓ Health inequalities programme launched.
- ✓ PCREF (Patient and Carer Race Equality Framework) programme in engagement phase.

Focus areas for Q3 and Q4:

- Finalising of anti-racist framework and testing.
- Review initial application of Enough is Enough.

Risks:

- Risks to delivery of this goal include any delays in recruitment of second EDI Manager and the potential cost of the Enough is Enough independent platform.

Goal: Black, Asian and Minority Ethnic colleagues believe that we provide equal opportunities for career progression or promotion.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Flourish programme has been launched
- ✓ Consultation with colleagues to confirm what they need to help them Flourish within the Trust.
- ✓ Offer developed and task and finish groups being mobilised to support implementation

Focus areas for Q3 and Q4:

- Development of:
- Values and Behaviours framework
- Civility and team culture framework
- Central repository point for all development and opportunities
- First line Manager training package
- Application and interview coaching and support offer
- Bands 5 – 7 First line manager collaboration and action learning set space
- Embedding the values-based appraisal process

Risks:

- Limited capacity within the OD function to support the number of task and finish groups required could affect delivery of this goal

Goal*: LGBTQ+ and Black, Asian and Minority Ethnic Colleagues do not experience disproportionate Bullying and Harassment from colleagues, managers, and service users.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Enough is Enough campaign launched specifically to support LGBTQ+ and Black and Minority Ethnic colleagues.
- ✓ First and second person reflective tool developed to ascertain if a colleague is demonstrating inappropriate behaviours in their everyday activities.

Focus areas for Q3 and Q4:

- Review lived experience of colleagues undertaking the Enough is Enough process and update as required using a QI methodology.
- Further engagement of colleague groups to feedback on current process.
- Review initial application of Enough is Enough

Risks:

- The potential cost of Enough is Enough independent platform could affect delivery of this goal.

* *There are two separate 2022/23 goals covered together as they have common narrative.*

12. Strategic priority: People

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Develop a clear strategy to support staff to speak up.

Transforming our Culture and Staff Experience

Key achievements:
- ✓ Freedom to speak up guardians in place
- ✓ Freedom to speak up champions model launched
- ✓ Links with EDI forged

Focus areas for Q3 and Q4:
- Embed Freedom to speak up champions in service areas
- Recruitment of 3rd guardian

Risks:
- None identified.

Goal: Improve our staff survey

Transforming our Culture and Staff Experience

Key achievements:
- ✓ Developed the vision and team-based OD plans based on last year's results.
- ✓ Continued to undertake the quarterly pulse surveys
- ✓ Participated in NHS Wide surveys.

Focus areas for Q3 and Q4:
- Staff Engagement Lead focussing on promoting staff survey throughout the Trust and supporting teams to dedicate time to enable completion.
- Regular staff comms to promote and encourage completion, both within team briefings and electronic means.

Risks:
- None identified.

Goal: HR process and process implementation are free from bias.

Modernising our people practice

Key achievements:
- ✓ Continue to review as policies are updated for consultation.

Focus areas for Q3 and Q4:
- People policies require attention to increase compliance and best practice. This is a People Team priority for Q3.
- Disciplinary, Dignity at work and Grievance polices all to be reviewed to ensure they are aligned with Trust values

Risks:
- None identified.

13. Strategic priority: Quality

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards.

Preventing harm

Key achievements:

- ✓ The door monitoring alarm system has now been installed in all ensuite doors in Acute Care as well as Citrine Ward.
- ✓ Safety huddles and risk huddles are in place to assess impact.
- ✓ MDT audits are in place.
- ✓ Clinical educators are supporting the development of capacity building.
- ✓ Audits evaluating the impact of actions taken.

Focus areas for Q3 and Q4:

- Roll out of door alarm system.
- Continuation of audits to assess impact.

Risks:

- None identified.

Goal: To improve the physical health monitoring of patients in our care.

Preventing harm

Key achievements:

- ✓ Training on physical health for inpatient teams, leading to better documentation.
- ✓ Changes to key physical health documentation within RiO, making information easier to input and access.
- ✓ QI project with primary care to process map the patient journey, leading to better care and experience.
- ✓ New physical health navigators being recruited.
- ✓ Improvement in links for serious mental illness (SMI) data and ICS developing project work in relation to key indicators for people with SMI.
- ✓ Community transformation physical health group continuing to develop this work.

Focus areas for Q3 and Q4:

- Project work with primary care.
- Further development of RiO to enhance physical health recording.
- Further refinement of data to enable teams to access information more easily.

Risks:

- Integrated access to data.

Goal: Improve the involvement of service users in MDT meetings and ensure that all service users have a copy of their care plan.

Improving service user experience

Key achievements:

- ✓ A QI project for inpatients being completed in Zinnia, testing the use of Dialog to improve service user involvement in the MDT discussion.
- ✓ Includes work with service users to develop an appropriate service user copy of the care plan. Initial feedback is positive.
- ✓ In the community the use of dialog+ care plan continues to be developed to facilitate more holistic assessment and discussion leading to improvements in goal focussed care plan with a greater focus on what is important to the individual.

Focus areas for Q3 and Q4:

- ✓ Finalise learning from the Zinnia QI project and share good practice across services.
- ✓ Begin implementation plan and roll out of the training package of Dialog+ to community staff.

Risks:

- Challenges to clinical team engagement due to workforce pressures could affect delivery of this goal.

14. Strategic priority: Quality

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Improve the involvement of carers in service user care and recovery.

Improving service user experience

Key achievements:

- ✓ Organisational change has been completed for the Participation and Experience Team and all posts filled.
- ✓ This has laid the ground for more capacity for the team to make contact and engage with carers and therefore increase involvement.
- ✓ Good practice examples where teams have embedded the family and carer pathway fully in their work.

Focus areas for Q3 and Q4:

- Review of family and carer pathway with stakeholders to be held in January.
- Establish next steps for the use of the family and carer pathway.
- To consider alternatives methods for services such as Home Treatment Team.

Risks:

- Challenges to clinical team engagement due to workforce pressures could affect delivery of this goal.

Goal*: Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table.

Improving service user experience

Key achievements:

- ✓ Working across BSOL system to identify collective learning and actions.
- ✓ Review of incidents managed at directorate level and outcomes fed into tier 2 structures through to Board
- ✓ Patient Safety training now available on the Trust's Learning Zone.
- ✓ Learning from Deaths Group continues to review incidents and is proactively identifying and collating themes for the annual thematic review to be produced in 2023.
- ✓ New NHS England Patient Safety Incident Response Framework (PSIRF) launched in August to replace the Serious Incident Framework, to be implemented over 12 months in 7 stages.
- ✓ Our Patient Safety Team have been moving through the 'orientation' (months 1-3) and 'diagnostic and discovery' (months 4-7) stages.

Focus areas for Q3 and Q4:

- Complete 'diagnostic and discovery' phase, producing a comprehensive profile of all incidents over the past 2 years.
- Understand how systems and processes already respond to incidents for purpose of learning and improvement and identify strengths and weaknesses and define where improvement is needed to support PSIRF requirements and transition.
- Begin 'governance and quality monitoring' stage to define oversight structures and ways of working, to include the role of Patient Safety Partners.

Risks:

- Resource: business case produced for additional resources to achieve delivery of PSIRF.

Goal*: Strengthen the approach to confidence in incident reporting and learning from incidents resulting in an improved safety culture.

A positive patient safety culture

* *These goals are both covered by the above narrative.*

15. Strategic priority: Sustainability

Goal: Bring together clinicians, ICT, service users and carers to develop a clear strategy and five-year roadmap for how digital and technology will enable clinical services, quality and people transformations and developments

Transforming with digital

Key achievements:

- ✓ Aim is to align our ICT strategy and digital roadmap with the ICS strategy, the trust strategy and the wider digital agenda.
- ✓ Clinical reference group and experts by experience/ user reference groups established and staff engagement initiated across the organisation.
- ✓ Clinical system team established under the Chief Clinical Information Officer.
- ✓ Contributed to development of the ICS Digital Strategy which is in draft for consultation. This will be the blueprint for the Trust ICT strategy.
- ✓ Agreed Medical Director will take leadership role in terms of clinical roles and engagement in the digital agenda.

Focus areas for Q3 and Q4:

- Building on from the discussion in a recent Senior Leaders session, develop a plan for wider engagement and involvement of clinicians to bring this goal back on track.

Risks:

- Rated as “Red” as we are not where we would want to be in terms of this goal.
- Competing pressures on capacity preventing teams and clinicians from being able to engage with this work is a risk to delivery of this goal.

16. Strategic priority: Sustainability

Goal: Develop delivery plans and timescales for efficiency schemes following development of the Project Initiation Documents and Clinical Quality Equality Impact Assessments (CQEIAs) for these

Balancing the books

Key achievements:

✓ Savings policy refreshed and shared at September Sustainability Board. Clear timetable set for development of plans in preparation for savings delivery from 1 April.

Focus areas for Q3 and Q4:

- Completion of CQEIAs for approved schemes by November 2022.
- Implementation from December 2022 onwards for full mobilisation from April 23.
- Identification of plans from outstanding teams and options considered for closing the gap.

Risks:

- Significant risk to the Trust of not developing and delivering savings plan - financial balance will not be achieved if not delivered in time. This has led to RAG rating of “Red”.

Goal: Formalise revenue and capital plans for the medium term.

Balancing the books

Key achievements:

✓ Whilst awaiting further planning guidance from NHSE we are preparing by reviewing and realigning revenue budgets to ensure our start point budget is as accurate as possible.

✓ Medium term capital planning is ongoing to determine Trust priorities, actual plans will be constrained by allocation of system capital envelopes still to be provided by NHSE.

Focus areas for Q3 and Q4:

- Planning round for 23/24 will need to be concluded and budgets set for new financial year. Key elements will be national guidance on funding and inflation.

Risks:

- Without savings plans, ability to meet balanced position (and therefore revenue and capital plans) for 23/24 will be compromised.

17. Strategic priority: Sustainability

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Driving the development of the BSOL MH provider collaborative aligned to the ICS and supporting our key tests of reducing inequalities, managing demand, improving access, experience and outcomes, improving safety, and achieving value for money, including lead provider governance and infrastructure and partnership governance.

Changing through partnerships

Key achievements:

- ✓ Programme team and governance in place.
- ✓ Assessment of internal capacity necessary to develop and implement the provider collaborative including what additional resource is needed.
- ✓ Agreement for the alignment of MH Commissioning Resource from BSOL ICB into BSMHFT from 21/11/22.
- ✓ Completion of Phase One of the Integrated Care Board's Delegation Assurance Process which assesses our collective vision, people and culture, improving outcomes and tackling inequalities, and governance structure.
- ✓ Submission of Phase Two documentation which assesses quality, performance and delivery, commissioning, governance/risk management, finance and use of resources, and IG, digital and cyber. Currently undergoing meetings with the ICB to discuss further.
- ✓ Key frameworks describing how we will work in the future are being finalised including Commissioning, Contracting, Quality and Assurance, Governance.
- ✓ Heads of Terms of the Partnership Agreement approved by CEO and issued to partners for signature. Work is underway to finalise the Partnership Agreement.

Focus areas for Q3 and Q4:

- ICB's decision on delegation expected January 2023.
- Identification of capacity to enable mobilisation.
- Understand the wider ICB resource to support the mobilisation and delivery of the MHPC and determine the gaps.
- Development and implementation of mobilisation plans taking us to 'go live' from 1 April 2023, covering key areas such as finance, contracts, commissioning, governance, and quality.
- Shadow governance arrangements from January 2023.
- Due diligence of contracts .
- Development of a communications and engagement strategy.

Risks:

- The following are risks to delivery of this goal:
  - Insufficient capacity to manage the change and deliver mobilisation plans by April.
  - Lack of clarity over appropriate resource transferred from the ICB to support the Lead Provider – posts/ budget.
  - Lack of clarity over roles and responsibilities between ICB and Lead Provider, and risk and gain share.
  - Agreement of third sector representation and contractual arrangements.

18. What's next: timeline

19. Key drivers for 2023/24 planning

Birmingham and Solihull Mental Health NHS Foundation Trust

Below are some of the key drivers at a national, regional/system and Trust level that will need to be considered as we develop our goals and plans for year three of the strategy.

This is not an exhaustive list; all potential drivers will be identified in our planning work.

National

Long Term Plan priorities

Health and Care Act

Draft Mental Health Bill

Outcomes from Mental Health and Wellbeing Plan consultation

Political and economic situation

Regional / System

ICS Strategy, including place and inequalities strategies

BSOL Mental Health Provider Collaborative

WM Provider Collaboratives – Reach Out, CAMHS, Eating Disorders, Perinatal

Trust

Workforce issues – staffing, morale, wellbeing, inclusion

Feedback – CQC, Staff Survey, Service User surveys and feedback

Financial position

Demand for clinical services

Progress with 2022/23 goals

Service user inequalities

10. GOVERNANCE & RISK

10.1. Charitable Funds Committee Chair’s Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM CHARITABLE FUNDS COMMITTEE**
Date	7 December 2022
Author	Mr W Weir, Non-Executive Director, Acting Chair
Executive sponsor	Mr P Nyarumbu, Executive Director of Strategy, People & Partnerships

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

The Charitable Fuds Committee met on the 12 October 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board of Directors. The following items were discussed at the committee:

Caring Minds Fundraising update: Summer 2022

- *The committee is pleased that seven fundraising champions have been identified. The committee would like to highlight the activities planned for Autumn and Winter 2022 which Board members and Governors might wish to take an interest and*

The fund balances as at end of September 2022

- *The committee is assured that the funds held on behalf of donations are recorded appropriately and is being spent. The committee noted the donations of £11k.*

The State of the invested funds with Cazenove at the end of September 2022

- *The performance of the fund in 2022 compared to 2021 presents some mild cause for concern. The committee is assured that the invested value exceeds the historic cost and requires further assurance of the investment policy, to minimize risk to the existing funds.*

Consideration of the use of Charitable funds to support Hardship Grants for staff

- *It is disappointing that Charitable funds cannot be used to support staff directly in the current economic circumstances. However, it has assurance that the organization has considered the legal scope of its charity.*

Reason for consideration

To demonstrate assurance for the recording, reporting, use of funds donated to the Trust's charities.

Strategic objectives

Sustainability
Sustainability
Being recognized as an excellent digitally enabled organization which performs strongly and efficiently, working in partnership for the benefit of our population.

Financial implications
The Trust has appointed Manager for Charitable Funds which should raise the profile of charitable giving and “Caring Minds” Charity. The impact should be an increase in charitable receipts and expenditure on staff wellbeing, service user well being.
Risks
There are no risks relating to this on the Board Assurance Framework. Financial and audit risks of financial use of funds in line with Charitable objectives but this is considered to be minimal
Equality impact
The Equality impact has not been done – this needs to be reviewed in relation to the balance of restricted and unrestricted funds, the service areas and spending plans.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM CHARITABLE FUNDS COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Caring Minds and Fundraising Update

The Committee received a detailed presentation from Louise John, Fundraising Manager, on the current priorities for the charity.

The committee noted the update and the ongoing work to date including:

- Bio-site raised £312 – Football Tournament for FIRST
- Staff Wellbeing Tournament – Ongoing page
- Amazon smile –Promoting this with all card holders and those that spend on Amazon on behalf of the trust and service user to utilise this platform
- Regular updates provided for Comms colleague briefing
- Managing Fundraising Inbox

Louise confirmed she has attended a number of networking and engagement events including presenting at the Trust Annual General Meeting to promote Caring Minds and showcase the work to date and ambitions for the future. Positive feedback has been received with positive staff engagement.

Louise was pleased to confirm the 12 Days of Christmas Campaign is being launched by Caring Minds and will visit Trust Sites with hot drinks and Mince Pies. A swap shop is being considered across sites to offer the opportunity to staff and service users to swop items for Christmas.

Caring Minds Companions initial uptake has been positive with seven staff from across a range of professions joining. Caring Minds will continue to engage and promote across the Trust.

The Caring Minds merchandise has been received including lip balms, stress balls and trolly key rings. Goody bags will be shared at events going forward to promote the charity.

The committee received a proposed staffing structure of the Caring Minds Charity Team. The committee noted that the job descriptions are scoped and the budget plans will be drafted and submitted for approval in January 2023.

Chair's assurance comments:

The committee noted with interest the fundraising activities during summer 2022. The committee are assured that these have stepped up with the appointment of its fundraising manager. The committee is pleased that seven fundraising champions have been identified. The committee would like to highlight the activities planned for Autumn and Winter 2022 which Board members and Governors might wish to take an interest and involvement.

1.2 Fund balances

The committee noted the position of the Charity as at 31st August 2022:

- Fund Balances total £462k
- Donations to 31st August 2022 £11k
- Expenditure to 31st August 2022 £53k
- Cash Balance as at 31st August 2022 is £60k

Chair's assurance comments:

The committee is assured that the funds held on behalf of donations are recorded appropriately and is being spent. The committee noted the donations of £11k.

1.3 Cazenove (Schroders) Update

The committee noted the report.
The market value of the fund as at 31st August 2022 is £577,887.20 (split between the multi asset fund and cash). This is compared to a historic cost value of £332,618. To date for the financial year investment income has been received of £9,492. In the previous financial year (2021/22) investment income of £17,983 was received.

The committee noted the need to receive a detailed update from Cazenove (Schroders) as soon as possible following the significant changes to the market and need to mitigate the associated risks.

Chair's assurance comments:

The performance of the fund in 2022 compared to 2021 presents some mild cause for concern. The committee was disappointed that its investment advisers could not provide a written report to explain what is being done to protect the invested funds in light of recent financial uncertainty in the UK Economy. The committee is assured that the invested value exceeds the historic cost and requires further assurance of the investment policy, to minimize risk to the existing funds.

1.4 Terms of reference

The committee noted and approved the terms of refence.

1.5 Hardship Grants

The committee received a tabled paper on the use of Charitable/ donated funds for hardship grants to staff. Based on NHS guidance and work being done at other NHS Trusts, it was confirmed that Charitable Funds were not to be used to provide direct grants to staff. However, the committee agreed to circulate the paper to its membership who were not present and for the Trust to consider other options to support staff in the current cost of living crisis.

Chairs assurance comments:

It is disappointing that Charitable funds cannot be used to support staff directly in the current economic circumstances. However, it has assurance

that the organisation has considered the legal scope of its charity. As there were insufficient numbers of committee members then this item (support to staff) should be considered in the round by the Executive team.

2. SUMMARY

Caring Minds Fundraising update: Summer 2022

- *The committee is pleased that seven fundraising champions have been identified. The committee would like to highlight the activities planned for Autumn and Winter 2022 which Board members and Governors might wish to take an interest and*

The fund balances as at end of September 2022

- *The committee is assured that the funds held on behalf of donations are recorded appropriately and is being spent. The committee noted the donations of £11k.*

The State of the invested funds with Cazenove at the end of September 2022

- *The performance of the fund in 2022 compared to 2021 presents some mild cause for concern. The committee is assured that the invested value exceeds the historic cost and requires further assurance of the investment policy, to minimize risk to the existing funds.*

Consideration of the use of Charitable funds to support Hardship Grants for staff

- *It is disappointing that Charitable funds cannot be used to support staff directly in the current economic circumstances. However, it has assurance that the organization has considered the legal scope of its charity.*

The key issues arising from the meeting are stated above.

WINSTON WEIR
NON-EXECUTIVE DIRECTOR
1 NOVEMBER 2022

10.2. Governance Task and Finish Group

Enclosure 1: Process to Select a Lead Governor & Deputy Lead Governor

Enclosure 2: Appointment Process for Senior Independent Directors

Enclosure 3: Governors Code of Conduct

Enclosure 3a: Code of Conduct Everyday Behaviours Guide

Enclosure 4: Process for receipt of a complaint against a Governor

Enclosure 5: Process for Complaints received against Chair or Non-Executive Directors

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10.2**
Paper title	**GOVERNANCE TASK & FINISH GROUP**
Date	7th December 2022
Author	Sharan Madeley, Company Secretary
Board Sponsor	Phil Gayle, Non Executive Director

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

Executive summary & Recommendations:
The purpose of the report is to seek Board of Directors approval of a number of formal procedures which the Governance Task & Finish Group was asked to address in line the Terms of Reference for the Group approved by the Council in November 2021. The proposals were submitted and approved by the Council of Governors in November 2022. The Council of Governors requested one amendment to the Process Relating to an alleged breach of Code of Conduct and Termination of Governors and this has been actioned and highlighted in red text for ease.
Reason for consideration:
For formal approval and inclusion within the Trust Constitution
Previous consideration of report by:
Governance Task & Finish Group & Council of Governors
Strategic priorities (which strategic priority is the report providing assurance on)
Not applicable for this report.

Financial Implications *(detail any financial implications)*
Not applicable for this report
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Not applicable for this report
Equality impact assessments:
Not applicable for this report.
Engagement *(detail any engagement with staff/service users)*
Engagement with Governors

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS

GOVERNANCE TASK & FINISH GROUP

1. BACKGROUND

1.1 Various governance matters during the last 18 months have highlighted the need for greater clarity in specific areas which needed to be reviewed with possible amendments being required to the Trust Constitution and Standing Orders for the Board of Directors and Council of Governors.

1.2 On the 11th November 2021, the Council of Governors established a Governance Task and Finish Group and agreed formal terms of reference to review specific procedural areas to be included within the Trust Constitution. The Group has met on several occasions to undertake the work detailed within the terms of reference.

2. GOVERNANCE TASK AND FINISH GROUP

2.1 The Governance Task and Finish Group is made up of the following:

Phil Gayle	-	Vice Chair/Non-Executive Director (Chair of Group)
Linda Cullen	-	Senior Independent Director
Winston Weir	-	Non-Executive Director
Mustak Mirza	-	Service User Governor
John Travers	-	Staff Governor
Ken Meeson	-	Stakeholder Governor

(Group was also joined by Gianjeet Hunjan (NED) and Maureen Johnson, Carer Governor, who left July 2022)

2.2 The remit for the Group was to review specific governance areas which had been highlighted as needing greater clarity. These included:

2.2.1 The role, selection/election, tenure, of the Lead Governor

2.2.2 The establishment of a new post of Deputy Lead Governor

2.2.3 The role, selection/election, tenure, and removal of the Senior Independent Director

2.2.4 The process for a breach of Code of Conduct involving complaints against a Governor

2.2.5 The process of investigations involving Non-Executive Directors, or the Trust Chair

3. SPECIFIC AREAS OF WORK

3.1 Appointment Process of Lead governor and the establishment of a new post of Deputy Lead Governor *(Enclosure 1)*

The Governance Task & Finish Group is proposing to the Council of Governors a process to appoint a Lead Governor, along with an associated role profile. In addition, to approve the establishment of a Deputy Lead Governor, and approval of a role profile.

The report includes the proposed process for appointment and includes the wording which will be included within the Trust Constitution.

3.2 The role, selection/election, tenure, and removal of the Senior Independent Director *(Enclosure 2)*

The Governance Task & Finish Group is proposing to the Council of Governors the process regarding the future appointment to the role of a Senior Independent Director along with the associated role profile for inclusion within the Trust Constitution.

3.3 Code of Conduct for Governors *(Enclosure 3)*

The Task and Finish Group is presenting a Code of Conduct document for Governors. The document includes the Trust's Everyday Behaviour Guide which clearly details the positive and negative behaviours in line with the Trust values. All current Governors will be required to sign the Code of Conduct and all newly elected Governors will be asked to sign as part of their induction into the Trust.

3.4 The process relating to an alleged breach of Code of Conduct and Termination of a Governor (*Enclosure 4)*

The Governance Task & Finish Group has drafted a process relating to an alleged breach of the Code of Conduct in relation to Governors.

3.5 The process of investigations following a complaint involving Non-Executive Directors, or the Trust Chair (Enclosure 5)

The Governance Task and Finish Group has drafted a process relating to the process to be followed following a complaint received against a Non Executive Director of Chair. The process has also incorporated recommendations from recent investigations.

4. NEXT STEPS

Amendments to the Constitution and associated Standing Orders are required before some important governance processes can occur.

Principal among these for the Council of Governors is the appointment of Lead and Deputy Lead Governors. Assuming proposed amendments are agreed and approved by both the Council and the Board of Governors, the recruitment and election process for these two roles will take place during December 2022, with a vote at the CoG meeting on 12 January 2023.

The Trust's role as Lead Provider for the Mental Health Provider Collaborative across Birmingham and Solihull will necessitate further changes and additions to the Constitution

and its Annexes. These will be drafted before the end of the year so that amendments can be approved at the CoG meeting on 12 January 2023. The Governance Task and Finish Group will be engaged in this process.

4. RECOMMENDATIONS

The Board of Directors is asked to:

4.1 Lead & Deputy Lead Governor *(Enclosure1)*

- **AGREE** the proposed criteria, eligibility and process for the appointment of Lead and Deputy Lead Governor for inclusion within the Constitution

- **AGREE** the proposed lead governor role description and the proposed process to elect a lead governor.

- **AGREE** to establish the role of deputy lead governor, the proposed deputy lead governor role description and the process to elect a deputy lead governor.

4.2 The role, selection/election, tenure, and removal of the Senior Independent Director *(Enclosure 2)*

- **AGREE** the process for the appointment of a Senior Independent Director for inclusion within the Trust Constitution

- **AGREE** the role profile for the Senior Independent Director

4.3 Code of Conduct for Governors *(Enclosure 3*

- **AGREE** the Code of Conduct for Governors

4.4 Process relating to an alleged breach of Code of Conduct and Termination of a Governor *(Enclosure 4)*

- **AGREE** the process relating to an alleged breach of the Code of Conduct and Termination of a Governor.

4.5 The process of investigations following a complaint involving Non-Executive Directors, or the Trust Chair

- **AGREE** the process relating to the process to be followed following a complaint received against a Non-Executive Director of Chair.

4.6 Amending the Constitution

- **UNDERSTAND** that the Corporate Governance team will incorporate amendments, once approved, into a new version of the Constitution and Annexes
- **UNDERSTAND** that that exercise will also afford an opportunity for the Company Secretariat to tidy up the existing document, e.g., by removing references to Monitor, and “initial” appointments to the NHS Foundation Trust when it was first licenced
- **UNDERSTAND** that these changes will be described at the next Annual Members’ Meeting, but that they will come into force immediately on approval by the Board of Directors.

PHIL GAYLE
CHAIR,
GOVERNANCE TASK AND FINISH GROUP

SHARAN MADELEY
COMPANY SECRETARY

Birmingham and Solihull Mental Health NHS Foundation Trust

EXECUTIVE SUMMARY REPORT TO THE COUNCIL OF GOVERNORS
APPOINTMENT OF A LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

1. PURPOSE OF THE REPORT

This paper is presented to the Council of Governors to agree the role profile and appointment process of the Lead Governor and to agree the establishment of a Deputy Lead Governor role, the role profile and appointment process.

2. KEY POINTS

- The Trust is required to nominate a Lead Governor to facilitate direct communication between NHS Improvement (NHSI) and the Council of Governors in the limited circumstances where it may not be appropriate to communicate through the normal channels.
- The vacancy for a Lead Governor triggered a benchmarking exercise to review Lead Governor arrangements at peer organisations.
- The Lead Governor role description is provided
- It is proposed to establish the role of Deputy Lead Governor. A Deputy Lead Governor role description is provided
- **The NHS Code of Governance:** "The role of the nominated Lead Governor" states "The Lead Governor may be any of the Governors." (See Appendix 1)
- Mechanisms are proposed to elect a Lead Governor and a Deputy Lead Governor once the process has been agreed and formally adopted within the Trust Constitution.

3. RECOMMENDATIONS

The Council of Governors is asked to:

AGREE the proposed criteria, eligibility and process for the appointment of Lead and Deputy Lead Governor for inclusion within the Constitution

AGREE the proposed lead governor role description and the proposed process to elect a lead governor.

AGREE to establish the role of deputy lead governor, the proposed deputy lead governor role description and the process to elect a deputy lead governor.

1. INTRODUCTION

The NHS Foundation Trust Code of Governance requires all NHS Foundation Trusts to nominate a Lead Governor; the basic role is prescribed in the Code and is attached as *Appendix 1.*

The primary purpose of the lead governor is to facilitate direct communication between the Regulator (NHSI) and the governors. NHSI does not envisage regular direct communication with governors save where there may be a real risk of the Trust significantly breaching its licence or constitution and where concerns cannot be satisfactorily resolved via the normal channels. Once there is a risk that this may be the case, and the likely issue is one of board leadership, NHSI may wish to make contact with the governors at speed, through one established point of contact – the lead governor. This will enable governors to understand the Regulator's concerns and in understanding the views of governors as to the capacity and capability of individuals to lead the Trust and to rectify, successfully, any issues.

The lead governor and the Deputy Lead Governors are accountable to the Council of Governors as a collective and the Trust Chair. Other than the specified and proposed additional responsibilities, the role does not hold any extended responsibility or powers beyond those of an individual governor.

2. CURRENT ARRANGEMENTS

The Council of Governors has a vacancy for a lead governor and this has triggered a benchmarking exercise to review lead governor arrangements at peer organisations. The exercise identified an expansion of the basic role of the lead governor to incorporate a range of supplementary responsibilities alongside the establishment of the role of a deputy lead governor, primarily to deputise in the absence of the lead governor but also to support the lead governor to carry out their role.

For BSMHFT the lead governor role has continued in line with the NHS Foundation Trust Code of Governance basic role description, to be the first point of contact for the Regulator in extremis, with only minor additions to the responsibilities previously agreed.

3. PROPOSAL

To align BSMHFT with current practice across the sector it is proposed to:

3.1 Invite expressions of interest from governors in standing in an election for the role of lead governor, role description attached as Appendix 2.

3.2 Establish the role of deputy lead governor; a proposed deputy lead governor role description attached at Appendix 3.

3.3 Agree the proposed criteria, eligibility and process for Lead Governor and Deputy Lead Governor is attached at Appendix 4.

4. SELECTION AND ELECTION CRITERIA

4.1 Expressions of interest to be received

4.2 A ballot will be held in the event of more than one expression of interest coordinated by the Governance & Membership Manager as the Returning Officer. All Governors are entitled to vote

4.3 If only one candidate submits an expression of interest, there will be a vote on that candidate at the next Council of Governor meeting

4.4 Only candidates with at least one year's experience as a Governor at BSMHFT may apply

4.5 The first term of office as Lead Governor runs until the end of the current term of office as a Governor, i.e., a maximum of 2 years for a Governor in their first term, and a maximum of 3 years during subsequent term

4.5 The Lead Governor may hold office for a maximum term of 6 years (maximum term for a Governor is 9 years).

4.6 At the end of their term of office (first or subsequent), the Lead Governor may apply themselves for the role of Deputy Lead Governor

5. PROPOSED TIMETABLE FOR NOMINATIONS AND ELECTIONS

5.1 Lead governor

Once the Council of Governors has agreed the role description and appointment process, for inclusion within the Constitution, the process to elect a Lead Governor will begin, Governors invited to express an interest. If multiple expressions of interest are received a ballot will be held.

5.2 Deputy Lead Governor

Once the Council of Governors has agreed to establish the Deputy Lead Governor role, the role description and appointment process for inclusion within the Constitution, the process to elect a Deputy Lead Governor will commence after the appointment of the Lead Governor .

5.3 Where more than one nomination is received for both roles, a confidential ballot of all governors will be held. Nominees will provide a short nomination statement describing their reasons for standing and a ballot paper showing all the candidates and their nomination statements will be distributed to all governors. The Governance & Membership Manager will act as returning officer and at the deadline for receipt of votes will provide the outcome of the ballot to the Chair for announcement of the result to the Council of Governors. Ballot papers will be kept for six months and made available for scrutiny if required.

5.4 Where only one nomination is received, the Council of Governors will be asked to ratify the appointment.

6. ADDITIONS TO THE CONSTITUTION

6.1 The selection criteria and appointment process for a Lead Governor and Deputy Lead Governor will be included within the Constitution within the Standing Orders for the Council of Governors.

7. RECOMMENDATIONS

The Council of Governors is asked to:

AGREE the proposed criteria, eligibility and process for the appointment of

Lead and Deputy Lead Governor for inclusion within the Constitution

AGREE the proposed lead governor role description and the proposed process to elect a lead governor.

AGREE to establish the role of deputy lead governor, the proposed deputy lead governor role description and the process to elect a deputy lead governor.

SHARAN MADELEY
COMPANY SECRETARY

Appendix 1

Excerpt from THE NHS CODE OF GOVERNANCE July 2014

THE ROLE OF THE LEAD GOVERNOR – STATUTORY ROLE DESCRIPTION

The lead governor has a role to play in facilitating direct communication between NHS Improvement (NHSI) and the Trust's Council of Governors. This contact is likely to be infrequent and will occur in a limited number of circumstances but particularly where it may not be appropriate for NHSI to communicate through the normal channels, which in most cases would be via the Trust Chair or the Trust Secretary.

It is not anticipated that there will be regular direct contact between NHSI and the Council of Governors in the ordinary course of businesses. Where contact is necessary it is important that it happens quickly and effectively. To this end a lead governor should be nominated and contact details provided to NHSI. *The lead governor may be nominated from any of the governors.*

The main circumstances where NHSI will contact the lead governor are where NHSI has concerns as to Board leadership provided to a Foundation Trust and those concerns may in time lead to the use by NHSI of its formal power to remove the Chair or Non-Executive Directors and it will usually be the case that NHSI will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the Trust and to rectify successfully any issues and also for the governors to understand NHSI's concerns.

NHSI does not envisage direct communication with the governors until such time as there is a real risk that the Trust may be in significant breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, NHSI will often wish to have direct contact with the Trust governors but at speed and through one established point of contact, the Trust's lead governor. The Trust should support the lead governor in understanding of NHSI's role, particularly the basis on which NHSI may take regulatory action, to ensure the lead governor is able to correctly communicate more widely with other governors.

Similarly, where individual governors may wish to contact NHSI, this would be expected to be through the lead governor.

The other circumstance where NHSI may wish to contact the lead governor is where, as the regulator, NHSI has been made aware that the process for the appointment of the Chair or other members of the Board, or elections for governors, or other material decisions, may not have complied with the Trust's Constitution, or alternatively, whilst complying with the Trust's Constitution, may be inappropriate. In such circumstances, where the Chair, other member of the Board of Directors or the Trust Secretary may have been involved in the process by which these appointments or other decisions were made, the lead governor may provide the point of contact for NHSI.

Accordingly, the NHS Foundation Trust should nominate a lead governor, and continue to update NHSI with their contact details as and when this change.

Birmingham and Solihull Mental Health NHS Foundation Trust

ROLE DESCRIPTION

Role Title: Lead Governor

Accountable to: Council of Governors and Trust Chair

Role Summary

- As required by the NHS Foundation Trust Code of Governance governors elect one governor to be lead governor to facilitate direct communication between NHS Improvement (NHSI) and the Council of Governors in the limited circumstances where it may not be appropriate to communicate through the normal channels.
- The role receives ongoing support from the Chair and Governance & Membership Manager and has access to training and development as appropriate.

Appointment and Tenure

The lead governor is elected to run concurrently with their term of office as a governor and if re-elected to the role, a maximum of six years can be serviced as a Lead Governor. The lead governor works closely with the deputy lead governor.

Key Duties and Responsibilities

In addition to the responsibilities set out in the NHS Foundation Trust Code of Governance the lead governor will:

- Chair of the Council of Governors' Nomination and Remuneration Committee.
- Meet informally with the Chair between four and six times per year.
- Where appropriate, support the Chair in ensuring that governors act within the Code of Conduct for Governors.
- Foster an inclusive culture amongst governors.
- Set a positive example through promoting and upholding the Trust's values.
- Represent the views of governor colleagues and facilitate effective communication and engagement between the Council of Governors and the Board of Directors.

Desirable personal qualities for a lead governor include:

- excellent interpersonal and communication skills
- the ability to deal with potential conflicts
- the ability to command the respect, confidence and support of their governor colleagues
- the ability to represent the views of their governor colleagues

The Lead Governor aims to:

- Encourage a unitary Council of Governors that is engaged constructively with the Board of Directors and the constituencies from which governors are elected.
- Establish governor leadership that embodies and promotes the Trust's values and sets a positive example to all stakeholders.

Key Relationships

The lead governor will engage with the following stakeholders and groups (this list is not exhaustive):

Regularly:

- Deputy lead governor
- Governor colleagues
- Trust Chair
- Governance & Membership Manager
- Senior Independent Director and other Non-Executive Directors

Occasionally:

- Trust Executive Directors
- Trust staff
- Trust Members
- Partner Organisations
- Members of the public and other external stakeholders
- Governors in other Foundation Trusts

Birmingham and Solihull Mental Health NHS Foundation Trust

ROLE DESCRIPTION
Deputy Lead Governor

Role title: Deputy Lead Governor
Accountable to: Council of Governors and Trust Chair

Role Summary

- The deputy lead governor plays an important role in deputising for the lead governor and to share the lead governor's workload
- The role receives ongoing support from the Chair and Company Secretary and has access to training and development as required.

Appointment and Tenure

The Deputy Lead governor is elected to run concurrently with the Deputy Lead governor's term of office as a governor and if re-elected to the role, a maximum of six years can be served as a Deputy Lead Governor. The Deputy lead governor works closely with the Lead governor.

Key Duties and Responsibilities

In addition to the responsibilities set out in the NHS Foundation Trust Code of Governance the deputy lead governor will:

- Member of the Council of Governors' Nomination and Remuneration Committee.
- Deputise for the lead governor as required.
- Work closely with the lead governor and act as a sounding board as appropriate.
- Meet informally with the Chair and Lead Governor between four and six times per year.
- Foster an inclusive culture amongst governors.
- Set a positive example through promoting and upholding the Trust's values.
- Represent the views of governor colleagues and facilitate effective communication and engagement between the Council of Governors and the Board.

Desirable personal qualities for a lead governor include:

- excellent interpersonal and communication skills
- the ability to deal with potential conflicts
- the ability to command the respect, confidence and support of their governor colleagues
- the ability to represent the views of their governor colleagues

The Deputy Lead Governor aims to:

- Support the lead governor in encouraging a unitary Council of Governors that is engaged with the Board of Directors and the constituencies from which governors are elected.
- Establish governor leadership that embodies and promotes the Trust's values and sets a positive example to all stakeholders.

Key Relationships

The deputy lead governor will engage with the following stakeholders and groups (this list is not exhaustive):

Regularly:

- Lead governor
- Governor colleagues
- Trust Chair
- Governance & Membership Manager
- Senior Independent Director and other Non-Executives

Occasionally:

- Trust Executive Directors
- Trust staff
- Trust Members
- Partner Organisations
- Members of the public and other external stakeholders
- Governors in other Foundation Trusts

TO BE INCLUDED IN THE CONSTITUTION & STANDING ORDERS FOR THE COUNCIL OF GOVERNORS

CRITERIA, ELIGIBILITY AND PROCESS FOR THE APPOINTMENT OF A LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR.

1 INTRODUCTION

1.1 Since 2010 Monitor, now NHS Improvement (NHSI), has required all NHS Foundation Trusts to have a lead governor to facilitate direct communication in the limited circumstances where it may not be appropriate to communicate through the normal channels.

The criteria, eligibility and process for the selection of a lead governor and deputy lead governor within the Trust ((BSMHFT) are outlined in this document.

2 PRIMARY ROLE AND ACCOUNTABILITY

2.1 Lead governor

The primary purpose of the lead governor is to facilitate direct communication between the Regulator (NHSI) and the governors. NHSI does not envisaged regular direct communication with governors save where there may be a real risk of the Trust significantly breaching its licence or constitution and where concerns cannot be satisfactorily resolved via the normal channels. Once there is a risk that this may be the case, and the likely issue is one of board leadership, NHSI may wish to make contact with the governors at speed, through one established point of contact – the lead governor. This will enable governors to understand the Regulator's concerns and in understanding the views of governors as to the capacity and capability of individuals to lead the Trust and to rectify, successfully, any issues.

The Trust should support the lead governor in understanding NHSI's role, particularly the basis on which NHSI may take regulatory action, to ensure the lead governor is able to correctly communicate more widely with other governors.

The lead governor is accountable to the Council of Governors as a collective and the Trust Chair. Other than the specified additional responsibilities, the role does not hold any additional responsibility or powers beyond those of an individual governor.

Similarly, but not exclusively, where individual governors may wish to contact NHSI, this would be expected to be through the lead governor.

2.2 Deputy lead governor

The primary role of the deputy lead governor is to deputise for the lead governor and to provide the Trust with a point of contact for the Council of Governors in the event that the lead governor is unavailable for a period of time or has a conflict of interest.

The deputy lead governor is accountable to the Council of Governors as a collective and the Trust Chair. Other than the specified additional responsibilities, the role does not hold any additional responsibility or powers beyond those of an individual governor.

3 Criteria and eligibility

3.1 The Council of Governors will select a governor to undertake the role of lead governor and deputy lead governor of BSMHFT.

3.2 Governors wishing to undertake the role of lead governor or deputy lead governor must:

- have served as a governor for at least one year
- be able to commit time to undertake the role
- be prepared to acquire knowledge and understanding of the arrangements/requirements of the role and the responsibilities attaching
- understand NHSI's role as an external regulator and the requirements of the Trust constitution
- uphold the values of the Trust, understanding and championing the Trust's values
- be committed to the success of the Trust

3.3 Desirable personal qualities for a lead governor include:

- excellent interpersonal and communication skills
- the ability to deal with potential conflicts
- the ability to command the respect, confidence and support of their governor colleagues
- the ability to represent the views of their governor colleagues

4. Process

4.1 The lead governor and deputy lead governor will be selected by the Council of Governors.

4.2 The process for the selection and appointment of the lead governor and deputy lead governor is as follows:

4.2.1 Upon a vacancy arising, the Chair will inform the Council of Governors of the vacancy and invite governors to express interest in the role.

4.2.2 Where more than one nomination is received, a confidential ballot of all governors will be held. Nominees will provide a short nomination statement describing their reasons for standing and a ballot paper showing all the candidates and their nomination statements will be distributed to all governors. Votes will be counted on a 'first past the post' basis. The Company Secretary will act as returning officer and at the deadline for receipt of votes will provide the outcome of the ballot to the Chair for announcement of the result to the Council of Governors. Ballot papers will be kept for six months and made available for scrutiny if required.

4.2.3 Where only one nomination is received, the Council of Governors will be asked to ratify the appointment at the next Council of Governors meeting.

4.3 The term of office of the lead governor and deputy lead governor will be for a period of their remaining term as a Governor or:

- until they resign the position by giving notice to the Chair; or
- until they are removed from the position by a resolution passed at a general meeting of the Council of Governors.

4.4 At the end of their term of office an individual may stand for re-election to the role. Governors serving as lead governor are eligible to nominate themselves for the role of deputy lead governor and visa versa.

4.5 The Governance & Membership Manager will notify NHSI of any change of lead governor.

Birmingham and Solihull Mental Health NHS Foundation Trust

APPOINTMENT PROCESS FOR APPOINTMENT OF A SENIOR INDEPENDENT DIRECTOR

1. NATIONAL CONTEXT

1.1 The Code of Governance for Foundation Trusts, states in paragraph A4.1

"In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson."

1.2 APPOINTMENT

Following the resignation of the current Senior Independent Director (SID) or the current SID is at the end of their Term of Office, the following appointment process will apply:

1. When a vacancy for a Senior Independent Director arises, the Trust Chair will seek expressions of interest from Non Executive Director colleagues regarding standing for the role of Senior Independent Director.

2. If only one Non Executive Director expresses an interest in the role, a report will be prepared for the Board of Directors in private session, proposing the Non Executive Director as the new Senior Independent Director.

3. If approved, following the meeting of the Board of Directors, a report will be presented to the next Council of Governors meeting to request endorsement to the appointment of the Non Executive Director as the new Senior Independent Director.

4. If more than one expression of interest is received, then the Non Executive Directors will be asked to write a supporting statement to the Board of Directors, detailing why they wish to be considered for the role. This will include ensuring they can deliver on the areas detailed within the role profile.

5. The statement will be circulated to Board Members and a formal vote undertaken. All Board Members will have a vote on the process. The process will be conducted in a timely manner by the Associate Director of Corporate Governance.

6. Once the results are known, the recommended candidate from the Board of Directors for the appointment of Senior Independent Director, will be presented for formal endorsement to the Council of Governors.

7. The Associate Director of Corporate Governance will then formally write confirming the appointment to the Non Executive Director as SID. This letter will be placed on their personal file in the central electronic filing system.

8. If the vote results in a tie, then the Chair will have a casting vote and a report will be prepared for the Council of Governors for formal endorsement.

October 2022

Appendix A

Birmingham and Solihull Mental Health NHS Foundation Trust

ROLE DESCRIPTION

SENIOR INDEPENDENT DIRECTOR (SID)

The Code of Governance (July 2014) recommends the Board should appoint one of the independent non- executive directors (NED) to be the senior independent director (SID). The role is to provide a sounding board for the Chair and to serve as an intermediary for the other directors when necessary.

The senior independent should be available to governors if they have concerns that contact through the normal channels of chair, chief executive, finance director or company secretary has failed to resolve, or for which such contact is inappropriate.

The current Trust's Constitution states *The Board of Directors, in consultation with the Council of Governors, should appoint one of the independent Non-Executive Directors to be the Senior Independent Director, for such period, not exceeding the remainder of his/her term as a member of the Board, as they may specify on appointing him/her.*

1. ELIGIBILITY

The Senior Independent Director (SID) is a non-executive director (NED) who is considered by the Board of Directors to fulfil the criteria of 'independence' set out by NHS England/Improvement Code of Governance. The Chair is not eligible. There is no bar on the holder of any other particular role also acting as SID, with the exception of the Vice Chair who would not be eligible while acting as Chair when the latter is absent.

2. APPOINTMENT AND ACCOUNTABILITY

The SID will share the same duties of NEDs, and in respect of these duties will be subject to the normal reporting relationships of NEDs. The SID will have specific additional duties, defined below, in respect of which the SID will be accountable to the Board of Directors. The SID is appointed by the Board of Directors on recommendation from the Chair and in consultation with the Council of Governors. The SID provides an annual report of activity to the Board.

The Chair will review the appointment as part of the annual NED review process and may re-assign the SID role to another NED subject to Board approval, and in consultation with the Council of Governors. Otherwise, the appointment of SID will lapse when the holder of this position ceases to hold the position of NED.

3. SPECIFIC DUTIES

In addition to the general duties of a NED, the SID will have the following specific duties:

COUNCIL OF GOVERNORS AND MEMBERS:

- To be available to Members and the Council of Governors if they have concerns which have not or cannot be resolved through contact with the Chair, the Chief Executive or the Company Secretary; or for which such contact is inappropriate. This will involve providing Members and Governors with details in order to make contact with the SID, and an obligation on the SID to respond to such contacts and to meet privately with Members or the Council of Governors if appropriate.

- To attend sufficient meetings of Council of Governors to gain a balanced understanding of the issues which are important to them and any concerns they may have. This should normally be accomplished by attending ordinary meetings of the Council of Governors.

- To ensure that the issues and concerns of Members and Council of Governors are communicated to the Board as a whole. The responsibility for communicating the issues and concerns of Members and Council Governors does not rest specifically with the SID. The role of the SID is to monitor the effectiveness of such communications and act if necessary.

PERFORMANCE EVALUATION OF THE CHAIR:

- To facilitate and oversee the annual performance evaluation of the Chair, and to report on this to the Nomination & Remuneration Committee of the Council of Governors and NHS England/Improvement. This will involve leading an annual evaluation process in consultation with the members of the Board and may include Governors and others as appropriate.

MAINTAINING HIGH PROFESSIONAL STANDARDS:

- To provide support to the organisation, be this for the Chair, Medical Director or the Director of Organisational Development & People or any other relevant members of staff in ensuring the fair and equitable implementation of the framework for Maintaining High Professional Standards in the Modern NHS for medical and dental staff in line with Department of Health guidance (2003).

Birmingham and Solihull Mental Health NHS Foundation Trust

GOVERNORS' CODE OF CONDUCT

This document sets out in very broad terms the role and responsibilities of all Governors of Birmingham & Solihull Mental Health NHS Foundation Trust and the standards of conduct expected of them.

GOVERNORS' ROLE

- To appoint the Chair and the Non-Executive Directors and, as appropriate, remove.
- Decide the remuneration and allowances and other terms and conditions of the Chair and other Non-Executive Directors.
- To approve the appointment of the Chief Executive.
- To appoint and, if appropriate, remove the auditors.
- To receive the annual accounts, any report of the auditors on them, and the annual report.
- In preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Governors Council.
- The Council (at least 50%) must approve an increase of 5% or more in non NHS income in any one financial year.
- The Council must approve all "significant transactions".
- To approve amendments to the Trust's constitution.
- To approve an application by the Trust to enter into a merger, acquisition, separation or dissolution.
- To hold the Non Executive Directors, individually and collectively to account, for the performance of the Board of Directors.
- To represent the interests of the members and of the public.

NOLAN PRINCIPLES

The Nolan Committee set out seven principles for all who serve the public in any way. Governors are holders of a public office and are therefore expected to adhere to the Nolan Principles – taken from the Nolan Committee's first report on standards in public life. These principles are listed below.

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or material benefit for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

DECLARATION OF INTERESTS
Governors on election or appointment are required to list all relevant interests which may reasonably be thought – by any other person – to influence his or her actions in the performance of his or her duties as a governor of this Trust. These interests are to be reviewed on a regular basis.

It is the responsibility of the governor to inform the Company Secretary immediately in writing of any changes to their interests and these should be recorded in the minutes of the Governor's Council.

VALUES

Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners. Our values describe our core ethics and principles. They help guide our culture by inspiring people's best efforts and constraining unwanted actions that do not align with our values. These are:

- Compassionate
- Inclusive
- Committed

BEHAVIOURS

Our everyday and detailed behaviours describe what our values look like in practice. They give us a shared language to help bridge the wide range of specialties and roles in our Trust. Governors will be expected to adhere to our Every Day Behaviours Guide. *(attached)*

CODE OF CONDUCT
I will:

- support the Trust, its Constitution, and the NHS Constitution.
- respect the whole Trust Team (Governors, Board, Staff and Members) and recognise and support the common purpose in achieving the Trust's Vision, Values and Behaviours.
- be a good Ambassador for the Trust and always work in the best interests of the Trust, its Patients and Members.
- always observe confidentiality on matters relating to the work of the Trust, its Patients and Staff .
- attend meetings of the Governor's Council and related Sub Committees during which I will observe good meeting practices.
- respect and accept the majority decisions of the whole Governors Council, understanding that this is the sole decision-making body for the Governors. Committees and working parties will advise the Council of their work for agreement and ratification by the full Governors Council.

- understand that I should never approach the media except through the Communications Office and wherever possible passing media approaches to that office.

- oppose any discrimination and claim no privileges in my role as Governor.

- undertake all appropriate training provided to enable me to fulfill my role as Governor.

- act responsibly, whilst contributing to the work of the Governors Council, bringing my strengths to bear, whilst respecting the strengths of the other Governors.

- represent and be accountable to the Membership of the Trust and the wider public.

- abide by the Polices and Procedures of the Trust, including the Whistleblowing policy and guidance.

- participate in public contacts, including visits to Trust sites after agreement and sanctioning by the Trust. I will act as an observer and not adopt a management role.

- make effective use the resources available to me.

Code of Conduct Acceptance

I, (name) representing (public constituency/staff constituency/partner organisation

…….. confirm that I have read and agree to abide by the Code of Conduct for the Council of Governors of Birmingham & Solihull Mental Health NHS Foundation Trust

Date …….

Signature ……..

Delete as appropriate
Copies of the signed declaration will be kept by the Company Secretary

APPENDIX 1

MEETING ETIQUETTE: GOOD GOVERNANCE ETIQUETTE OF THE COUNCIL OF GOVERNORS

We will:

- Respect one another as possessing individual and corporate skills, knowledge and responsibilities.
- Show determination, tolerance and sensitivity – rigorous and challenging questioning, tempered by respect.
- Show group support and loyalty towards each other.
- Listen carefully to all ideas and comments and be tolerant to other points of view – be sensitive to colleagues' needs for support when challenging or being challenged.
- Be honest, open and constructive.
- Be courteous and respect freedom to speak
- Regard challenge as a test of the robustness of arguments – ensure no one becomes isolated in expressing their view. Treat all ideas with respect.
- Read all papers before the meeting.
- Arrive on time and participate wholeheartedly.
- Focus discussion on material issues and on the resolution of issues.
- Make the most of time.
- Support the chair, colleagues and guests in maximising scope and variety of viewpoints heard.
- Ensure individual points are relevant and short.
- Take decisions and abide by these.
- Refer to past systems or mistakes as being responsible for today's situation.
- Act in a positive manner.
- Ensure Governor has the right to challenge/question another.
- Be ready to apologise if offence is taken.
- Stay open to discussion.
- Maintain a view of the strategic picture.

Birmingham and Solihull Mental Health NHS Foundation Trust

Everyday Behaviours Guide

Our values:	Compassionate	Inclusive	Committed
Supporting statements These statements expand on the values to broaden their meaning.	• **Supporting recovery for all and maintaining hope for the future.** • **Being kind to ourselves and others.** • **Showing empathy for others and appreciating vulnerability in each of us.**	• **Treating people fairly, with dignity and respect.** • **Challenging all forms of discrimination.** • **Valuing all voices so we all feel we belong.**	• **Striving to deliver the best work and keeping service users at the heart.** • **Taking responsibility for our work and doing what we say we will.** • **Courage to question to help us learn, improve and grow together.**
Core behaviours The behaviours describe what our values look like in practice, i.e. it's how we demonstrate our values. These are the core top five behaviours for each of our values.	1. Use strategies to manage my emotions to avoid creating a negative atmosphere. 2. Offer forgiveness and do not judge others or myself harshly when we get things wrong. 3. Notice when someone is struggling and offer help. 4. Focus on finding a solution and do not blame the person responsible. 5. Look for, and praise, the achievements and contributions of other people.	1. Treat everyone with respect irrespective of their perceived difference (i.e. beliefs, background, characteristics, culture, role or circumstance). 2. Respect other people's personal space, privacy and dignity. 3. Privately and sensitively challenge my own behaviours or those demonstrated by others, that are not in line with our values. 4. Involve others to develop a shared understanding of what needs to change. 5. Proactively and willingly share relevant information with others.	1. Proactively identify what needs to happen to get the job done. 2. Own up to my mistakes without delay, apologise and take responsibility for putting them right. 3. Share my concerns with appropriate people to find a resolution. 4. Balance service user (or internal customer) needs with resources available when making decisions. 5. Check to ensure service users (or internal customers) are happy with the service received.
Leadership behaviours These are for our people leaders in addition to the core behaviours above.	1. Enable people to work in a way that balances our Trust's priorities and suits them as an individual. 2. Put people's wellbeing and needs ahead of my goals. 3. Check in regularly with direct reports, to ask how things are and to offer support.	1. Include those affected when creating plans. 2. Coach people to identify issues and create their own solution without imposing my own ideas. 3. Ensure people have the required training, knowledge, skills, time and space to do their work comfortably and safely.	1. Build a strategy that is clearly aligned with anticipated future service user needs. 2. Find opportunities for people to use and develop their strengths. 3. Seek regular feedback on my leadership style and make adjustments to suit my people.
Negative impact behaviours These behaviours describe things that often have a negative impact on others and therefore, are what we don't want to see or experience.	**Non-compassionate behaviours** • Not listening to others. • Failing to realise and accept, or ignoring the negative impact of your behaviour on others. • Using force, coercion or power to bully or impose.	**Non-inclusive behaviours** • Dismissing other people's experiences or views, as untrue or unimportant. • Being rude, using inappropriate banter or making discriminatory/derisory comments about others. • Pretending other people's work was done by you and taking the credit for it.	**Non-committed behaviours** • Ignoring issues, saying they are somebody else's problem. • Dismissing feedback about service user or staff care. • Not involving service users and their families in care and service decisions.

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Birmingham and Solihull Mental Health NHS Foundation Trust

PROCESS RELATING TO ALLEGED BREACH OF CODE OF CONDUCT AND TERMINATIONS OF GOVERNORS

1. INFORMAL RESOLUTION

1.1. Upon receiving information or a concern about the conduct of a governor, the Chair will take fair and reasonable steps over a period of up to 14 days to resolve the matter informally if appropriate.

1.2. Where during the informal discussions the governor admits to a breach of the Code of Conduct, the need to proceed to a panel hearing may be avoided with the agreement of the governor. Any admission of a breach of the Code of Conduct must be confirmed in writing by the governor. Following discussion, if the Chair agrees not to proceed to a hearing, they must obtain 50% support from members of the Council present to enable them to decide on an appropriate resolution in agreement with the governor concerned. However, the governor reserves the right to proceed to a formal panel process if informal resolution is not agreeable to them.

2. ESTABLISHING THE PANEL

2.1. If the matter cannot be resolved informally as at paragraph 1.2 it shall be open to a panel consisting of the Senior Independent Director of the Board of Directors *(who will chair the panel)* and 4 (four) governors to consider the allegations and what (if any) action should be taken. Where there is a need to form a panel, members will be selected by the Senior Independent Director in consultation with the Lead Governor. If the Lead Governor has been involved as per paragraphs 1.1 – 1.2, the Deputy Lead Governor with support the Senior Independent Director.

2.2. The panel should conduct a fair investigation which may include the need to commission an investigatory report. The panel should, in the first instance, seek one or more individuals with relevant experience to conduct an investigation, either from within or outside the Council of Governors. For example, the Trust's HR department has considerable experience in advising on such issues and the panel may commission a senior member of the HR team to be a member of the investigation team. Any governor who is a member of the panel should not be part of the investigation team. The Company Secretary will support the panel with the administration processes of commissioning and investigator.

2.3. The panel will be quorate if the Senior Independent Director and 3 governors are present. If in this scenario members of the panel are

required to vote and a majority cannot be reached, the chair of the panel will have the casting vote.

3. SUSPENSION

3.1. The panel may on a majority vote of its members suspend a governor who is the subject of allegations that the panel is investigating.

3.2. This suspension will not be communicated to the wider Council of Governors or Trust employees.

4. INVESTIGATION PROCESS

4.1. The governor will be informed that an investigation will be undertaken. Where possible this should be face to face but if this is not practicable then it is appropriate for this information to be provided over the telephone and confirmed in writing at the earliest opportunity. This communication should include a copy of this Annex of the Trust's Constitution.

4.2. The investigating officer(s) may request written statements from parties involved or witnesses to the incident(s) being investigated ahead of an investigation meeting. All parties must be advised that during the investigation the issue must remain confidential.

4.3. The investigating officer(s) will arrange a meeting with the governor concerned. They will also arrange a meeting with any other witnesses as deemed necessary.

4.4. Where the governor who is the subject of the investigation is invited to the meeting, they will be advised of their right to be accompanied by a companion (not acting in a legal capacity). Reasonable notification will be given of the meeting. The governor will inform the investigating officer of the name of the companion they wish to accompany them in advance of such a meeting.

4.5. The investigating officer(s) will reasonably gather other documentation relevant to the investigation.

4.6. If the investigating officer(s) feels that they need to obtain further information from a witness it is appropriate for a further statement to be requested or another interview arranged in accordance with the above process.

4.7. It is important that all investigations are carried out thoroughly and should be undertaken normally within 20 working days. The governor who is the subject of the investigation should be informed in writing by the investigating officer(s) if this timescale is not likely to be met and given a revised timescale for completion; outlining any reasons for the delays.

4.8. Upon completion of the investigation an investigation report will be submitted to the panel members and the governor concerned. The panel will consider the

report.

If necessary a panel hearing will be called as soon is reasonably practical to consider the allegations and if applicable any potential sanctions.

5. THE PANEL HEARING PROCESS

5.1. The governor concerned is permitted to make written and/or oral representations to the panel for consideration in the panel hearing irrespective of whether the governor has been interviewed as part of an investigation.

5.2. The governor has the right to be accompanied at the panel hearing by a companion (i.e. an advocate). The companion can speak on the governor's behalf, with permission from the governor.

5.3. The investigating officer(s) will present their case to the panel members. Once the presentation is completed, the panel members may question the investigating officer(s). The governor will then present their case and panel members may question the governor.

5.4. After questions from the panel, the investigating officer(s) and the governor will have the opportunity to sum up.

5.5. There will be an adjournment for the panel members to consider the cases presented and reach a conclusion. The panel will reach its conclusions based on a majority vote of its members. This may include a recommendation to the Council of Governors to consider terminating the tenure of the governor in question. By way of example, lesser sanctions may include but are not limited to one or more of:

5.5.1. Requirement that the governor signs the Code of Conduct;

5.5.2. Requirement that the governor attends specified training;

5.5.3. Requirement that the governor desists from specified conduct.

5.6. If possible, the meeting will reconvene the same day and the chair of the panel will issue their decision and the reasoning that directed their conclusion. The decision will be confirmed in writing to the governor within 5 working days. If it is not possible to reconvene the same day, the panel should meet within 10 working days and issue their decision in writing to the governor within 5 working days of this meeting.

6. PANEL DECISION NOT COMPRISING A RECOMMENDATION TO TERMINATE TENURE

6.1. Any decision made by the panel may be appealed in writing by the governor concerned within 28 days of the date upon which notice in writing of the panel's decision is communicated to the governor concerned (time of the essence).

The appeal will be heard by the Council of Governors in private session within 14 days of the date upon which the notice of the appeal is received by the Trust.

6.2. If it is not possible to hear an appeal within the 14 days' time limit, then the Council of Governors shall be asked to agree either to hold an exceptional meeting for an appeal hearing within the 14 days' time limit or to extend the time limit to the date of the next meeting of the Council of Governors after expiry of the time limit.

6.3. The governor has the right to have the appeal against the panel's decision heard by the full Council of Governors, however, the governor may request that a sub group of the Council of Governors hear the appeal instead. This request will need to be agreed by the Council of Governors.

6.4. If the Council of Governors agrees to the above the sub group will consist of four (4) governors and the Chair who will act as chair of the sub group.

7. APPEAL PROCESS TO COUNCIL OF GOVERNORS OF A DECISION NOT COMPRISING A RECOMMENDATION TO TERMINATE TENURE

7.1. The Chair or (if the Chair is disqualified) the Vice Chair shall act as the chair of the appeal. If both the Chair and Vice Chair are disqualified, then the Chief Executive in consultation with the lead governor shall nominate another Non-Executive Director of the Trust to act as the chair of the appeal. At the start of an appeal hearing, the Council of Governors must approve the appointment of the chair of the appeal if he or she is not the Chair or Deputy Chair.

7.2. The Council of Governors will receive the original investigation report and outcome letter and the written grounds for appeal.

7.3. At the decision appeal hearing:

7.3.1. The chair of the panel will present their reasons for the conclusions reached and decision taken.

7.3.2. Governors may ask the chair of the panel clarification questions about their decision.

7.3.3. The appellant may address the Council of Governors outlining their grounds of appeal. The representation may be time limited at the absolute discretion of the chair of the appeal.

7.3.4. The appellant has the right to be accompanied at the hearing by a companion (i.e. an advocate). The companion can speak on the appellant's behalf, with permission from the appellant.

7.3.5. Governors may ask the appellant clarification questions about his or her comments, response and representations.

7.3.6. The appellant and the chair of the panel may make final summary representations to the Council of Governors which may be time limited at the absolute discretion of the chair of the appeal.

7.3.7. The chair of the appeal may make such recommendations as he or she considers appropriate to the Council of Governors.

7.3.8. The chair of the appeal may exclude the appellant and the chair of the panel from the meeting so that the Council of Governors may discuss the chair of the appeal's recommendation in their absence. The chair of the appeal shall invite the appellant and the chair of the panel to return to the meeting on the conclusion of such discussion.

7.4. The Council of Governors shall decide whether to uphold the panel's decision or to apply any other sanction by a majority vote of all governors present and voting. The members of the panel who are present will count towards the quorum but will be omitted from the vote. The Council of Governors' decision will be communicated in writing to the appellant within 5 working days of the date of the Council of Governors' meeting.

7.5. The chair of the appeal may in his or her absolute discretion at any time adjourn the appeal hearing to a date and time to be fixed.

7.6. The chair of the appeal may at any time before or during an appeal hearing take such advice as he or she considers to be appropriate from the Trust's officers and/or advisers and if necessary may adjourn an appeal hearing to do so in private.

8. APPEAL PROCESS TO A SUB GROUP OF A DECISION NOT COMPRISING A RECOMMENDATION TO TERMINATE TENURE

8.1. The Chair or (if the Chair is disqualified) the Vice Chair shall act as chair of the appeal. If both the Chair and Vice Chair are disqualified, then the Chief Executive in consultation with the Lead Governor shall nominate another Non-Executive Director of the Trust to act as chair of the appeal. At the start of an appeal hearing, the Council of Governors must approve the appointment of the chair of the appeal if he or she is not the Chair or Vice Chair.

8.2. At the sub group decision appeal hearing:

8.2.1. The chair of the panel will present their reasons for the conclusions reached and decision taken.

8.2.2. The sub group except the appellant may ask the chair of the panel clarification questions about their decision.

8.2.3. The appellant may address the sub group outlining their grounds of appeal. The representation may be time limited at the absolute discretion of the chair of the appeal.

8.2.4. The appellant has the right to be accompanied at the hearing by a companion (i.e. an advocate). The companion can speak on the appellant's behalf, with permission from the appellant.

8.2.5. The sub group may ask the appellant clarification questions about his or her comments, response and representations.

8.2.6. The appellant and the chair of the panel may make final summary representations to the sub group which may be time limited at the absolute discretion of the chair of the appeal.

8.2.7. The chair of the appeal may make such recommendations as he or she considers appropriate to the sub group.

8.2.8. The chair of the appeal may exclude the appellant and the chair of the panel from the meeting so that the sub group may discuss the chair of the appeal's recommendation in their absence. The chair of the appeal shall invite the appellant and chair of the panel to return to the meeting on the conclusion of such discussion.

8.3. The chair of the appeal may in his or her absolute discretion at any time adjourn the appeal hearing to a date and time to be fixed.

8.4. The chair of the appeal may at any time before or during an appeal hearing take such advice as he or she considers to be appropriate from the Trust's officers and/or advisers and if necessary may adjourn an appeal hearing to doso in private.

8.5. The sub group shall decide whether to uphold the panel's decision or to apply any other sanction by a majority vote of sub group members present and voting.

8.6. The sub group decision will be presented to the full Council of Governors for ratification.

9. PANEL DECISION COMPRISING A RECOMMENDATION TO TERMINATE THE TENURE OF A GOVERNOR

9.1. Following a panel hearing the panel may recommend to the Council of Governors the termination of a governor's tenure. The chair of the panel will set out the reasons for the recommendation of termination of tenure.

9.2. At the termination hearing:

9.2.1. The chair of the panel will present their reasons for the recommendation to terminate the governor's tenure.

9.2.2. The Council of Governors, except the governor concerned, may ask the chair of the panel clarification questions about their recommendation.

9.2.3. The governor concerned has the right to be accompanied at the hearing by a companion (i.e. an advocate). The companion can speak on the governor's behalf, with permission from the governor.

9.2.4. The governor may address the Council outlining their case for non-termination

9.2.5. The Council may ask the governor concerned clarification questions about his or her comments, response and representations.

9.2.6. The governor concerned and the chair of the panel may make final summary representations to the Council of Governors which may be time limited at the absolute discretion of the Chair.

9.2.7. The Chair may make such recommendations as he or she considers appropriate to the Council of Governors.

9.2.8. The Chair may exclude the governor concerned and the chair of the panel from the meeting so that the Council of Governors may discuss the chair of the panel's recommendation in their absence. The Chair shall invite the governor concerned and the chair of the panel to return to the meeting on the conclusion of such discussion.

9.3. Termination of a governor's tenure of office requires the approval of two-thirds of the members of the Council of Governors present and voting providing the meeting is quorate in accordance with the Standing Orders for the Practice and Procedure of the Council of Governors. The members of the panel who are present will count towards the quorum and will be able to vote.

9.4. A governor whose tenure has been terminated by the Trust is not eligible to stand again for election as a governor of the Trust.

9.5. In the event of an appeal being referred to the Council of Governors if the governor concerned is aggrieved at the decision s/he may apply in writing within 7 days to the Council of Governors for the decision to be referred to an independent assessor. The independent assessor will then consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

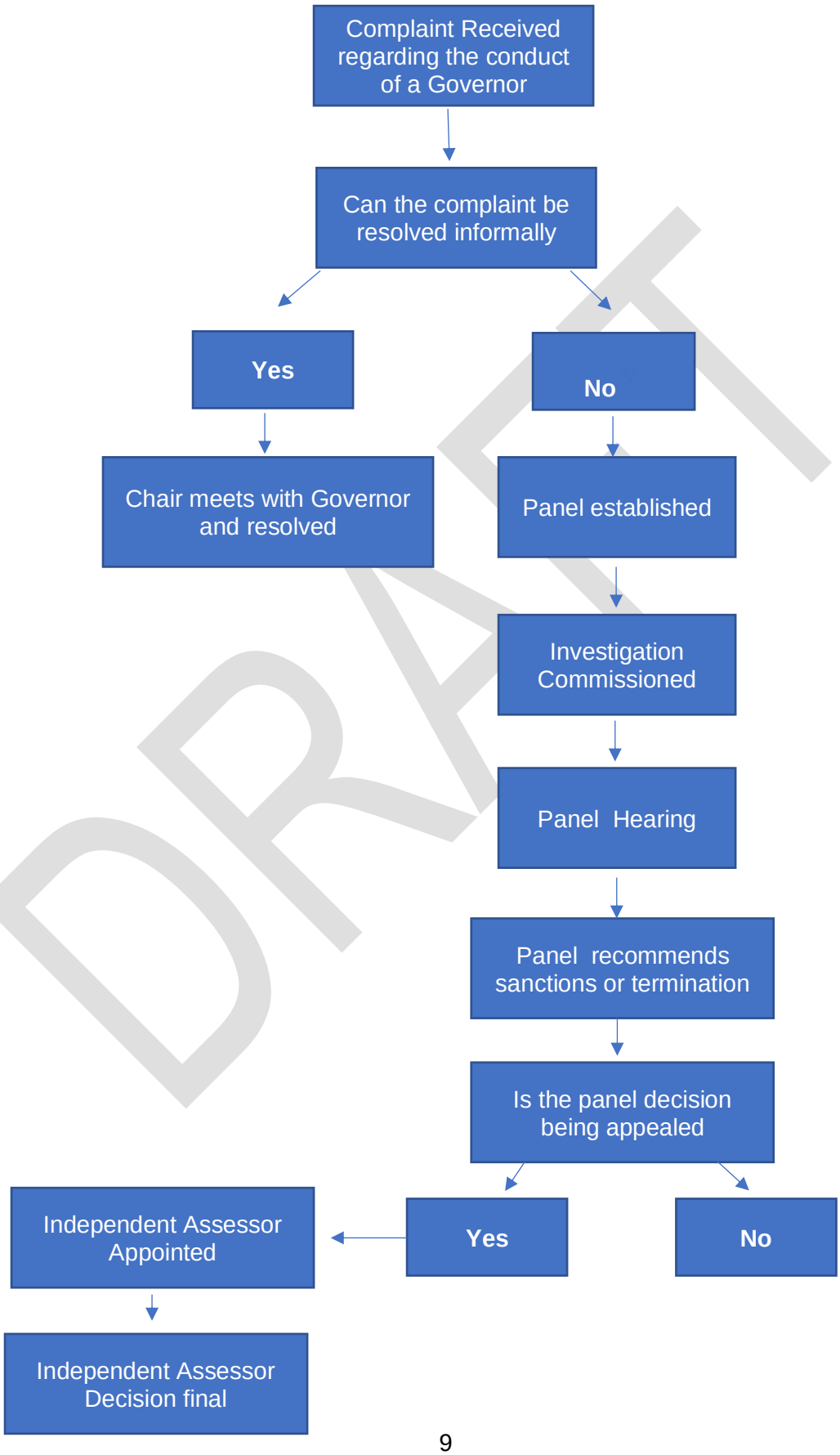
9.6. On receipt of an application the Chair and Lead Governor and the applicant governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on an independent assessor

within 21 days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Centre for Effective Dispute Resolution to nominate the independent assessor. The independent assessor's decision will be binding and conclusive on the parties.

TIME

9.7. All time limits specified in this section are for guidance only unless it is stated that time is of the essence. Breach of a time limit shall not invalidate any step taken or decision made unless time is of the essence.

DECISION TREE



ENCLOSURE 5

Birmingham and Solihull Mental Health NHS Foundation Trust

PROCESS FOR THE RECEIPT OF COMPLAINTS/BREACH OF CODE OF CONDUCT AGAINST CHAIR/NON-EXECUTIVE DIRECTOR

1. INTRODUCTION

1.1 Governors have a range of roles to fulfil incorporating legal, oversight and governance responsibilities. They have strategic stewardship responsibilities and are expected to act in the best interest of the NHS foundation trust. They represent the interests of NHS foundation trust members and hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, including ensuring the Licence is complied with. It is therefore essential that Governors are fully aware of the values, vision and behaviours the Trust seeks to promote to staff, members, patients and the wider public.

2. PURPOSE

2.1 The purpose of this procedure is to provide a robust process to follow in the event that a Non-Executive Director or the Chair is alleged to have breached the Board Code of Conduct in Appendix 1.

3. DEFINITIONS

The following definitions apply for terms used in this procedure:

3.1 *Chair*: the chair of the Trust.
3.2 *NEDs* : Non-Executive Directors of the Trust.
3.3 *Council of Governors*: the Council of Governors as constituted in the BSMHFT Constitution.
3.4 *Associate Director of Corporate Governance*: Trust Lead for Corporate Governance.
3.5 *Governor*: a member of the Council of Governors.
3.6 *Member*: a member of the BSMHFT Trust.
3.7 *Complainant(s):* the person(s) who is raising the complaint or concern.
3.8 *A Complaint* is any expression of dissatisfaction that requires a response.
3.9 *Conflict of interest*: a situation in which an individual has more than one interest which prevents the proper exercise of their duties and finds themselves unable to be impartial under this procedure. If Governors have any doubt as to the relevance or materiality of an interest, this should be discussed with the Chair.
3.10 I*nvestigator*: the person requested to conduct a fair, prompt and proportionate investigation under this procedure
3.11 *CoG Investigation Panel*: (responsible for the investigation and takes the role of the "Commissioning Manager as detained in Trust Policies.
3.12 *Lead Governor*: A Governor elected by the Council of Governors to the role of Lead Governor.
3.13 *Deputy Lead Governor*: A Governor elected by the Council of Governors to the role of Deputy Lead Governor.

3.14 *Terms of Reference*: the framework used by the Investigator, setting out the issues to be investigated and matters to be considered as part of the investigation.

3.15 *Supporter*: to support a NED or Chair/Complainant during the process.

3.16 *Suspension*: the process of placing on a NED or the Chair so that they do not participate in the work of the Trust, while an investigation is undertaken into the allegations reported. Suspension is a neutral act; it is neither a disciplinary action nor an assumption of guilt. A suspended Chair or NED shall continue to be required to adhere to the Board Code of Conduct.

3.17 *Present at a meeting*: this can be virtually as well as face-to-face.

If any post holder is conflicted or otherwise unavailable to act, references in this procedure to that post holder shall be construed as references to a suitable deputy agreed by the Lead Governor. If the Lead Governor is conflicted, then the Deputy Lead Governor shall deputise.

4. DUTIES AND RESPONSIBILITIES

4.1 The Lead Governor is responsible for undertaking their role as per this procedure and for being able to take immediate action where necessary under 5.3 of this Procedure.

4.2 The Council of Governors is responsible for ensuring that in the event of the need to sanction or remove a NED or the Chair that the process is fair, rigorous, lawful and transparent.

4.3 The Associate Director of Corporate Governance is responsible for ensuring that the procedure is enacted and followed, and supporting the Lead Governor, the Council, and the CoG Investigation Panel to discharge their duties, including receipt of external advice.

4.4 The NED's and the Chair are responsible for their own conduct and for demonstrating an appropriate standard of behaviour at all times in line with the Board Code of Conduct.

The NED's or the Chair should be aware that complaints of inappropriate conduct or behaviour and/or breaches of the Board Code of Conduct may still be dealt with under this procedure, and could still therefore lead to their removal as a NED or the Chair, where the complaint in question relates to events occurring outside of their specific duties as NED or the Chair. This is because such behaviour and/or breaches of the Code of Conduct still have the potential to adversely impact on the Trust's reputation and/or may still be considered relevant to the question of whether they are fit to carry out their duties. The NED's or the Chair are responsible for engaging with any action taken in line with this procedure and for arranging their own support for formal meetings.

4.5 The CoG Investigation Panel is responsible for undertaking its role as per this procedure. The CoG will meet to identify and agree on 3 Governors to form the CoG Investigation Panel.

4.6 Supporters are responsible for recognising this is confidential business of the Trust.

5. MISCELLANEOUS

5.1 Any written correspondence may be by electronic means (email). Any documents attached to emails should be protected by password.

5.2 It is anticipated that all timescales set out within this procedure will be met; however, the Lead Governor in consultation with the Company Secretary may extend any timescale given, if they

have a clear reason to do so. Where a time limit imposed on is not met, or the Chair/NED indicate that they do not intend to engage with the procedure, the Lead Governor may continue to progress the procedure without further process or delay.

5.3 At any time, the Lead Governor is authorised to take such interim measures as may be immediately required, including the exclusion of the NED or the Chair concerned from a meeting or suspension from duties, on the basis that such measures are necessary to:

5.3.1 enable an effective investigation to be undertaken into any concern or complaint about a NED or the Chair;

5.3.2 address or prevent any significant disruption to the effective operation of any part of the Trust;

5.3.3 manage risk to the health or well-being of any NED or the Chair, Governor, employee, volunteer or patient of the Trust;

5.3.4 protect the reputation of the Trust;-

Any suspension should be within the terms of the applied Policy. The suspension should be ratified and kept under review in line with the applied Policy.

5.4 During any period of suspension from duties, the NED or the Chair is not permitted to:

5.4.1 attend or enter the Trust's premises unless he or she is doing so as a patient of the Trust, as a carer or family member of a patient of the Trust or with the consent of the Lead Governor;

5.4.2 contact any of the Trust's NED or the Chair, Governors, employees, suppliers, volunteers or patients without the express prior permission of the Lead Governor, other than in circumstances where any such contact is purely of a personal nature and unrelated to their position or duties as a Chair/NED or in relation to this process.

5.5 Any decision by the Lead Governor under paragraph 5.3 shall be communicated to the CoG Investigation Panel as soon as reasonably practicable and is effective when the NED or the Chair is notified either verbally or in writing. The NED or the Chair will be required to maintain confidentiality in regards to their suspension and the process being undertaken, save that they may disclose information about the process being followed to their Supporter required for the purposes of paragraphs 9 and 11 below.

5.6 The Lead Governor shall notify the Council of Governors that an interim measure has been imposed as soon as reasonably practicable.

5.7 In order to protect the legitimate interests of a NED or the Chair and any Complainant, the Council of Governors shall not be entitled to receive any further information regarding the use of this procedure in relation to any NED or the Chair until it is notified of any charge on which it is being asked to make a decision.

5.8 Notwithstanding the use of this procedure, a NED or the Chair is entitled to resign at any time. Where a NED or the Chair who is subject to this procedure resigns, the Lead Governor will provide an overview of the complaint to the Council where this would not unduly prejudice the interests of the NED or the Chair, and the complaint may still be investigated under this

procedure if the Council of Governors considers necessary or appropriate to do so in the circumstances.

5.9 The CoG Investigation Panel or Council of Governors are authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The costs of such advice must be agreed with the Trust via the Chief Executive.

5.10 Any meeting or hearing under this Procedure may be conducted remotely, by telephone or video conference technology, if the Lead Governor, following consultation with the Associate Director of Corporate Governance, considers it possible and appropriate in the circumstances. If any meeting or hearing is conducted remotely in this way, instructions for how to attend the meeting or hearing will be sent (usually by email) to all parties who are invited to attend, prior to the start of the meeting or hearing itself. Specific rules for remote participation in the meeting or hearing may also be circulated to all attendees in advance, and any failure to adhere to these rules by any NED or the Chair attending the meeting or hearing may be treated as a breach of the Board Code of Conduct and dealt with accordingly.

5. 11 Normally this Procedure will apply as set out; however, in some circumstances it may not meet the circumstances of a complaint and investigation, for example where multiple complaints and counter complaints arise. The aim should be to incorporate the essential elements of the Procedure and the final decision of the most appropriate process will remain with the Lead Governor, following consultation with the Associate Director of Corporate Governance.

6. PROCESS ON INITIAL RECEIPT OF COMPLAINT/ALLEGATION

6.1 This procedure shall apply where the Lead Governor identifies, or becomes aware of, a complaint about a NED or the Chair from any source (it may be necessary to consider section 5.3 at this stage).

6.2 The Lead Governor shall ensure that all complaints are documented before proceeding.

6.3 The Lead Governor, in consultation with the Associate Director of Corporate Governance, will determine whether and how to proceed with a complaint: either informally or formally. Consideration should be given to undertaking a without prejudice wellbeing check of the NED or the Chair against whom the complaint has been received and the Complainant(s). This check will be with the informed consent of the person being assessed.

6.4 If the Lead Governor decides a complaint shall be dealt with informally, the Lead Governor will discuss it with the NED or the Chair and if appropriate, offer advice or support to the NED or the Chair in an effort to avoid any further breaches of the Board Code of Conduct or the Trust Constitution. This will be documented in writing to the NED or the Chair and kept on file for a period of 12 months. The complaint shall not be taken further under this procedure, unless the Lead Governor subsequently determines that the complaint is more serious than first thought and should be dealt with as in paragraph 7 below.

6.5 If the Lead Governor decides a complaint shall be dealt with formally, the provisions of paragraph 7 below will apply.

6.6 With the support of the Associate Director of Corporate Governance, the Lead Governor shall document:

6.6.1 their reasons for their decision under paragraph 6.4;

6.6.2 any advice or support offered to a NED or the Chair under paragraph 6.4; and provide a copy to the Associate Director of Corporate Governance.

6.7 The Lead Governor shall report all complaints and any actions taken to the CoG Investigation Panel.

6.8 In the event that the NED or the Chair complained against raises a counter-complaint, the Lead Governor and the Associate Director of Corporate Governance, shall decide how to proceed with that counter-complaint.

7. INITIAL CONSIDERATION BY THE COG INVESTIGATION PANEL

7.1 The Lead Governor shall provide written details of the complaint to the NED or the Chair and advise them that the matter will be referred to the CoG Investigation Panel. The Lead Governor will invite the NED or the Chair to provide a response to the complaint within 10 working days so that this can be considered by the Panel. If the NED or the Chair requests any further information in relation to the complaint than that which has already been provided, the Lead Governor, with support by the Associate Director of Corporate Governance, will determine whether it is appropriate or necessary to provide this information.

7.2 If the NED or the Chair fails to provide a response to the complaint or fails to provide a response within 10 working days (without providing a good reason for the delay), this may be deemed a breach of the Code of Conduct, which requires a NED or the Chair to cooperate fully and in a timely manner with any authorised due process or investigation. This alleged breach may be added to the existing allegations made against the Chair/NED in the complaint, which will then be considered by the CoG Investigation Panel as detailed at paragraph 7.5 below.

7.3 The complaint and any response received from the NED or the Chair will be sent to the CoG Investigation Panel for discussion at the next meeting which should be convened at the earliest opportunity.

7.5 At the next meeting of the CoG Investigation Panel, the Panel shall be asked to determine by a majority of those present and voting whether the complaint requires further investigation. In the event the NED or the Chair has not provided a response to the complaint as envisaged in paragraph 7.1 (or has not provided a response within the required timeframe set out in paragraph 7.1), the CoG Investigation Panel will be entitled to consider and vote on whether the complaint requires further investigation solely based on the information available to it at that meeting.

7.6 If the majority required for the decision under paragraph 7.5 is not achieved, no further action shall be taken against the Chair/NED under this procedure in relation to that complaint unless the Lead Governor receives new information or evidence and subsequently determines that the complaint is more serious than first thought and asks the CoG Investigation Panel to reconsider the matter or the NED or the Chair refuses to engage with the help and support offered as set out in paragraph 7.7 below. The NED or the Chair will be informed of the decision by the Lead Governor in writing within ten (10) working days, and will be offered advice or support.

7.7 For the purposes of this procedure, advice and support may include:

7.7.1 Helping a NED or the Chair to understand their obligations under the Board Code of Conduct and the Trust's Constitution;

7.7.2 Offering an opportunity for a NED or the Chair to discuss their behaviour with the Lead Governor to help them to comply with their obligations under the Board Code of Conduct and the Trust's Constitution;

7.7.3 Offering mediation between a NED or the Chair and a Complainant.

8. INVESTIGATION

8.1 If the majority required for the decision under paragraph 7.5 is achieved, the Committee shall agree Terms of Reference (ToR) for an investigation into the complaint and instruct the Associate Director of Corporate Governance to initiate an investigation. The Associate Director of Corporate Governance may delegate responsibility for undertaking the investigation to an external third party with relevant experience.

8.2 The Terms of Reference will be documented.

8.3 The NED or the Chair shall cooperate with the investigation, and any failure to do so may be considered to be a breach of the Board Code of Conduct. Any such breach may be added to the existing allegations made against the NED or the Chair in the complaint, and investigated accordingly in accordance with this paragraph 8.

8.4 The Committee shall also require the Complainant to cooperate with the investigation, in so far as it is possible for the Panel to do so.

8.5 An investigation should be completed as soon as practicable, and ideally within thirty (30) working days, subject always to paragraph 5.2 above. If a significantly longer period than 30 working days is required for the investigation to be completed, then this should be agreed by the CoG Investigation Panel. Under the terms of the relevant Policy, the "Commissioning Manager" will be the COG Investigation Panel.

8.6 Where further complaints about the NED or the Chair are identified in the course of an investigation, the Investigator may ask the CoG Investigation Panel to widen the ToR or decide whether a new investigation is required.

8.7 The Investigator shall produce a draft investigation outcome report setting out:

8.7.1 The ToR and the evidence obtained for each element of the ToR;

8.7.2 Any information obtained from the NED or the Chair,

8.7.3 Any other information that the Investigator deems appropriate.

8.8 The draft investigation outcome report shall then be sent to the Lead Governor and then to the NED or the Chair for them to provide any comments on factual accuracy, which must be provided within 10 working days of receipt of the report. If the NED or the Chair does not provide any comments within 10 working days, the NED or the Chair will be deemed not to have any comments to make in relation to the conclusions in the report, and this procedure will continue to be followed as set out below. Once any factual accuracy amendments have been made, the report will change from "draft" to "final" status.

8.9 The final investigation report, along with any comments from the NED or the Chair, shall be sent to the members of the CoG Investigation Panel by the Associate Director of Corporate Governance in good time to be read before the meeting at which it is to be discussed.

9. CONSIDERATION OF FINAL INVESTIGATION REPORT

9.1 The CoG Investigation Panel can decide to hold preliminary meetings in private to consider the Investigation Report to consider whether any further information is required before the Investigation is complete.

9.2 The CoG Investigation Panel shall hold a meeting in private to consider the investigation report.

9.3 The NED or the Chair shall be entitled to (but can choose not to) attend a CoG Investigation Panel meeting convened for the purposes of paragraph 9.2. They shall be entitled to make representations relevant to the contents of the investigation report. They may attend the CoG Investigation Panel meeting with a supporter, but that supporter shall not be entitled to address the meeting. Where the NED or the Chair seeks to rely on information that they have not previously provided to the Investigator, they will only be allowed to do so where this is agreed by the Lead Governor. The NED or the Chair and Supporter shall be required to withdraw from the meeting after making representations, and shall not be allowed to be present when the CoG Investigation Panel discusses the investigation report and vote on any matter.

9.4 A Complainant shall not be entitled to attend a CoG Investigation Panel meeting convened for the purposes of paragraph 9.2 without the permission of the Lead Governor. Where a Complainant is asked to attend a CoG Investigation Panel meeting, they may attend with a Supporter, but that Supporter shall not be entitled to address the meeting. The Complainant and Supporter shall not be allowed to be present when the panel discusses the investigation report and vote on any matter.

9.5 Having considered the investigation report and any submissions, the panel shall be asked to determine by a majority of those present and voting whether the complaint should be taken forward by means of the formal route set out at paragraph 10.

9.6 If the majority required for the decision under paragraph 9.5 is not achieved, the panel shall adopt the informal route set out at paragraph 6 above.

10. FORMAL COUNCIL OF GOVERNORS ROUTE

10.1 If the majority required in paragraph 9.5 is achieved, the panel shall instruct the Company Secretary to prepare a draft statement stating that the NED or the Chair has breached the Board Code of Conduct or the Trust's Constitution or both.

10.2 The panel shall consider the draft statement and the evidence of the breaches and make any amendments. A majority of those present and voting at a meeting of the panel shall be required to approve the terms of the statement and propose a sanction. Abstentions are not included in the voting total.

10.3 A confidential Extraordinary Council of Governors meeting shall be called. A copy of the statement, the evidence, the proposed sanction and the evidence relied upon by the panel in support of the statement, along with any information or representations that have been received from the NED or the Chair in the course of this procedure, shall be sent at least 7 days prior to the meeting to:

10.3.1 The NED or the Chair who is subject to this process, with an invitation to attend the Extraordinary Council of Governors meeting to make representations and then withdraw. The NED or the Chair shall be asked to respond in writing to the invitation at least five (5) working days before the meeting;

10.3.2 All members of the Council of Governors, with a request that they each confirm safe receipt of the information.

10.4 For the avoidance of doubt, the Extraordinary Council of Governors meeting will take place and the Council will consider the issues as set out in paragraph 10.7 below regardless of whether the NED or the Chair who is subject to this process responds to the invitation as set out in paragraph 10.3.1 or attends the meeting itself.

10.5 If the NED or the Chair attends the meeting convened for the purposes of paragraph 10.3, they shall be entitled to make representations relevant to the contents of the charge statement. They may attend the Council meeting with a Supporter but that Supporter shall not be entitled to address the meeting. Where the NED or the Chair seeks to rely on information that they have not previously provided to the Investigator or the CoG Coordinating Committee, they will only be allowed to do so where this is agreed by the Lead Governor. The NED or the Chair (with their Supporter) shall be required to withdraw from the meeting after making their representations, and shall not be allowed to be present or to vote when the Council discusses the charge statement and votes.

10.6 In recognising this is confidential business of the Trust, where the Complainant is not a member of the CoG, a Complainant shall not be entitled to attend a Council meeting convened for the purposes of paragraph 10.3 without the permission of the Council. Where a Complainant is asked to attend a Council meeting, they may attend with a Supporter, but that Supporter shall not be entitled to address the Council. The Complainant (and Supporter) shall not be allowed to be present or to vote when the Council discusses the charge and votes.

10.7 If a quorum as laid down in the Constitution is not achieved for any reason, the meeting will be rescheduled for another date which will be as soon as practicably possible taking into account the notice requirements set out in Trust's Constitution. Any Governor who has any conflict of interest in the matter which is the subject of the complaint, shall disclose their conflict as soon as is practicable after the commencement of the meeting and will not take part in the consideration or discussion of the charge. The Lead Governor should consider whether to exclude that Governor from the meeting entirely.

10.8 At the meeting called under paragraph 10.3, the Council will review the available evidence, determine whether the allegations set out in the statement are proven and decide by way of a vote whether to impose a sanction.

10.9 Sanctions may include (but are not limited to):

10.9.1 A written warning. A time limit of up to 12 months will be applied to this sanction.

10.9.2 Removal from office as a NED or the Chair from the Trust.

10.10 The threshold of votes required in order to impose a sanction on a NED or the Chair is as follows:

10.10.1 in the case of the sanction of removal from their office as NED or the Chair, this shall only be imposed with the support of not less than two-thirds of the Governing body; or

10.10.2 in the case of any other sanction, this shall only be imposed with the support of a majority of those present and voting at the Council meeting where the statement is considered.

10.11 If the relevant threshold as set out in paragraph 10.10 is not reached for the purposes of imposing a sanction, no further action shall be taken against the NED or the Chair under this procedure in relation to that complaint.

10.12 The NED or the Chair shall be notified of the Council's decision by the Lead Governor in writing usually within ten (10) working days of the decision. Where a sanction is proposed, the NED or the Chair shall be asked to acknowledge in writing receipt of the sanction within ten (10) working days, although any failure to do so on the NED or the Chair part will not affect the imposition of the sanction, which will take effect regardless from the date of the letter confirming the Council's decision.

10.13 If the imposed sanction is removal from office, the NED or the Chair will be required to return all Trust property (ID badge, parking permit, papers etc.) to the Company Secretary immediately.

10.14 If the NED or the Chair was suspended at any time during the process under paragraph 5.3, then the suspension is concluded when the outcome and any sanction is communicated to the NED or the Chair under paragraph 10.13.

11. APPEAL

11.1 The NED or the Chair has the right to appeal the decision reached by the CoG Investigation Panel, not the findings nor the process taken to reach those findings. An appeal must be raised in writing.

11.2 An appeal must be lodged within ten (10) working days of receipt of the outcome letter. The NED or the Chair should state in full their grounds of appeal.

11.3 Appeals should be sent to the Associate Director of Corporate Governance and an independent external Lead Governor will be appointed.

11.4 Appeal hearings will normally be set up within 15 working days of receipt of the appeal letter.

11.5 It is the responsibility of the NED or the Chair to state their case for appeal. The Associate Director of Corporate Governance will have available to them the original hearing information and any further information submitted by the NED or the Chair in advance of the appeal hearing.

11.6 The decision may be given on the day or may be deferred for further consideration in which case the NED or the Chair will usually be written to within 7 working days of the hearing with the details of the decision reached. The outcome will also be presented to the Council of Governors, usually within 7 working days of the hearing.

11.7 The Complainant will be notified in writing of the completion of the process.

11.8 The outcome is final and there is no further right of appeal.

12. COMMUNICATIONS

12.1 If a NED or the Chair is removed, a communications plan will be produced the Chief Executive/Associate Director of Corporate Governance.

13. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE PROCEDURE

13.1 Frequency
Each time the Procedure is used, the internal auditors will audit compliance to ensure that this Procedure has been adhered to and a formal report will be written and presented to the Council of Governors.

13.3 Dissemination of Results
At the next Council of Governors meeting.

13.4 Recommendations/ Action Plans
Implementation of the recommendations and action plan will be monitored by the Council of Governors.

13.5 Any barriers to implementation will be risk-assessed and added to the risk register.

Appendix 1

CODE OF CONDUCT FOR BOARD OF DIRECTORS

1. INTRODUCTION

High standards of corporate and personal conduct are an essential component of public service. The purpose of this code is to provide clear guidance of the standards of conduct and behaviour expected of all directors.

This code of conduct applies to all voting members of the trust board, namely the chair, non-executive and executive directors and other directors who participate in Board meetings. These are all referred to as directors.

This code, together with the Trust constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the trust. The code is designed to operate in conjunction with the NHS Improvement code of governance, the trust's constitution and standing orders and other relevant codes of practice.

This code is complementary to the trust's values:

Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners.

Our values were developed by listening to feedback about what people wanted to see and experience when working for us, with us or accessing our services.

Our values describe our core ethics and principles. They help guide our culture by inspiring people's best efforts and constraining unwanted actions that do not align with our values.

Our values will only make a difference when we each let them guide our own thoughts, feelings, decisions, attitudes and actions.

The more we demonstrate our values through our work, the more likely others are to experience our values when working with us.

Our everyday and detailed behaviours describe what our values look like in practice. They give us a shared language to help bridge the wide range of specialties and roles in our Trust.

Compassionate

- Supporting recovery for all and maintaining hope for the future.
- Being kind to ourselves and others.
- Showing empathy for others and appreciating vulnerability in each of us.

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Valuing all voices so we all feel we belong.

Committed

- Striving to deliver the best work and keeping service users at the heart.
- Taking responsibility for our work and doing what we say we will.

● Courage to question to help us learn, improve and grow together.

Directors are responsible for complying with the provisions of this code whenever they conduct business of the trust or act as its representative.

2. PRINCIPLES OF PUBLIC LIFE AND PUBLIC SERVICE VALUES

In 1995, the Committee on Standards in Public Life (the Nolan Committee) identified three public service values and seven principles of conduct underpinning public life "for the benefit of those who serve the public in any way". These are as follows:

There are three crucial public service values that underpin the work of the trust.

- *Accountability* – everything done by the trust must be able to stand the test of external scrutiny, public judgements on propriety and professional codes of conduct. *Probity* – there should be an absolute standard of honesty in dealing with the assets of the trust; integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and others, and in the use of information acquired in the course of NHS duties. *Openness*- there should be sufficient transparency about the activities of the trust to promote confidence in the organisation, by its key stakeholders and the public. These three public service values are underpinned by seven principles of public life applied to members of the trust board, as holders of public office:

- *Selflessness*

  Directors should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- *Integrity*

  The trust board and its individual directors should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of official duties.

- *Objectivity*

  In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards or benefits, the trust board should make choices on merit.

- *Openness*

  The trust board should be as open as possible about all the decisions and actions that it takes. The board should give reasons for its decisions and only restrict information when the wider public interest clearly demands.

- *Honesty*

  Directors have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- *Leadership*

  Directors should promote and support these principles by leadership and example.

3. GENERAL PRINCIPLES

Public sector values matter in the trust and directors have a duty to conduct trust business with probity. They have a responsibility to respond to staff, patients and their families, and other stakeholders impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this code depends on a vigorous and visible example from the trust board and the consequential behaviour of all those who work within the organisation.
The Board therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct.

The Board will lead in ensuring that the provisions of the NHS constitution, the standing orders, financial standing instructions and accompanying scheme of delegation, conform to best practice and serve to enhance standards of conduct. The Board expects that this code will inform and govern the decisions and conduct of all directors.

The Board has confirmed its commitment to compliance with the Bribery Act and to ensure that all staff are aware of their responsibilities in relation to the prevention of bribery and corruption and that the risk of trust exposure to acts of bribery is mitigated. Directors must ensure that they are aware of the implications of the Bribery Act 2010, and of its underpinning principles, and will support related initiatives.

4. PUBLIC SERVICE VALUES IN MANAGEMENT

The Board will ensure that public service values guide the organisation in achieving its results. The Board has a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda for the Board.

Accounting, tendering and employment practices will reflect the highest professional standards. Public statements and reports by the trust board will be clear, comprehensive, understandable and balanced, and fully represent the facts. Annual and other key reports will be issued in good time to all stakeholders in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

The Board will maintain a sound system of internal control and establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with all its stakeholders.

5. DECLARATION OF INTEREST AND CONFLICTS OF INTEREST

Directors will act impartially and will not be influenced by social, family or business relationships. They will not use their public position to further their private interest.

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity. Directors must make a declaration of interests in accordance with the trust's conflicts of interests policy on appointment, as changes arise and annually.

These will be formally recorded in the minutes of the trust board and entered into a register, which is published on the trust's website. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

If directors acquire any relevant interest subsequent to their appointment, they must declare this at the next board meeting so that it is formally recorded in the minutes, and entered into the register.

Declaration of interests is a standing item at the beginning of every meeting of the trust board or its committees, to ensure that any change in interests is declared and that board or committee members declare any interest they have that is relevant to a matter on the agenda. Their subsequent participation at the meeting will be at the chair's discretion.

6. HOSPITALITY AND OTHER EXPENDITURE

Directors will set an example to the trust in the use of public funds and the need for good value in incurring public expenditure. All expenditure on these items should be capable of justification as reasonable in the light of general practice in the public sector.

The Board is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the organisation in the eyes of the immediate community and its wider stakeholders.

The trust has adopted a conflict of interests policy, which covers gifts and hospitality, and which will be followed at all times by directors and all employees. Directors must not accept gifts or hospitality other than in compliance with this policy and must make disclosures in accordance it. Advice on the acceptance of gifts and hospitality should be sought from the Company Secretary

The Board should also take cognisance of the trust's Fraud, Corruption and Bribery Policy and is legally bound by the Bribery Act 2010, under which it is an offence for employees to pay or receive bribes.

7. RELATIONS WITH SUPPLIERS

The conflict of interests policy includes provisions relating to the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation must be carefully considered and the decision recorded. The trust board should be aware of the risks of incurring obligations to suppliers at any stage of a contracting relationship. Suppliers will be selected on the basis of quality, suitability, reliability and value for money.

8. FIT AND PROPER PERSON

All directors are required to comply with Care Quality Commission Regulation 5: fit and proper persons: directors. Directors must certify on appointment, and each year within the appraisal process, that they are/remain a fit and proper person. If circumstances change so that a director can no longer be regarded as a fit and proper person or if it comes to light that a director is not a fit and proper person, they are suspended from being a director with immediate effect pending confirmation and any appeal. Where it is confirmed that a director is no longer a fit and proper person, their board membership is terminated.

9. PERSONAL CONDUCT

Directors must conduct themselves in a manner which maintains the integrity of the organisation and its standing in the NHS and the wider community.

Specifically directors must: act in the best interests of the trust and adhere to its values and this code of conduct;

- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the board in order for it to fulfil its role and functions;
- recognise that the board is collectively responsible for the exercise of its powers and the performance of the trust;
- raise concerns and provide appropriate challenge regarding the running of the trust or a proposed action where appropriate;
- recognise the differing roles of the chair, senior independent director, chief executive, executive directors and non-executive directors;
- make every effort to attend meetings where practicable;
- adhere to good practice in respect of the conduct of meetings and respect the views of others;
- take and consider advice on issues where appropriate;
- acknowledge the responsibility of the council of governors to hold the non-executive directors individually and collectively to account for the performance of the board;
- represent the interests of the trust's members, public and partner organisations in the governance and performance of the trust; and to have regard to the views of the council of governors;
- not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person; and
- accept responsibility for their performance, learning and development.

10. **OPENNESS AND PUBLIC RESPONSIBILITIES**

The Board will make its decisions in public unless there is a justifiable and properly documented reason for not doing so.

The needs of the population that the trust serves and the resulting provision of services are subject to constant change. The trust board will be open with the public, patients and staff as the need for change emerges. Major changes will be consulted upon before decisions are reached in accordance with statute, guidelines and best practice. Clear and understandable information supporting those decisions will be made available and positive responses will be given to reasonable requests for information.

The trust will act in a socially responsible and inclusive manner. The Board will forge an open relationship with the communities it serves. The Board will actively involve staff, the Council of Governors and other key stakeholders and partners in setting out a vision for the organisation, which demonstrates concern for the wider health of the population and best use of public resources allocated to the trust. The trust will work in partnership and co-operate with local and national bodies to support the delivery of safe, high quality care.

11. CONFIDENTIALITY AND ACCESS TO INFORMATION

Directors must comply with the trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the trust board and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation, and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act (now replaced by the General Data Protection Regulation - GDPR), the Freedom of Information Act and other relevant legislation which will be followed at all times by the trust board.

Nothing said in this code precludes directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998.

12. RAISING MATTERS OF CONCERN – "SPEAKING UP" OR "WHISTLE-BLOWING"

The trust board acknowledges that directors and staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The trust board has adopted a policy (speaking up policy and procedure ((incorporating whistleblowing/raising concerns policy and procedure)) which should be followed at all times by directors and all staff.

Where a director believes that a board colleague is non-compliant with all or part of this code, they should raise the matter with the chair of the board. Where the chair is the person who is alleged to have contravened the code, the concerns should be raised with the senior independent director.

The trust board will seek to ensure that NHS resources are protected from fraud, corruption and bribery and that any incident of this kind is reported to the Local Counter Fraud Specialist in line with the counter fraud policy.

13. EXTERNAL COMMUNICATIONS

The trust has a guideline for communicating with the media. Directors will be familiar with, and abide by, this policy. All press enquiries must be referred to the communications team.

When speaking as a director of the board, whether in a public forum or in a private or informal discussion, directors should ensure that they reflect the current policies or view of the trust. They should do so only with the prior knowledge and approval of the Communications Team. Where this is not practicable, they should report their action to the communications team as soon as possible.

Directors must ensure that their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of the trust.

14. COMPLIANCE

Directors must satisfy themselves that the actions of the board and its members in conducting business fully reflect the values in this code and, as far as is reasonably practicable, that concerns expressed by staff and others are fully investigated and acted upon. All directors are required, on appointment, to subscribe to the code of conduct.

The chair and non-executive directors of the board are responsible for taking firm, prompt and fair disciplinary action against any executive or other director in breach of the code of conduct.

The corporate nature of the organisation will mean that, in most cases, if a decision is open to criticism individual directors will not be legally liable due to the specific statutory protections where they are acting in good faith. However directors who commit a criminal offence will carry personal responsibility for any liability.

Directors will be cognisant of their responsibilities and appropriate conduct relating to equality and human rights and the related legislation. Non-executive directors have a key role in applying proper scrutiny to equality and human rights in NHS organisations.

CODE OF CONDUCT TRUST BOARD MEMBERS DECLARATION

I (full name)……..have read, understood and agree to comply with BSMHFT code of conduct for trust board members.

Signature ……..

Date ……

Please return this completed, signed form to:
Associate Director of Corporate Governance

10.3. Fit & Proper Persons Policy

Enclosure 1: Appendix: Fit & Proper Persons

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10.3**
Paper title	**FIT & PROPER PERSONS POLICY**
Date	7th December 2022
Author	S. Madeley, Company Secretary
Executive sponsor	P. Nyarumbu, Executive Director of Strategy, People & Partnerships

This paper is for: ***[tick as appropriate]***		
☒ Action	☐ Discussion	☐ Assurance

Executive summary

The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Director Positions at Birmingham & Solihull Mental Health NHS Foundation Trust comply with the Fit and Proper Persons requirements. All Directors, upon appointment will be subject to additional employment checks regarding ensuring they are a Fit & Proper Person, in line with CQC Regulations, to discharge their duties as a Board Member.

This includes the posts of Chief Executive, Executive Directors, Chair and Non-Executive Directors. Fit and Proper Person checks will also be undertaken on an annual basis and the results reported through to the Council of Governors and Board of Directors.

Reason for consideration

For formal approval by the Board of Directors

Strategic objectives/ priorities

Sustainability

Financial implications

Detailed within the report

Risks

Equality impact

Non specific.

Our values

Committed
Compassionate
Inclusive

FIT & PROPER PERSONS POLICY

1. BACKGROUND

1.1 The Fit and Proper Person Requirement (FPPR) for directors of NHS bodies is a direct response to the Francis Report. The FPPR came into force in 2014, brought into being by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and properto carry out this important role.

1.2 The Care Quality Commission (CQC) issued its own guidance on FPPR. The guidance makesit clear that it is a matter for NHS Bodies to ensure that the FPPR is met. CQC's role is to monitor and assess how well NHS Bodies discharge their responsibility.

2. POLICY

2.1 The Trust has undertaken Fit & Proper Person tests annually for Board Members with Board Members completing an annual declaration.

2.2 This new policy ensures that the process is clearly documented along with the responsibilities of key individuals.

2.3 The draft policy was presented twice to the Policy Development Management Group (PDMG) for comment with suggested changes being implemented.

2.4 The PDMG has requested that the Policy is now formally presented and approved by the Board of Directors.

3. RECOMMENDATION

The Board of Directors is requested to approve the Fit & Proper Persons Policy.

SHARAN MADELEY
COMPANY SECRETARY

Birmingham and Solihull Mental Health NHS Foundation Trust

Fit & Proper Persons Policy

Policy number and category	**CG 11**	**Corporate Governance**
Version number and date	**3**	**10th November 2022**
Ratifying committee or executive director	**Board of Directors**	
Date ratified		
Next anticipated review	**28th March 2024**	
Executive director	**Executive Director of Strategy, People & Partnerships**	
Policy lead	**Associate Director of Corporate Governance**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

The intention of the Fit & Proper Persons Policy is to adhere to regulations to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

Policy requirement (see Section 2)

The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Director Positions at Birmingham & Solihull Mental Health NHS Foundation Trust comply with the Fit and Proper Persons requirements.

Birmingham and Solihull Mental Health NHS Foundation Trust

APPENDICIES

Birmingham and Solihull Mental Health NHS Foundation Trust

1. INTRODUCTION

The Fit and Proper Person Requirement (FPPR) for directors of NHS bodies is a direct response to the Francis Report. The FPPR came into force in 2014, brought into being by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The Care Quality Commission (CQC) issued its own guidance on FPPR. The guidance makes it clear that it is a matter for NHS Bodies to ensure that the FPPR is met. CQC's role is to monitor and assess how well NHS Bodies discharge their responsibility.

The Fit and Proper Person Requirements focus on assessing the applicant's honesty, integrity, suitability and fitness, for example that they have the right level of qualifications, skills and experience, and that, with all reasonable adjustments, is able to undertake the roles and responsibilities of the position being offered

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.'

2. POLICY STATEMENT

The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Director Positions at Birmingham & Solihull Mental Health NHS Foundation Trust comply with the Fit and Proper Persons requirements. All Directors, upon appointment will be subject to additional employment checks regarding ensuring they are a Fit & Proper Person, in line with CQC Regulations, to discharge their duties as a Board Member. This includes the posts of Chief Executive, Executive Directors, Chair and Non-Executive Directors. Fit and Proper Person checks will also be undertaken on an annual basis and the results reported through to the Council of Governors and Board of Directors.

3. THE PROCEDURE

The Care Quality Commission states that unless an individual satisfies all the requirements set out in Regulation 5, a service provider must not appoint or have in place an individual as a director of the service provider, or performing the functions of, or functions equivalent or similar to the functions of a director.

The requirements that are referred to are that:

- the individual is of good character

- the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
- the individual is able by reason of their health, after reasonable adjustments are made,of properly performing tasks which are intrinsic to the office or position for which theyare appointed or to the work for which they are employed,
- the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided inEngland, would be a regulated activity, and

Where an individual who holds a relevant position but no longer meets the requirements, the Trust must:

- take such action as is necessary and proportionate to ensure that the position in question is held by an individual who meets such requirements, and

- if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

Who do the Regulations apply to?

The CQC guidance describes “directors” as executive and non-executive directors and any other person performing the functions of, or equivalent or similar functions to, a director. It applies to executive and non-executive directors, permanent, interim and associate positions, irrespective of voting rights. It does not apply to governors.

The Trust will ensure that the FPPR is applied to all board members (voting and non-voting). Due consideration will be given to the application of FPPR for individuals that are covering board member positions in the absence of Director colleagues. This will be undertaken by the Chief Executive and Chair and decisions will be fully documented.

Process for Assessing FPPR Compliance
The FPPR must be applied to an individual before appointment. There is then a requirement to ensure FPPR is complied with during the course of the employment relationship.

a) Pre- Employment Checks
The Trust will undertake all relevant employment checks prior to appointment of the identified ‘directors’ following the standard checks as outlined within the NHS Employment Check Standards – see checklist at Appendix 3.

Employment contracts and appointment letters for directors will include a statement that acondition of continuing employment is that the individual remains a fit and proper person as required under the Regulations, the CQC guidance and under NHS Provider licence (including future amendments) as well as the consequences of non-compliance with the Regulations.

Good Character - A self-declaration will be undertaken (as shown at Appendix 4) and a criminal records check as appropriate.

Competence – evidence of qualifications and references will be obtained. On-going assessment will be undertaken via regular appraisal and the development of personal development plans, ensuring training and development needs are met.

Health - All directors will be required to complete an Occupational Health self-declaration. Clearance as 'fit' for the position applied for will be gained.

Misconduct or Mismanagement - This is the most difficult area of assessment within the Regulations and refers to individuals *not being responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement….* This test is clearly wide ranging. Past employment history will be checked in detail through gaining a complete employment history and detailed references.

Miscellaneous - There are also a number of grounds of unfitness relating to for example, bankruptcy, which will also need to be assessed. These checks will be completed online through the Insolvency Register and Disqualified Directors Register

Information Requirements - The CQC regulations requires key information to be maintained on personal files, the checklist has been developed to ensure all required information is maintained.

b) Requirement for Assessment of continued Fitness

In order to ensure the on-going assessment of continued fitness it is proposed that a combination of the following activities is used:

- On-going duty to report as included in contracts of employment and offer letters
- Annual self-declaration
- Annual checks for bankruptcy and registration
- Regular health checks where required
- Completion of robust appraisals

The checklist at Appendix 5 will be completed to demonstrate continued fitness.

4 ROLES AND RESPONSIBILITIES

Post(s)	Responsibilities
Head of Recruitment	Is responsible for ensuring all employment checks are carried out in accordance with this policy and collating the evidence for insertion in personal files.
Policy Lead	The Associate Director of Governance will approve and sign off all FPPR checks carried out and will provide annual compliance reports.

Post(s)	Responsibilities
Executive Director	In the event that a Director is at the point of commencing employment or is found whilst employed to be unable to evidence all requirements, the Executive Director of Strategy, People & Partnerships will bring this to the attention of the Chair and Chief Executive.
Chair and Chief Executive	In the absence of evidence to support appointment, will jointly undertake a risk assessment and consider any potential and proportionate restrictions in working practice that should be placed on the individual prior to evidence becoming available to facilitate commencement or continuation of employment

5: DEVELOPMENT AND CONSULTATION PROCESS consisting of:

Consultation summary		
Date policy issued for consultation	28th March 2022	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
Director of Strategy, People & Partnerships	31st March 2022	
Deputy Director of Human Resources	31st March 2022	
Where received	**Summary of feedback**	**Actions / Response**

*(*Add rows as necessary)*

6. REFERENCE DOCUMENTS

The Care Act 2014
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
The Health and Social Care Act 2008 (Regulated Activities) (Amendment Regulations 2015
Companies Act 2006
NHS Employment Check Standards (NHS Employers)
Standards of conduct, performance and ethics (Health and Care Professions Council)
The seven principals of public life (Committee on standards for public life)
CQC Guidance - Fit and proper persons: directors

Related BSMHFT Documents:

- Recruitment Policy
- DBS Policy

7. BIBLIOGRAPHY

Care Quality Commission: Guidance for Providers: Fit and Proper Persons: Directors

8. GLOSSARY consisting of:

CQC:	Care Quality Commission
FPPR	Fit and Proper Person Requirement

8. AUDIT AND ASSURANCE consisting of:

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Provision of assurance that all Non Executive Directors have met FPRR	Associate Director of Corporate Governance	Report	Annual	Nomination & Remuneration Committee to Council of Governors
Provision of assurance that all Directors have met FPRR	Associate Director of Corporate Governance	Report	Annual	Private Board of Directors Meeting

Appendix 1

Birmingham and Solihull Mental Health NHS Foundation Trust

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Fit & Proper Persons Policy		
Person Completing this proposal	Company Secretary	**Role or title**	
Division	Corporate	**Service Area**	Not applicable
Date Started	4th March 2022	**Date completed**	6th April 2022
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To adhere to regulations which require members of the Board of Directors to undergo specific checks in relation to their ongoing suitability for the role			
Who will benefit from the proposal?			
The Trust by ensuring Board Members are fit for their roles			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.			

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	X			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees				

What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	X			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No X**		

What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

How will any impact or planned actions be monitored and reviewed?

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Birmingham and Solihull Mental Health NHS Foundation Trust

Full Equality Analysis Form

Title of Proposal	**Fit and Proper Persons Policy**		
Person Completing this proposal	**Sharan Madeley**	**Role or title**	Company Secretary
Division/Department	**Corporate**	**Service Area**	Corporate
Date Started	**2nd February 2022**	**Date completed**	12th February 2022
Looking back at the screening tool, in what areas are there concerns that the proposal treats groups differently, unfairly or disproportionately as a result of their personal protected characteristics?			
The regulation for Fit & Proper Persons governed by the CQC is clear that all members of the Board of Directors are treated fairly in ensuring upon appointment and on an ongoing basis, all Board Members remain fit for their role and are therefore not unfairly or disproportionately treated as a result of their personal protected characteristics			
Summarise the likely negative impacts		**Summarise the likely positive impact**	
No negative impacts		Board Members adhering to the regulations remain fit for their role as a Board Member	
What previous or planned consultation or research on this proposal has taken place with groups from different sections of the community?			

		Please provide list of groups consulted.		**Summary of consultation / research carried out or planned. If already carried out, what does it tell you about the negative impact?**	
Group(s) (Community, service user, stakeholders or carers					
Staff Group(s)					
What up-to-date information or data is available about the different groups the proposal may have a negative impact on?					
Are there any gaps in your previous or planned consultations, research or information? If so are there any other experts, groups that could be contacted to get further views or evidence?					
Yes		**No**	x		
If yes please list below					
As a result of this Full Equality Analysis and consultation, what changes need to be made to the proposal? (You may wish to put this information into an action plan and attach to the proposal)					
None. This is a policy based on national regulations governing NHS Trusts					
Will any negative impact now be:					
Low:		**Legal:**		**Justifiable:**	

Will the changes made ensure that any negative impact is lawful or justifiable?
Have you established a monitoring system and review process to assess the successful implementation of the proposal? Please explain how this will be done below.
Regular annual checks will be undertaken on all Board Members to ensure they comply with the regulations
Action Planning: How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic?

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix 2

CQC GUIDANCE ON REGULATION 5

Component of the regulation	Providers must have regard to the following guidance
5(1) This regulation applies where a service provider is a body other than a partnership	• This regulation applies to all providers that are not individuals or partnerships.
5(2) Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual— (a) as a director of the service provider, or (b) performing the functions of, or functions equivalent or similar to the functions of a director. (c)	• For NHS bodies it applies to executive and non-executive, permanent, interim and associate positions, irrespective of their voting rights. The requirement will also apply to equivalent director posts in other providers, including trustees of charitable bodies and members of the governing bodies of unincorporated associations. • Where a local authority is a provider, the regulations will not apply to elected members as they are accountable through a different route.
5(3)(a) the individual is of good character	• When assessing whether a person is of good character, providers must follow robust processes to make sure that they gather all available information to confirm that the person is of good character, and they must have regard to the matters outlined in Schedule 4, Part 2 of the regulations. It is not possible to outline every character trait that a person should have, but we would expect to see that the processes followed take account of a person's honesty, trustworthiness, reliability and respectfulness. • If a provider discovers information that suggests a person is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. • Where a provider considers the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the provider's reasons should be recorded for future reference and made available.

Component of the regulation	Providers must have regard to the following guidance
5(3)(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,	• Where providers consider that a role requires specific qualifications, they must make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional regulator. • Providers must have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required, (which may included appropriate communication and leadership skills and a caring and compassionate nature) to undertake the role. These must be followed in all cases and relevant records kept. • We expect all providers to be aware of, and follow, the various guidelines that cover value-based recruitment, appraisal and development, and disciplinary action, including dismissal for chief executives, chairs and directors, and to have implemented procedures in line with the best practice. This includes the seven principles of public life (Nolan principles).
5(3)(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,	• This aspect of the regulation relates to a person's ability to carry out their role. This does not mean that people who have a long-term condition, a disability or mental illness cannot be appointed. When appointing a person to a role, providers must have processes for considering their physical and mental health in line with the requirements of the role. • All reasonable steps must be made to make adjustments for people to enable them to carry out their role. These must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010.

Component of the regulation	Providers must have regard to the following guidance
5(3)(d) the individual has not been responsible for, been privy to, contributed to or facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and	• Providers must have processes in place to assure themselves that a person has not been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement in the carrying on of a regulated activity. This includes investigating any allegation of such and making independent enquiries. • Providers must not appoint any person who has been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity. • A director may be implicated in a breach of a health and safety requirement or another statutory duty or contractual responsibility because of how the entire management team organised and managed its organisation's activities. In this case, providers must establish what role the director played in the breach so that they can judge whether it means they are unfit. If the evidence shows that the breach is attributable to the director's conduct, CQC would expect the provider to find that they are unfit. • Although providers have information on when convictions, bankruptcies or similar matters are to be considered 'spent' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

Component of the regulation	Providers must have regard to the following guidance
5(3)(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.	• A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to a check by the Disclosure and Barring Service (DBS). • Providers must seek all available information to assure themselves that directors do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1. Robust systems should be in place to assess directors in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. In addition, where a director meets the eligibility criteria, providers should establish whether the person is on the children's and/or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act. • If a provider discovers information that suggests an individual is unfit after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter.
5(6) Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must— **(a)** take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and **(b)** if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.	• Providers must assess and regularly review the fitness of directors to ensure that they remain fit for the role they are in. Providers must determine how often to review fitness based on the assessed risk to business delivery and/or to the people using the service posed by the individual and/or role. • Providers must have arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they have been appointed to a role, which either they or others have identified, and providers must adhere to these arrangements. • Providers must investigate, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, they must take proportionate, timely action. Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to people who use the service.

Appendix 3

TRUST RECRUITMENT CHECKLIST

REGULATION 5: FIT AND PROPER PERSON REQUIREMENTS
DIRECTORS AND NON-EXECUTIVE DIRECTORS – RECRUITMENT CHECKLIST

Post Title:
Preferred Candidate:

(To be read in conjunction with the NHS Employment Check Standards)

	Yes	**No**
Documents Checked confirming right to work in the UK		
Documents checked confirming identity		
Recent photograph checked and kept on file		
Detailed review of full employment history has been undertaken to include review of external information as necessary Comment on any information/issues identified		
Two detailed referenced have been received (one from most recent employer)		
Original documentation relating to Qualifications and Professional Registration Checked		
Occupational Health Review undertaken (if required)		
Disclosure and Barring Service check completed		
Search of insolvency and bankruptcy register, and disqualified directors register completed		

Recruitment Checks completed by:

NAME: **POSITION** **SIGNED**

Fit and Proper Person Regulation Compliance confirmed

NAME: **POSITION**: **SIGNED**:

DATE:

Appendix 4

Regulation 5: Fit and Proper Person Requirements
Directors and Non-Executive Directors - Self-Declaration form

On 20th November 2014 the Care Quality Commission (CQC) published guidance on the fit and proper person requirements and duty of candour which came into force for all NHS providers from 27th November 2014. These regulations play a major part in ensuring the accountability of directors (executive, non-executive, permanent, interim and associate positions, irrespective of voting rights) of NHS bodies and outline the requirements for robust recruitmentand employment processes for board level appointments. As part of the assurance against the new Fit and Proper Person requirements for new and existing board members, you are required to answer the following questions, sign, date and return.

STATEMENT	YES	NO
Have you got the qualifications, competency, skills and experience which are necessary for your current position at BSMHFT?		
Are you able by reason of health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the office or position for which you are employedat SFHFT		
Have you been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity		
Have you been subject of any of the following: • undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged. • subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland. • a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986. • a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it. • included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland. • prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.		
Have you been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence?		
Have you been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals?		
Have you ever been found not to be a fit and proper person for the purposes of Regulation 5		

As a Director, it is also recommended that you also familiarise yourself with the Trust's Constitution and also the NHS Foundation Trust Code of Governance, as these are the Trust's core governance documents with which the Board of Directors and Council of Governors are expected to comply. Corporate Services office will also offer support and adviceas appropriate.
I hereby agree that the above is accurate

Name	Position
Signed	Date

Appendix 5

Personal File Checklist for on-going fitness

Regulation 5: Fit and Proper Person Requirements

Directors and Non-Executive Directors – Information Requirements:

Annual Checklist

POST:

Signed Annual Declaration provided	Yes	No
Proof of Identity including a recent photograph	Yes	No
Where relevant, DBS check and/or barring information under the Safeguarding Vulnerable Groups Act 2006	Yes	No
Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care, or children of vulnerable adults	Yes	No
In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform	Yes	No
A full employment history, together with a satisfactory written explanation of any gaps in employment	Yes	No
Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity ☐	Yes	No
Annual Checks completed including Disqualified Directors Registers, disqualified Trustees Charities Commission and web search checks using the words "theft, fraud, arrest".	Yes	No

Information Requirements completed by:

Name Position

Signed Date

Fit and Proper Person Regulation Compliance Confirmed:

Name Position

Signed Date

10.4. Governance Action Plan: Six monthly Review

Birmingham and Solihull Mental Health NHS Foundation Trust

INTERNAL GOVERNANCE ACTION PLAN

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
GGI R1	Review the cycle of business of the Board and its Committees in response to the refreshed organisational strategy	New Terms of Reference for all Board Committees aligned to Trust Values and the themes and headings in the Trust Strategy. This included: Audit Committee Finance, Performance & Resources Committee (*approved by Board of Directors November 2021)* Integrated Quality Committee *(approved by Board of Directors November 2021)* Charitable Funds Committee *(approved by Board of Directors November 2021)* People Committee *(approved by Board of Directors November 2021)* Decision by the Board of Directors to change name from Integrated Quality Committee to Quality, Patient Experience & Safety Committee (*to ensure clarity regarding the domains covered)* On agreement by the Board of Directors, Mental Health Legislation Committee has been dissolved. The QPES Committee to receive quarterly reports from the Mental Health Legislation Sub Committee	• Cycles of business for the next twelve months in draft and being presented to Board of Directors and Board Committees in February 2022. • Further work to be undertaken in March 2022 aligning the cycle of business for Board/Committee meetings to strategic risks • Board of Directors Terms of Reference: Provider & Commissioning Responsibilities to be approved by the Board of Directors in March 2022 • Remuneration Committee Terms of Reference to be approved by the Board of Directors March 2022 • Audit Committee to be agreed by the Board of Directors in February 2022. • Updated Governance Chart detailing Board & Committee Structures to be uploaded onto the Website/Intranet		CoSec Report to the Chair and Committee Chairs in June 2022 detailing results of an audit of Committee papers to review discussions aligned to the BAF
GGI R2	Strengthen the role of the Audit Committee in assuring the Trust's risk management	• New Terms of Reference for Audit Committee agreed in December 2021 and strengthened to detail their role in monitoring risk management processes	• To review outcome on internal audit on BAF/Risk Management processes currently underway in Q4 as part of preparation of assurance on annual accounts.		May 2022

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
		• Risk Policy amended and ratified by Clinical Governance Committee in December 2021			

GGI R3	Develop a revised Board Assurance Framework in response to the refreshed strategy	• A desktop review of the Board Assurance Framework was undertaken in January 2021 by ANHH Consulting
		• New BAF developed reflecting the refreshed strategy and presented in draft at the Board Development Session on 22nd February 2021
		• Designed and facilitated a Board Development Session discussing the purpose of a BAF, with the new Chair present. Purpose of session was to:
		  • Reach a position that the board reaffirms its role in the delivery of the strategy and the purpose of the BAF
		  • The Board identifies and scores risks linked to the delivery of the strategy (strategic risks)
		  • The board allocates strategic risks to board committees
		  • The Board establishes its risk appetite for those strategic risks
		  • The Board agrees how risk tolerance and threshold will be set
		  • The Board reflects on the lessons to be learned from the governance during covid
		  • The Board aligns its decision making with the Trust's core values
		• Following the development session consultative meetings were held with Chair and Committee members of People, FPP and IQC to further develop and refine the draft BAF agreeing the risks, the impact, controls and assurances, the scoring and ownership.
		• Each Board member was consulted, and feedback implemented, which in turn was circled back to ensure every member and committee was on the same page.
		• Draft risks went to March Committees; draft BAF with controls and assurances went to April Committees.
			• Work needs to continue to evolve the controls and assurances with Executive Leads
			• BAF is coordinated and held by the Company Secretariat, but risks need to be owned and assured by lead EDs and Committees.
			• Board of Directors to undertake an annual review of the strategic risks to agree they are still relevant for the new financial year 2022/2023
			• From Quarter 1 2022/2023 the BAF will move to an electronic system – yet to be determined
			• Internal Audit are undertaking a review of the BAF for 2021/2022 as part of the preparation for the Annual Accounts (assurance to how they consider the BAF to be operating)
			• The CoSec is leading a process to review the risk descriptions, controls, and assurances for consideration by the March Committees and Board. This will also address the three Clinical Services strategic headings for which there are currently no strategic risks
			
			October 2022
			
			Ask ANHH to update on new refreshed BAF
					CoSec
					Review of risk descriptions, controls, and assurances for March Board
					Internal Audit recommendations on the BAF will be reviewed and implemented Q1 2022 (May 2022)

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
		• Final version of the revised BAF presented to the Board for ratification 23 April 2021.			
GGI R4	Undertake a detailed review of the Trust's risk management systems and processes for the corporate risk register and operational risk registers	• Detailed critique of risk documents by ANHH in early December 2020 with meeting with DoF and Associate Director of Governance on 21 Dec 20 • New Associate Director of Governance has used ANHH critique to develop version 17 of the Risk Policy, which is going through the process of approval and ratification	The Risk Policy will be presented to Audit Committee for assurance		April 2022
GGI R5	Develop a risk management framework to describe risk management accountabilities and responsibilities at service, divisional, executive and Board levels				
GGI R6	Develop an approach to driving the conduct, responsibilities and business of the Board and its Committees in response to the Trust's strategic risks	• Designed and facilitated a NED and Exec Lead Governance Review Development session held on 9th December 2020. To establish a cohesive understanding of the role of Committees, their responsibilities to assure delivery of the 2020-2025 strategy. • ANHH Consulting fed back observations of IQC, FFP and People Committees and introduced the concepts of Committee Assurance Reports and Hot Topics Reports.	• The cycle of business and forward plan of the Board and its Committees needs to be more closely aligned to strategic risks and kept under constant review by Committee Chairs • The adoption of the Lead Provider role for Reach Out is still to be embedded in governance processes, particularly how the Board of Directors avoids any conflicts of interest. • To meet with Chair of Reach Out to discuss proposals to escalate this Committee to a Board Committee reporting directly into the Board with a separate agenda for "Commissioning".		CoSec. An audit of agendas for all Committees to be undertaken to test alignment to the strategic objectives. June 2022 A decision on a Board Level Provider Commissioning Committee to be discussed by March 2022
GGI R7	Ensure that every paper demands an active response	• A simplified report template was introduced for Board and Committee Meetings • Report writing training was arranged for senior leaders within the Trust explaining the role of reassurance v assurance.	• The Board and Committees still need to do more to enhance the quality of papers and the role of cover sheets as not all reports have clear recommendations or are completed fully • An audit of all Committee papers for the month of April will be undertaken to review the content and implement any required changes for the new reporting year.		CoSec. Ongoing monitoring of the quality of reports

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
			• A discipline needs to be instilled to ensure all reports received for Committees need to be formally signed off by the Lead Executive before submitted for distribution the content/assurance/risk identification • A guidance note to be prepared for report authors • No reports to be accepted by the secretariate unless fully completed		
GGI R8	Ensure that Committee Assurance Reports are written by Committee Chairs and describe the tone of the meeting and confidence in the assurance provided	• Committee Assurance Reports are now a standing element of governance processes, reporting to the Board of Directors. • The reports are currently drafted by company secretary who minutes the meetings, with the Chair of the Committee adding comments on the level of assurance provided. This varies across Committees in length/detail	• The reports need to be owned, and ideally written, by the Committee Chair • There needs to be standardisation regarding the content of the reports • Discussions must be linked to the strategic risks • From the Chair's perspective, discussions must detail the level of assurance provided		CoSec
GGI R9	Simplify front cover sheets to Board reports	• A new front sheet was implemented with a revised number of key information to complete.	• Equality Lead has made amendments regarding reporting health inequalities. Equalities lead is producing a guidance note on what to include for authors consideration		CoSec
GGI R10	Reschedule Committee dates to facilitate greater interaction between Chairs	• The Committee cycle remains as it was, with the three principal functional committees – FPP, QPES and PC – are all held on the same day, which is the day before papers for the following week's BoD meeting are required. This poses challenges for the secretariate to ensure Committee Reports are drafted, shared with the Chair of the Committee, and distributed with the meeting pack for the Board of Directors • There is good cross cover between NEDs on the various committees, so there is real-time sharing of information, but there is no time to consider the inter-relationships between Committees in any depth.	• The People Committee is moving to bi-monthly meetings, which will allow greater time for the delivery of insightful data analysis. • The timing of Committee meetings needs to be reviewed in six months' time to ensure that the cycles of business are workable. • The Trust needs to be mindful of the impact of this on the workload of the Company Secretariat. **October 2022 Update**		CoSec
GGI R11	Ensure that pre-Committee meetings are held between Committee Chair and Lead Executive	• Pre-Meetings are scheduled now in the diary between Lead Executive, their deputy, Company Secretary and NED Chair to agree agendas and review actions	• Where Chair of the Trust has not attended Committee meetings, a de-brief will be scheduled with the Chair and Committee Chair		CoSec

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
GGI R12	Conduct a detailed skills and capacity assessment of the Board	• There has been changes of both executive and non-executive directors during 2021. • 30th November 2020 1:1 discussions held with all NED's to establish the roles held by each NED, their skills and qualifications, working knowledge, other relevant experience/roles and their opinion of when the Board worked at its best. • A document was produced and presented to the Company Secretariat reflecting the evidence-based discussions. • The feedback, reflections and emerging themes were shared with the new Chair on 7th December 2020. • Appraisals all undertaken late 2021/early 2022 for all NEDs	• A process for succession planning and skills development is still needed for the Board. • The Deputy Company Secretary has left the organisation, capacity within corporate governance needs to be addressed • The Board also needs to consider its capacity and capability around key functions, e.g., commissioning • Chair/CoSec drafting NEDs Skills Assessment in March 2022.		Chair/CoSec
GGI R13	End every Committee or Board meeting with a consideration of the messages that would or will be filtered back down through the organisation	• The Board of Directors meeting now includes a dedicated session for a rotation of Board Members to reflect on where the Trust Values have been in evidence during the month • At the end of the Board meeting there is a reflection discussion from a Board Member regarding how discussions were held • A rotation of Board Members is in place to produce a Board Blog for distribution into the organisation each month via the Communications Team	• Further development regarding the use of the Board Blog in ensuring authors also capture the key messages from the Board to also disseminate into the organisation rather than just a reflection of the meeting.		CoSec/Comms
GGI R14	Undertake a detailed review of the Committees and their sub-committees and groups with the explicit aim to rationalise the number and remove duplication	• Work was undertaken by the previous AD Quality Governance to review reporting structures into the Quality, Patient Experience & Safety Committee, reviewing their remit and removing groups.	• Within Q1 of 2022, further work to be undertaken regarding reporting and decision-making processes of internal groups, for example, Executive Team, Operational Management Team, Performance Delivery Group, Transformation Board. To ensure clear and open accountability for decision making.		CoSec May 2022
GGI R15	Make time for the Board to interact in a less formal way	• Due to the pandemic, this has been challenging to ensure interaction in less formal ways.	• The Company Secretary is producing a Board Development Programme for the 12 months to be presented to the Board of Directors in February 2022. • This will include information awareness sessions along with the cultural and behavioural aspects of governance.		Chair/CoSec

Reference	Description	Actions to Date	Further areas of development/improvement	BRAG rating	Lead/Timeline
			The programme is to improve the quality of the Board discussions, deepen and retain interpersonal relationships, promote NED technical skills and development, give the Board specific time to discuss broader topics beyond the agenda items e.g. social, political and technical, to continuously align themselves to the Trust core values. • Further work is required to agree ways in which the Board could interact less formally but still virtually to replace the informal face to face discussions held over Board lunches, breakfast and other informal gatherings whilst moving to a hybrid model of working • The Board needs to consider how it will transition back to face-to-face meetings. **October 2022 Update**		
GGI R16	Introduce a Hot Topics paper to cover operational issues of the moment	"Hot Topics" is a standing agenda item on Committee meetings and is used to raise any issues of concern not previously raised on the agenda.	• Hot Topics is a verbal report. The opportunity to table papers should not be discounted. • Meetings should raise the item up the agenda so it receives appropriate airtime, and sets the context for the rest of the meeting.		CoSec Continual monitoring of the use of Hot Topics
GGI R17	Take time to discuss the experience of the last few months and the (dis)benefits it has realised for governance, thereby to establish the new normal of governance		• Following remote working for the last two years, discussions to be undertaken regarding impact on governance reporting. Linked to GGI R15 and discussions required on the hybrid way of working regarding Teams/Face to Face meetings.		Chair/CoSec

ADDITIONAL AREAS OF GOVERNANCE DEVELOPMENT

Reference	Description	What we have done	What more we still need to do	BRAG rating	Lead/Timeline
+ 1	Establish governance processes to support the Reach Out lead provider function	• Board received independent assurance report from ANHH on the governance processes for the Reach Out Commissioning Function • A new governance structure has been agreed and is now in operation. This was developed using best practice and focused on separation of decision-making and decision-taking responsibilities, and the need for assurance. The designing of the governance architecture was fundamental to the creation of strong processes and systems of reporting and assurance. • The FPP and QSC have new assurance responsibilities; the Reach Out Commissioning Sub-Committee has been convened and has been functioning since August 2021; there is a well-defined architecture for mental health and learning disability and autism services that sits below ROCSC.	Separate ToR and processes need to be produced and followed to enable the BoD to meet, under a separate agenda, to fulfil its lead provider responsibilities. The adoption of the Lead Provider role for Reach Out is still to be embedded in governance processes, particularly how the Board of Directors avoids any conflicts of interest. Still a concern Agreement with Chair and Reach Out Commissioning Sub Committee Chair regarding the reporting arrangements moving forward with a Board Committee: Provider Commissioning Committee. Following discussions, a proposal is required for the Mach 2022 Board meeting **October 2022 Update**		CoSec March 2022
+ 2	Develop a lead provider risk register	• Co-production exercise with Reach Out Commissioning Sub Committee to agree key risks associated with being Lead Provider • Four risks existed on the BSMHFT risk register ECLIPSE. Three dated back to 2016. These have been rationalised into two. In close consultation with the Lead Provider Officers and NED's a further four risks have been added, and their impact and the ownership have been agreed. • To ensure consistency of terminology, risk scoring and approach, the same framework and risk scoring policy has been used as was employed for the BAF.	The inherent (initial) risk score, residual (post mitigations) and target (for ultimate achievement) have yet to be agreed with the Reach Out Sub Commissioning Committee (11 November 2021). This will then become a driving agenda item for the lead provider function. Facilitate a Committee Development Session specifically on Risk for this committee – support will be provided for Anne Baines who will lead the session. **October 2022 Update**		CoSec

Reference	Description	What we have done	What more we still need to do	BRAG rating	Lead/Timeline
+3	Review the Constitution and Standing Orders	NED and Governor Governance Task and Finish Group has been established. Terms of Reference agreed by the Board of Directors and Council of Governors. Group to review, amend and create Standing Orders for: • The role, selection/election, tenure, and removal of the Lead Governor • The establishment of a new post of Deputy Lead Governor, and the role, selection/election, tenure, and removal • The role, selection/election, tenure, and removal of the Senior Independent Director • The process of investigations involving Governors, or Non-Executive Directors, or the Trust Chair • Codes of Conduct for the Board of Directors and the Council of Governors • The role, selection/election, tenure and removal of the Deputy Chair.	• A page-by-page review of the Constitution has commenced to remove old terminology and include changes agreed to date. • Governance Task & Finish Group to make recommendations on revised processes to the Council of Governors and Board of Directors • Revised Constitution, Standing Orders to be presented to the Board of Directors/Council of Governors for approval. **October 2022 Update**		March 2022 March 2022 April 2022
+ 4	Review the SFIs and Reservation of Powers	• The Deputy Director of Finance is leading a piece of work to review these documents, to reflect SSL, Reach Out and business development which were presented in draft to the Audit Committee in October 2021	• Deputy Director of Finance to present final documents to the April Audit Committee. • These will need to be aligned with the Constitution and Standing Orders within one Governance Framework document for the Trust. To be presented to the Board of Directors and Council of Governors in April 2022. **October 2022 Update**		CoSec April 2022
+ 5	Dissolve the Mental Health Legislation Committee	• The Board, IQC and MHLC agreed in September 2021 to dissolve the MHLC and to incorporate its duties into QPESC • Terms of Reference for the QPESC have been amended to incorporate mental health legislation reporting • Terms of Reference for a new MHL Sub-Committee have been drafted and	Complete		

Reference	Description	What we have done	What more we still need to do	BRAG rating	Lead/Timeline
		approved by the QPES and MHLC in October 2021. • First meeting of Mental Health Legislation Sub Committee has been held			
+6	Community Mental Health Provider Collaborative	• Meeting held 14 December 2021 with Community Mental Health Transformation Programme Lead (BSOL) to review current governance reporting structures • ANHH Consulting has provided a critique of the existing governance arrangements	The scope and specification for provider collaborative governance continue to evolve and expand. The BSOL Mental Health PC is the primary programme, into which the CMHTP will report. The MH PC is now, potentially, to include CAMHS Tier IV and learning disability and autism services, which would bring at least two more partners to the table. A meeting is scheduled for 18th February 2022, at which the EDoF, DDoF, Associate Director and ANHH will discuss a programme plan and scope of governance work. Timelines for implementation of new governance arrangements are likely to be extremely tight. Meeting arranged with Lead Directors and ANHH Consulting 28th February 2022 to review and agree next steps **October 2022 Update**		ANHH/ V. Devlin D. Tomlinson P Nyarumbu
+7	BSOL Mental Health Provider Collaborative	• Meeting held with Director of Strategy, People & Partnerships on the 4th January 20212 • A review of key documentation regarding proposed governance reporting has been reviewed by ANHH Consulting • A specification of work is being prepared for further discussion with			

10.5. Move to Shadow Governance Arrangements for Lead Provider Responsibilities

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**10.5**
PAPER TITLE	**MOVE TO SHADOW GOVERNANCE ARRANGEMENTS FOR LEAD PROVIDER RESPONSIBILITES**
DATE	7 December 2022
AUTHOR	ANHH Consulting
EXECUTIVE SPONSOR	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships

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

Equality & Diversity *(all boxes MUST be completed)*	
Does this report reduce inequalities for our service users, staff and carers?	Yes
What data has been considered to understand the impact?	National guidance on the Provider Collaboratives and integrated care systems

Executive summary & Recommendations:

The Board of Directors is aware that planning continues relating to the establishment of new contractual frameworks across the BSol ICS.

The Trust has been identified as the lead provider for the Mental Health Provider Collaborative. The ICB's assurance process is largely concluded and the MHPC and BSMHFT, as Lead Provider, must now prepare for go live on 1 April 2023.

The Board of Directors is asked to:

- **NOTE FOR ASSURANCE** the work that is continuing to develop and embed revised governance arrangements
- **APPROVE** the proposal to move to shadow governance arrangements in both MHPC and the Trust from January 2023
- **NOTE FOR ASSURANCE** that meetings will be scheduled to reduce the burden of additional governance to a minimum.

Reason for consideration:

The provider collaborative model affords significant opportunities for the Trust to deliver its strategic, partnership, and quality ambitions.

As Lead Provider, the Trust will adopt responsibilities and risks that need to be understood fully by the Board, and necessitates changes to existing and provision of new governance instruments.

Previous consideration of report by:

N/A

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

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.

Financial Implications ***(detail any financial implications)***

Part of a significant strategic change for the Trust.

Board Assurance Framework
(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities

FPP1 – There is a risk that the Trust fails in its responsibilities as a partner, and does not structure and resource itself properly to take advantage of new contractual mechanisms

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

None.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

BOARD OF DIRECTORS, PART I MEETING, 7 DECEMBER 2022

MOVE TO SHADOW GOVERNANCE ARRANGEMENTS FOR LEAD PROVIDER RESPONSIBILITIES

- For Decision and Assurance –

1. INTRODUCTION and PURPOSE

The Board of Directors is aware that planning continues relating to the establishment of new contractual frameworks across the Birmingham and Solihull Integrated Care System.

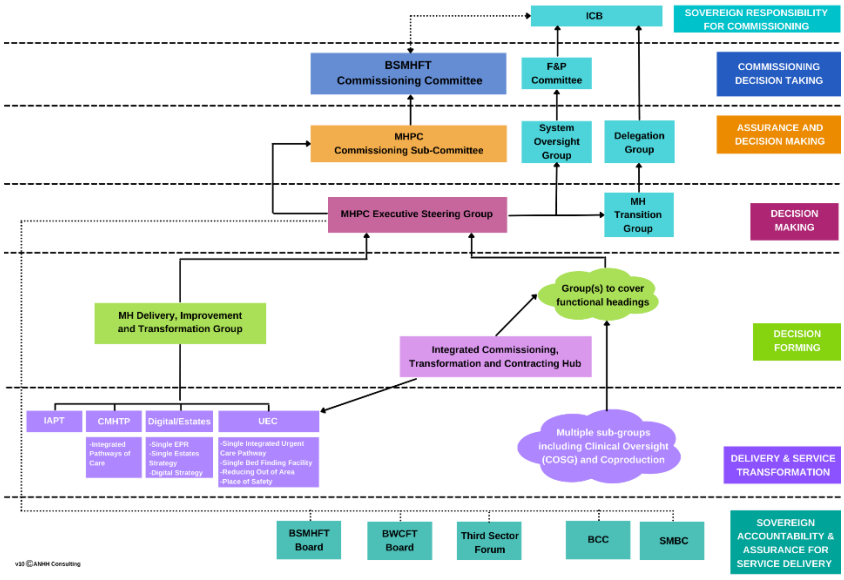
The Trust has been identified as the lead provider for the Mental Health Provider Collaborative ("MHPC"), which will be one of four provider collaboratives.

The ICB's assurance process for delegated responsibilities is largely concluded and will inform a decision on delegation at the ICB meeting on 9 January. Assuming a positive recommendation, the MHPC would go live on 1 April 2023, and the MHPC and ICB have agreed that it would be prudent to move to shadow governance arrangements for the final quarter 2022/23 so to test and, as necessary, tweak reporting and decision-shaping processes.

The Board is asked to consider the recommendations at the end of the Report.

2. MHPC GOVERANCE ARRANGEMENTS

The current arrangements within the provider collaborative are focused on establishment and mobilisation of the partnership. The shadow and future substantive arrangements will focus on delivery, and the governance architecture is shown below.



Terms of reference (amended or new, depending on existing status) are needed to shape this new position.

The position is summarised in the table below.

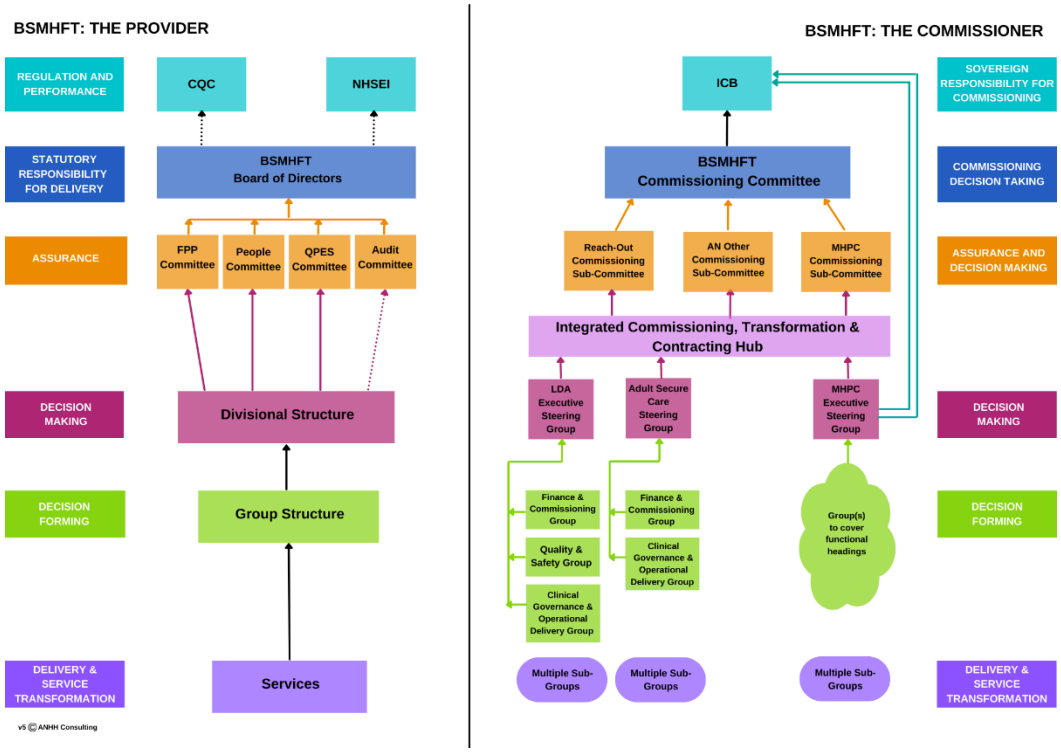
Existing Forum	Future Forum	Status of Terms of Reference	Next Steps in Approval and Implementation
Programme Board	Executive Steering Group	Drafted	To be considered at first meeting of ESG, 19-01-23 To be approved by MHPC Commissioning Sub-Committee, TBC
Programme Steering Group	N/A	N/A	N/A
Quality, Safety and Outcomes Group (QSOG)	Quality and Safety Group	Drafted	To be approved by ESG, 19-01-23
Finance, Contracting, Commissioning and Governance Group (FCCGG)	Finance, Contracting and Commissioning Group	Drafted	To be approved by ESG, 19-01-23
People, Culture and Leadership Group (PCLG)	People, Culture and Leadership Group (PCLG)	Drafted	To be approved by ESG, 19-01-23
Communications and Engagement Group (CEG)	Communications and Engagement Group (CEG)	Drafted – but awaiting input from Comms Lead when appointed	To be approved by ESG, 19-01-23
MH Delivery, Improvement and Transformation Group (MHDIT)	MH Delivery, Improvement and Transformation Group (MHDIT)	Drafted	To be submitted as part of the feedback response to the ICB on 16 December
N/A	Clinical Oversight Group	Drafted	To be approved by ESG, 19-01-23

In addition to these terms of reference, the MHPC will be founded on a series of key partnership documents:

- **Partnership Agreement** – the PA has been drafted and follows the NHSE template. Partners have been involved in the drafting and any final comments are welcome prior to its issue.
- **Memorandum of Understanding** - the MoU is in final draft state. The Lead Provider will confirm the list of required signatories, including names and roles, and the document can then be signed.
- **Information Sharing Protocol** - the ISP is in final draft state prior to signature.
- **Risk and Benefit Framework** - this is still being drafted in discussion with the ICB and will then be shared with partners for consideration and agreement.

3. LEAD PROVIDER GOVERNANCE ARRANGEMENTS

As the Board of Directors has previously discussed, the delegated responsibilities will require clear separation of the Trust's provider and commissioner responsibilities, as shown in the governance architecture below.



Terms of reference (amended or new, depending on existing status) are needed to shape this new position, e.g., to remove any reference to commissioning from the BoD or Committee responsibilities.

The position is summarised in the table below.

Existing Forum	Future Forum	Status of Terms of Reference	Next Steps in Approval and Implementation
Board of Directors	Board of Directors	Drafted	CoG, 12-01-23 Audit Committee, 19-01-23 BoD, 01-02-23
FPP Committee	FPP	Drafted	BoD, 01-02-23
QPES Committee	QPES	Drafted	BoD, 01-02-23
People Committee	People	Drafted	BoD, 01-02-23
Audit Committee	Audit Committee	Drafted	BoD, 01-02-03
N/A	Commissioning Committee (CoCo)	Drafted	CoG, 12-01-23 Audit Committee, 19-01-23
Reach Out Commissioning Sub-Committee	ROCSC	Drafted	To be approved by CoCo, TBC
N/A	MHPC Commissioning Sub-Committee	Drafted	To be approved by CoCo, TBC

In addition to these terms of reference, various important Trust governance instruments will need to be amended and added to enable the change.

The position is summarised in the table below.

Existing Instrument	Change Required	Status	Next Steps in Approval and Implementation
Constitution	General “tidy up” to introduce CoCo CoCo Standing Orders Potential changes for CoG	In discussion with Co Secretariat Drafted TBC	CoG, 12-01-23 Audit Committee, 19-01-23 BoD, 01-02-23
Standing Financial Instructions	Introduction of CoCo and its sub-committees	In train, working with Finance Team TBC	Audit Committee, 19-01-23 BoD, 01-02-23 CoCo, TBC
Reservation of Powers to The Board and Delegation of Powers (SoD)	Introduction of CoCo and its sub-committees Potential new delegated limits	In train, working with Finance Team TBC	Audit Committee, 19-01-23 BoD, 01-02-23 CoCo, TBC
Risk Policy	Introduction of CoCo and its sub-committees Process for risk management and escalation in PCs	In train, working with ADs of Governance	To be considered at Risk Management Group BoD, 01-02-23 CoCo, TBC
Board Assurance Framework	Commissioning BAF to be produced to separate from provider strategic risks	In train, senior officers working with ANHH to draft	CoCo, TBC

This is a significant change for the Trust, and this work is critical to embedding the change in statutory and governing documents.

4. RECOMMENDATIONS

The Board of Directors is asked to:

- **NOTE FOR ASSURANCE** the work that is continuing to develop and embed revised governance arrangements
- **APPROVE** the proposal to move to shadow governance arrangements in both MHPC and the Trust from January 2023
- **NOTE FOR ASSURANCE** that meetings will be scheduled to reduce the burden of additional governance to a minimum.

ANHH Consulting
4 December 2022

10.6. Board Assurance Framework

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10.6**
Paper title	**Development of the Board Assurance Framework (BAF)**
Date	7/12/2022
Author	Andrew Hughes, ANHH Consulting Gill Mordain, Associate Director of Clinical Governance David Tita, Associate Director of Corporate Governance
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

The Board approved the refreshed provider BAF in October and the proposal to develop a commissioning BAF.

The BAF has been reviewed by the Trust's main committees who have considered and endorsed the proposed inherent, current and target risk scores and risk appetite statements.

The Risk Management Group met for the first time in November and agreed next steps and responsibilities.

The Board is asked to note this update, approve the BAF including the scores for the risks included.

Reason for consideration:

To consider proposals for further developing the Board Assurance Framework.

Previous consideration of report by:

Executive Directors

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

Clinical Services, Quality and Sustainability

Financial Implications *(detail any financial implications)*
None
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
N/A
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Staff involved in Risk Management, Deputy Directors, Executive Directors, Committees, Risk management Group.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

DEVELOPMENT OF THE BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

The Trust Board's focus is strategic. Board members need to know the key strategic objectives and be able to identify the principal risks to achieving those objectives. Assurance goes to the heart of the work of any NHS Board of Directors. The provision of healthcare involves risk and being assured is a major factor in controlling risk.

The Board Assurance Framework (BAF). The BAF brings together in one place all the relevant information on the risks to delivery of the Board's strategic objectives. It is an essential tool for Boards and provides a structure and process that enables focus on those risks that might compromise its principal objectives.

At its meeting in October, the Board:

- Approved the refreshed provider BAF
- Noted the establishment of a Risk Management Group
- Approved the proposal to develop a separate commissioning BAF

2. UPDATE

The refreshed BAF was considered and endorsed by the Quality, Patient Experience & Safety Committee, Finance, Performance and Productivity Committee and People Committee at their meetings in October. The committees also considered and endorsed the proposed inherent, current and target risk scores and risk appetite statements.

The newly established Risk Management Group met for the first time on 18 November and agreed next steps and responsibilities which will include:

- Review and refresh of the Risk Management Policy
- Development of a commissioning BAF
- Review, moderation and refresh of the non-BAF-related risks
- Providing updates to Board (this report) and Audit Committee and then via cycle of normal quarterly updates

Due to the strong alignment of strategic objectives, any risks recorded on the Board Assurance Framework will be monitored by the associated committee structures in place as set out in the table below.

Strategic Objective	22/23 Goal	Executive Lead	Committee Oversight
Quality	Preventing Harm	Director of Nursing and Quality Sarah Bloomfield (Deputy: Gill Mordain)	QPES
	Improving Patient Experience		
	A Positive Patient Safety Culture		
	Improving Quality Assurance		
	Clinically Effective		
Clinical Services	Leader in Mental Health Recovery Focused Rooted in Communities Prevention and Early Intervention Clinically Effective Changing how we Work	Directors of Operations Vanessa Devlin (Deputy: Coumarassamy Marimouttou)	QPES People Committee Finance, Performance and Productivity
People	Shaping our Future Workforce	Director of Strategy, People and Partnerships Patrick Nyarumbu (Deputy: Byron Currie)	People Committee
	Transforming our Culture and Staff Experience		
	Modernising our People Practice		
Sustainability	Transforming with Digital	Director of Finance Dave Tomlinson (Deputy: Richard Sollars)	Finance, Performance and Productivity
	Changing through Partnerships		
	Caring for our Environment		
	Balancing the Books		
	Good Governance		

3. RECOMMENDATIONS

The Board is asked to:

- **NOTE** this update and the actions by committees
- **APPROVE** the BAF including the scores (see Appendix I)

BOARD ASSURANCE FRAMEWORK

OUR VALUES

Compassionate. Inclusive. Committed.

VISION

Improving mental health wellbeing.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board, we are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

NB All risk scores detailed in Appendix I – BAF Risk Scores November 2022

QUALITY AND CLINICAL SERVICES

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

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

Assurance Committee: Quality, Patient Experience and Safety Committee

Preventing harm

QPES1 The Trust fails to focus on the reduction and prevention of patient harm, resulting in:

- Failure to meet population needs and improve health
- Variations in care
- Unwarranted incidents
- Less safe care

Improving service user experience

QPES2 The Trust fails to engage and co-produce with all people who use its services including their families, resulting in:

- A reduction in quality care
- Service users not being empowered
- Services that do not reflect the needs of service users and carers
- Service provision that is not recovery focused
- Increased regulatory scrutiny, intervention, and enforcement action
- Failure to think family

A positive patient safety culture

QPES3 The Trust fails to be a learning organisation that embeds a patient safety culture, resulting in:

- A culture where staff feel unable to speak up safely and with confidence
- Failure to learn from incidents and improve care
- A failure to develop pathways of care within the Integrated Care System
- Increased regulatory scrutiny, intervention, and enforcement action

Quality Assurance

QPES4 The Trust fails to be a self-learning organisation that embeds quality assurance, resulting in:

- Missed opportunities to drive health change across the population
- Insufficient understand and sharing of excellence in its own systems and processes
- Lack of awareness of the impact of sub-standard services
- Variations in standards between services and partnerships
- Demotivated staff

- Missed opportunities for System Engagement

Leader in Mental Health (QPES & FPP)

CS1 The Trust fails to lead and take accountability for the development of system-wide approaches to care, and to exploit its status and position to advocate for mental health services and service users, resulting in:

- Inferior and poor care
- Detrimental impact for service users
- Higher critical caseloads
- Missed income opportunities
- Limited brand awareness
- Unexploited research and innovation opportunities
- Breakdown in critical relationships with key partners

Clinically effective and Prevention and Early Intervention (QPES, FPP & People)

CS2 The Trust fails to respond to service users' holistic needs, resulting in:

- Increased mental health and physical health morbidity
- Potential increased mental and physical ill health
- Unacceptable patient experience
- Missed opportunities for cost improvement
- A demotivated workforce
- Inequity in mortality and morbidity rates
- Unacceptable patient experience
- Missed opportunities for improving lives of our populations
- Weak system working
- Increased system cost

Recovery Focused (QPES)

CS3 The Trust fails to focus on recovery focused care model, resulting in:

- Acknowledgement that each person is an individual
- Failure to enable individuals to have control of their life
- Individuals not feeling empowered or supported

- Segmented care model
- Inequity in health and wellbeing

Rooted in Communities **(QPES, FPP & People)**

CS4 The Trust fails to provide care that is focused on the needs of our communities resulting in:

- Inequality across patient population
- Workforce that is not culturally competent to support populations and colleagues
- Failure to provide resources that support health, wellbeing and growth
- Lack of engagement
- Reactive rather than proactive service model
- Increased service demand

Changing how we Work **(QPES, FPP & People)**

CS5 The Trust fails to adapt to change as required, resulting in:

- Failure to develop services and premises that enhance service delivery
- Effectively embed digital solutions to enhance care and outcomes
- A workforce that is not fit for purpose
- Increased turnover
- Inability to manage waiting lists enhancing risk within the population

OVERALL RISK SUMMARY

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Triangulated evidence that the controls are in place, being followed, and making a difference*
Quality, Patient Experience and Safety	***There is a risk that the Trust fails to deliver safe, high-quality care***		
	caused by:		
	• *lack of implementation of a quality improvement process* • *unwarranted variation of clinical practice outside acceptable parameters* • *insufficient understanding and sharing of excellence and learning in its own systems and processes*	Internal: • Mortality Reviews • Rapid Improvement Week • Mortality Case Note Reviews • Structured Judgement Reviews • Physical Health Strategy and Policy • Learning from Deaths Group • Clinical Effectiveness Advisory Group External: • CQC Insight Data • CQC Alerts • Public View • Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme) • Coroner's Reports • QSIS compliance	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Learning from Deaths Reports • Community Deaths Reports • Medical Examiner Reports • NHS Digital Quarterly Data Learning for improvement: • Serious Incident Reports • Executive Chief Nurse's Assurance Reports to QPES Committee and Board • Legal Quarterly Report • Never Events Reports • Commissioner and NED quality visits Third level assurance: • CQC planned and unannounced inspection reports • Internal and External Audit reports
	• *lack of self-awareness of services that are not delivering*	Clinical Governance meetings Directorate/Specialty governance meetings Improvement Programme	Improvement Plans
	• *poor management of the therapeutic environment*	Capital prioritisation process SSL Service Agreement Forum	Contract KPIs

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Triangulated evidence that the controls are in place, being followed, and making a difference*
		CQC well-led and unannounced visits	CQC inspection reports Ligature Risk assessments Environmental Risk Assessments
	• *insufficient focus on prevention and early intervention*		Independent annual assessment against the 68 NHS Core Standards for EPRR
	• *limited co-production with services users and their families*	Patient Safety Advisory Group Patient Stories	FFT Scores
	• *insufficient staff with the correct skill set*	Ward Accreditation Programme Improvement Programme Improvement Plans Governance Forums: • Clinical Governance meetings • Directorate/Specialty governance meetings Safety Huddles Professional Codes of Conduct • NMC Code • GMC Good Medical Practice Guide • HCPC Standards of Conduct, Performance and Ethics • Code of Conduct for NHS Managers • Health and Social Care Act 2008 (amended 2014 – Part C)	Exception reports: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports Internal inspection and review reports: • TBC Data sets: • PALS contacts data • Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board
	resulting in:	Contingency Plan	

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Triangulated evidence that the controls are in place, being followed, and making a difference*
	• *poor patient outcomes, including increased mortality and increased regulatory scrutiny, intervention, and enforcement action*		

SUSTAINABILITY

Strategic Priority: *Being recognised as an excellent, digitally enabled organisation, which performs strongly and efficiently, working in partnership for the benefit of our population.*

Assurance Committee: Finance, Performance & Productivity Committee

Finance. Governance and Environment Aspirational Risk Appetite (Open): *We are willing to consider all potential delivery options and choices whilst also providing an acceptable level of reward.*

Digital and Partnerships Aspirational Risk Appetite (Seek): *We are eager to be innovative and to choose options offering higher business rewards, despite greater inherent risk..*

CQC Well Led Key Line of Enquiry: Use of Resources, 4 (roles and systems for good governance and management), 5 (managing risks, issues and performance), 6 (information effectively processed, challenged, and acted on)

System finances and partnership working

FPP1 There is a risk that the Trust fails in its responsibilities as a partner, and does not structure and resource itself properly to take advantage of new contractual mechanisms, resulting in

- An inability to support the system's medium to long-term financial viability
- Reductions in service provision as a result of insufficient funding
- Continued inequality in health status and outcomes
- Inability to invest in improvement
- Increased regulatory scrutiny, intervention, and enforcement action
- A breakdown in critical relationships with key partners

Transforming with digital

FPP2 There is a risk that the Trust fails to focus on the digital agenda and to harness the benefits of digital improvement, resulting in

- Less the optimal data security and sharing
- Not addressing cyber security threats
- Inefficiencies and ineffectiveness in critical processes
- Unacceptable care for service users

Caring for the environment

FPP3 There is a risk that the Trust fails to behave as a socially responsible organisation, resulting in

- Poor waste management
- Unnecessary journeys
- Higher than necessary energy costs
- Failure to hit zero emissions targets
- Damage to reputation and public trust

Caring for the environment

FPP4 There is a risk that the Trust fails to manage the safety and quality of its therapeutic environment, resulting in

- Increased maintenance costs
- Health and Safety Executive scrutiny
- Failure to meet statutory standards
- Patient harm and increased untoward incidents related to the environment
- Increased regulatory scrutiny, intervention, and enforcement action
- Damage to reputation and public trust

OVERALL RISK SUMMARY

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Evidence that the controls are in place, being followed, and making a difference*
Sustainability	***There is a risk that the Trust fails to make best use of its resources***		
	caused by:		
	• *the unknown impact of the establishment of ICSs and ICPs*	ICS ICP budget workstream Attendance at ICS Board	
	• *inefficient delivery as Lead Provider*	Work needed!	
	• *limited focus on the digital agenda and a failure to harness the benefits of digital improvement*	Work needed!	
	• *non-delivery of financial plan*	Business Case ICS financial support	Reporting to FPP Committee Reporting to Board of Directors
	• *incomplete or poorly implemented sustainability plans*	Strategic Estates Board (ICS) Sustainability Strategic Plan Green Travel Plan Procurement Strategy Model Hospital	Reporting to FPP Committee PAM and ERIC data Utility costs
	• *poor financial management by budget holders and/or inappropriate or inadequate internal processes*	Accountability Framework Standing Financial Instructions Model Hospital efficiency benchmarking NHS Benchmarking Club Local benchmarking Joined-up cashflow forecasting Prudent financial forecasting	Delivery Plan Monthly cashflow and I&E reports Expenditure budgets reconciled to LTFM Block income covers costs Financial planning driven by ICS and national assumptions Reporting to FPP Committee

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Evidence that the controls are in place, being followed, and making a difference*
		CIP forecasting Rollover budgets Assurance level provided as part of Committee and Board reporting	
	resulting in:	Contingency Plan	
	• *an inability to provide accessible care and best outcomes to its patients and population*		

PEOPLE

Strategic Priority: *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..*

Aspirational Risk Appetite (Significant): *We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.*

CQC Well Led Key Lines of Enquiry: 1 (leadership capacity and capability), 2 (clear vision and credible strategy to delivery high quality, sustainable care) 3 (culture of high quality, sustainable care), 4 (roles and systems for good governance and management), 5 (managing risks, issues, and performance), 6 (information effectively processed, challenged, and acted on)

Inherent Risk Score: 20 (5 “Almost Certain” x 4 “Major”)
Current Risk Score: 16 (4 “Likely” x 4 “Major”)
Target Risk Score: 6 (2 “Unlikely” x 3 “Moderate”)

Shaping our Future Workforce

P1 There is a risk that the Trust fails to deliver its ambition to shape the future workforce will result in:

- Failure to recruit a workforce that supports the values of the organisation
- Support the progression and development of the workforce An underperforming workforce
- Failure to represent the profile of the organisation within the workforce
- Sustained patterns of inequality and discrimination
- High turnover
- Non-compliant behaviours
- Employee relations cases

Transforming our culture and staff experience

P2 There is a risk that the Trust fails to develop an inclusive and compassionate working environment, resulting in:

- Failure to protect workforce and service users from anti racist and anti-discriminatory behaviour
- Disproportionate bullying and harassment
- Reduced productivity
- Lack of compassion resulting in failure to protect our populations
- Failure to enable staff to speak up resulting in lack of psychological safety and learning
- Increased legal costs
- Increased regulatory scrutiny, intervention, and enforcement action
- Increased levels of sickness absence
- Unacceptable workforce retention
- Failure to attract talent
- Demotivated workforce
- Absence of values-led culture

Modernising our people practice

P3 There is a risk that the Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and representatives the communities served by the Trust, resulting in

- Poor employer brand limiting recruitment
- Staff feeling vulnerable and unable to speak up resulting in missed opportunities to improve practice
- Increased retention of a valuable workforce
- Compensation costs
- Increased regulatory scrutiny, intervention, and enforcement action

High performing workforce

P4 There is a risk that the Trust fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multi-disciplinary values-based leadership, resulting in:

- An unhealthy and poor leadership
- An underperforming workforce
- Sustained patterns of inequality and discrimination
- High turnover
- Non-compliant behaviours
- Employee relations cases

OVERALL RISK SUMMARY

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Evidence that the controls are in place, being followed, and making a difference*
People	***There is a risk that the Trust fails to sustain an engaged and effective workforce***		
	caused by:		
	• *lack of focus on an inclusive and compassionate working environment*	Embedding of a values-led culture: Values and Behavioural Framework Restoration and Recovery Group NHSE&I Quarterly Pulse Check Survey National Annual Staff Survey Friends and Family Test	Values-based recruitment Trend for days lost to sickness absence Signature to the NHS Compact Access to wellbeing services for disadvantaged protected groups Trend for pulse check staff engagement Scores for motivation, ability to contribute to improvements, and recommendation of the organisation Staff Survey results improving to top quartile performance
		Addressing inequality and discrimination: EDI Plan and Policies ICS Anti-Racism Pledge and Action Plan Disability Confident Checklist Stonewall Checklist Freedom to Speak Up Guardian Staff Network	High Impact actions for achieving EDI aims People Committee Reports and Cycle of Business Investors in People Charter Mark National Accredited Living Wage employer Reporting against Model Employer Goals Trends for WRES data Trends for WDES data

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Evidence that the controls are in place, being followed, and making a difference*
			Gender pay gap FTSU Quarterly Board Report Staff training records
	• *inability to attract and retain the required and representative workforce talent and skills*	Management of the workforce market: ICS workforce programme to manage demand and competition in the system in collaboration with partners Membership of the ICS People Committee Assertive recruitment to areas with chronic vacancy challenges National payment mechanisms and banding panels Remuneration Committee	Reports to People Committee Close collaboration with universities Close collaboration with HEE Greater employability in local population
		Recruitment Policy and processes Stabilisation Plan Retention Plan	Recruitment times: advert to in-post Number of applicants Trend in staff retention rate Trend in staff turnover Analysis of exit interviews % staff who leave for a higher banded job
		Opportunities for professional development: Career development pathways Lateral opportunities into other roles Talent Management Plan	Trend for appraisal rates Personal Development Plans Well-led rating by service and for the Trust

Reference	Risk Description	Controls *Things in place to address the cause*	Assurances *Evidence that the controls are in place, being followed, and making a difference*
		Leadership and Board Development	
	• *inability to define and implement transformative workforce models*	System approach to integration: Provider Collaboratives Long-term workforce model Place based plans	Delivery of MMUH benefits plan Annual Operating Plans
	resulting in:		
	• *Unsustainable services and unsafe staffing levels*		

APPENDIX I ALL RISKS

Likelihood/Consequence		Inherent L	Inherent C	Inherent Score	Current L	Current C	Current Score	Target L	Target C	Target Score
QPES	**There is a risk that the Trust fails to deliver safe, high-quality care**	4	4	16	3	4	12	1	4	4
QPES1	The Trust fails to focus on the reduction and prevention of patient harm	4	3	12	3	3	9	2	3	6
QPES2	The Trust fails to engage and co-produce with all people who use its services including their families	3	3	9	3	3	9	2	3	6
QPES3	The Trust fails to be a learning organisation that embeds a patient safety culture	4	4	16	4	4	16	2	2	4
QPES4	The Trust fails to be a self-learning organisation that embeds quality assurance	4	4	16	3	4	12	2	4	8
CS1	The Trust fails to lead and take accountability for the development of system-wide approaches to care, and to exploit its status and position to advocate for mental health services and services users	4	4	16	3	4	12	2	4	8
CS2	The Trust fails to respond to service users' holistic needs	4	4	16	4	4	16	2	4	8
CS3	The Trust fails to focus on recovery focused care model	4	3	12	3	3	9	2	3	6
CS4	The Trust fails to provide care that is focused on the needs of our communities	4	3	12	4	3	12	2	3	6
CS5	The Trust fails to adapt to change as required	3	4	12	3	3	9	2	4	8
FPP	**There is a risk that the Trust fails to make best use of its resources**	4	4	16	3	4	12	1	4	4
FPP1	There is a risk that the Trust fails in its responsibilities as a partner, and does not structure and resource itself properly to take advantage of new contractual mechanisms	4	4	16	3	4	12	2	4	8
FPP2	There is a risk that the Trust fails to focus on the digital agenda and to harness the benefits of digital improvement	5	4	20	3	4	12	2	4	8
FPP3	There is a risk that the Trust fails to behave as a socially responsible organisation	4	3	12	2	3	6	2	3	6
FPP4	There is a risk that the Trust fails to manage the safety and quality of its therapeutic environment	4	5	20	3	5	15	1	5	5

APPENDIX I ALL RISKS

People	**There is a risk that the Trust fails to sustain an engaged and effective workforce**	5	4	20	4	4	16	2	3	6
P1	There is a risk that the Trust fails to deliver its ambition to shape the future workforce	5	4	20	4	4	16	2	4	8
P2	There is a risk that the Trust fails to develop an inclusive and compassionate working environment	5	4	20	4	4	16	2	4	8
P3	There is a risk that the Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and representatives the communities served by the Trust	5	4	20	4	4	16	2	4	8
P4	There is a risk that the Trust fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multi-disciplinary values-based leadership	4	4	16	3	4	12	2	3	6

10.7. Summerhill Services Limited (SSL) Business Report

April 2022–October 2022

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	10.7
PAPER TITLE	SSL Quarterly Report
DATE	7th Dec 2022
AUTHOR	Shane Bray – Managing Director
EXECUTIVE SPONSOR	David Tomlinson, Executive Director of Finance

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

Equality & Diversity ***(all boxes MUST be completed)***	
Does this report reduce inequalities for our service users, staff and carers?	Yes
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

The report highlights the financial and operational performance of SSL. The key areas to note are:

- Developments across all SSL FM services provided to the Trust
- Development and progress of Summerhill Pharmacy
- Development of our external services – ICS and Primary Care
- New commercial opportunities

Reason for consideration:

For information and assurance

Previous consideration of report by:

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

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

Financial Implications ***(detail any financial implications)***
Group financial position
Board Assurance Framework ***(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities***
Engagement ***(detail any engagement with staff/service users)***

Summerhill Services Limited (SSL) Business Report

April 2022–October 2022

This report summarises the performance and activities of SSL from April 2022 to October 2022.

The first half year has been very busy, with implementing the numerous capital projects across the Trust, the introduction of a new estates management tool, which will provide more in-depth information on maintenance tasks and the full implementation of new national cleaning standards.

We have also been working hard with our staff. We completed our “Town Hall” meetings spread over 20 sites. These are held quarterly and they are a review meeting to inform staff of SSL progress but more importantly give staff the opportunity to raise any questions or queries. Over 50% staff attended the meetings and we received valuable feedback and comments. We also held our second EDI Forum and it was extremely pleasing to see we had even more EDI advocates attending. We covered a number of topics including how our training could be extended to enable the EDI Advocates to support even more staff.

Recruiting quality staff remains a high priority for SSL. We are experiencing the same recruitment challenges as the rest of the health system, with significant reduction in applications. To help to elevate this issue, SSL has engaged with iCan Program. The iCan program puts people who are coming back into the work place or have found it difficult with potential employers. Two SSL staff members attended and presented at the last iCan meeting to potential candidates. Our staff members explained what it was like to work for SSL, what does a domestic and catering assistant do in a health setting. We received positive feedback from all who attended and we had 30% applied for roles in SSL.

SSL continues to support the system with COVID related activities, however these are now being reduced by the ICB at least during the summer, but we could expect this to increase again with the announcement the vaccination programme now being extended to over 50’s.

SSL Pharmacy services performance has been affected by staffing issues provided by the Trust. We are working the Trust pharmacy team to look at options on how we can improve this situation.

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.

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

- PFI Management
- Pharmacy Services

Review March 2021 to October 2022

Facilities Management

- **Domestic and Housekeeping Services**

The successful implementation of the New National Cleaning Standards has been completed, but recruitment is still underway.

Cleaning Quality Operational Group developed members comprising Infection Prevention and Control Team, Matrons and Service Partners, SSL and Amey Community Ltd, This group reports into the Infection Prevention Partnership Committee (IPPC). 21/22 has seen a continuation of high infection cleaning and deep cleaning across the Trust, in particular by the SSL Rapid Response Decontamination and Deep Cleaning Team

Cleanliness is continually quality monitored through our FM (Facilities Management) systems and audit processes

LOCALITY	NORTH PFI LOCALITY BUILDINGS	BNHP LOCALITY BUILDINGS (Barberry, Oleaster & Zinnia)	COMMUNITY SITES Dan Mooney House, David Bromley House, Hertford House, Maple Leaf Centre Juniper	SECURE & COMPLEX CARE SITES Tamarind Ardenleigh Reaside	Corporate Buildings B1 Uffculme
Quarter 2 22/23 Trust Score	95.96%				
Quarter 2 22/23 Individual Localities	92.58%	96.14%	97.17%	97.15%	97.81%

FM First Cleanliness Scores: Technical, Managerial and External/Joint Audit Scores

- **Catering Services**

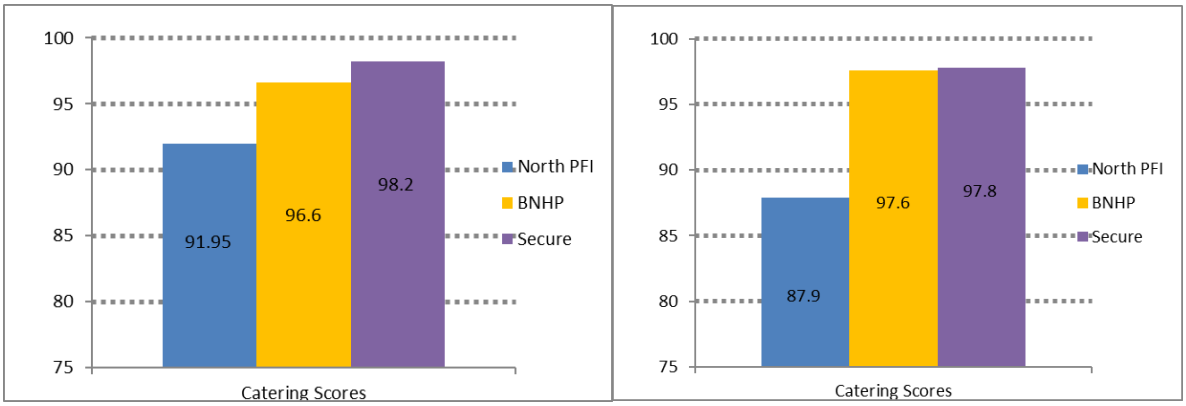
SSL have been working collaboratively with NHS Supply Chain; Food (Tower 10) integrating the Multi-Temperature Distribution model to achieve value for money.

Trust Food Group has been re-established. The group chaired by Chief Nursing Officer/Director of Quality & Safety and members comprising of Trust Dieticians and SSL management team. The objective of the group is to oversee food quality, safety and nutrition across the Trust and implement recommendations from the Independent Review of NHS Hospital Food.

Programme of kitchen inspections, and food safety and quality audits continue (reporting to Trust IPCC) along with food wastage pilot, Master Catering Programme 22/23, New 4 weekly menu and recipe book. New food management and tablet based ward ordering software and re-branding of all SSL managed cafeterias

Continuing to provide compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS "Plastic Pledge".

The Estates and Facilities Training Hub continues to provide accredited training programmes such as the British Institute of Cleaning Science (BICSc) and the Chartered Institute of Environmental Health (CIEH).
See below ref Production kitchen audit scores :



Note: North PFI catering provides a "Cooked Chilled" solution rather than freshly made meals, which has impacted to the lower catering scores.

SSL continue to work with Deaf Services @ the Jasmine Suite- The Barberry, to promote better communication and customer service at Service User mealtimes, with Makaton and British Sign Language signs included in SSL Customer Service Training.

- **Audits / PLACE**

PLACE lite audits carried out in house over the past 2 years (during COVID times) to maintain consistency and standards in preparation for next external PLACE audit. Scores remain consistently high due to in-house training, audit regime and general performance management.

Cleanliness Audits – To maintain consistent standards across all sites the domestic teams audit using FM First software package. Audits are carried out monthly by the supervisors with management audits in place quarterly. Scores remain consistently above KPI's.

Catering Audits – SSL's Facilities Training & Quality Assurance Manager completes regular production kitchen audits to maintain standards alongside catering supervisors who audit on a monthly basis. Scores remain consistently above KPI'

- **Laundry and Linen Management**

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

We are also exploring different opportunities by way of maintaining or improving service provision.

- **Estates Policies, Assurance and Jobs**

Multiple SSL / Trust policies and procedures were updated and reviewed including H&S, Management of Contractors, SSL Estates & Facilities Overarching Operational Policy, Legionella Management Plan / Polices, etc.

Across SSL we now have appointed Authorised Engineers - AE's for electrical HV and LV, lifts and water safety.

Detailed live premises compliance data has been formulated across all BSMHFT and SSL sites.

Quarterly Estates and Facilities Risk / Health and Safety Meetings reinitiated.

Water Safety:

- Legionella risk assessments across operational sites have been updated and combined onto a master spreadsheet, PFI risk assessment updates are ongoing.
- Combined Sampling results are now collated into a single spreadsheet including actions taken. This is then reviewed at the operational and strategic water safety groups.

Sampling Overview:

- Reaside: We had 2 post flush positive result (75CFU's and 50CFU's) in July 2022, additional flushing was put in place with the latest results all clear.
- North PFI: Eden Acute, Forward House and George Ward have had positive results to isolated outlets, detailed action plans have been put in place with updates communicated Weekly to Strategic Water Safety Group Members.
- South PFI: Last Quarter all results are clear.

Estates Misc:

PPM package of works specifications nearing completion to gain economies of scale and make contract management a leaner process.

CAFM (computer aided facilities management) system - trials have been concluded with FM first coming out as the preferred system across the retained estate, prior to PO being raised and then population of system and implementation.

Grounds and Gardens:

- Escalation meetings have been held over the past months with Gould Landscapes ref the quality of service delivery.
- Goulds have also stated that they would like a contract price uplift of 7.5% which equates to £12,424.00 per annum – SSL / BSMHFT
- Mutual contract termination has been agreed with Goulds Landscapes, implementation plan is in place with the incoming contractor (Ground Control), go live date mid October 2022.

Corporate, Property and Sustainability

- SSL has led (on behalf of the Trust) in completing and returning numerous returns over the period including; PAM, ERIC, Capital Programmes annual and 5 year programme, Trust Fleet, Sustainability and Disposals. All submission have been completed on time to NHSI/E
- SSL have completed the first online draft iteration of the new online NHS Premise Assurance Model (PAM) – 400+ self-assessment questions required annually.
- SSL have produced a Trust Property Report separate document to challenge in particular on vacant buildings within BSMHFT.
- Trust Strategic Property Group planned; SSL will play key roles.
- SSL developed and issued Sustainable Development Strategy and Action Plan (Green Plan) on behalf of BSMHFT. This was presented to the Trust Board May 2022.
- SSL have developed B1 Options proposals and have appointed Management Surveyors to carry out multi-million vacation negotiations, looking for Trust early exit from their lease obligations.

Transport & Logistics

- SSL continues to provide pick, pack and distribution of all PPE throughout the Trust, included Lateral Flow Kits from our warehouse.
- PPE – Stock levels regarding normal daily issue are where they need to be. The Warehouse Team welcomes the partnership with ***Birmingham Community Hospitals.*** Both teams cooperate well, which helps in building relationships for future projects.
- SSL have signed the lease on a new Warehouse to allow expansion of services including; PPE, Partnership with BCH (Equipment Loans, PPE, etc), Provision and distribution of Trust Uniforms, Laundry services, vacation of B1 inc ICT relocation.
- Effective and Efficient NEPT service through time of COVID, this service adapting to single patient service.
- SSL still able to provide effective GT service – pharmaceutical, specimen, samples, post – additional activity undertaken during COVID with delivery of samples for testing to acute hospitals.

Capital Projects

- Trust provided approval and cost codes for Capital Programme July 2022, leaving circa eight months to deliver a challenging £7.4m programme, consisting of over 200 separate

projects. There has been a considerable delay on the programme development and approval by the Trust.

- BSMHFT and SSL need to be minded that the delivery of the 2022/23 Capital programme will be massively challenging due to; acuity on wards, qualified nurse escorting on site, COVID outbreaks, the inflation and scarcity hitting resources and components in the construction industry.
  Spend position M6 circa £1m, commitment £4.5m and cashflow established for rest of the programme.
- SSL has supported the Trust on the CQC required works and reports. SSL are managing the Physical Environmental works associated with the replacement of compliant anti-ligature doorsets with new anti-ligature doorsets incorporating continuous alarm monitoring. The current programme includes replacement of over 250 doorsets and connectivity to Staff Assist Systems.
- SSL continues to support the development of the Strategic Outline Case information associated with Reaside and Highcroft major developments and, ensures these projects remain at high level within the ICS/ICB prioritised schemes.
- We have also been successful in winning a Salix bid for decarbonation for the Trust. 25 sites are currently being surveyed to look to submit external works bids and underpin the 23/24 programme.
- SSL has costed all prioritised works requested by BSMHFT for the 2023/24 Capital Programme including major and minor projects, Fire/ security/ environmental and Ligature Risk Assessment works, Statutory Standards and Backlog Maintenance Programme – (SSBM) programmes. Anticipated new version to be issued to the Trust November 2022.

SSL PFI/Contract Management

- SSL contract manages two significant and complex PFI contracts c £25m p.a.
- SSL is finalising negotiated Settlement Agreements across both PFI's following performance management challenges of services. These agreements will deliver a high six figure settlement values. Plus an Energy Management settlement of six figure sum.
- 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 of relationships with other trusts to assist them with their PFI needs and requirements.
- PFI Health Check Paper is progressing well, where we are seeking Intellectual Rights governance to protect the document for SSL. Marketing strategies for delivery within the NHS under review.
- SSL are starting our 9th Market Test, this being the BNHP Joint Security Market Test. Challenging, with significant cost avoidance, whilst retaining positive relations with all stakeholders.
- PFI Expiry Presentation being held October to Trust Finance and PFI Team.
- The Trust to provide SSL with a clear brief in regard to the future Door Specification as Clinical teams are requesting changes to the locking mechanism – to include Dead Locks.

- Water Management concerns from the Trust ref to Eden, Forward House. Significant resources and investment have been conducted since May to mitigate the Legionella risk. Weekly water meetings with DIPSI & Water Management Group. SSL & Supply chain are doing all we can do, and communicate accordingly, issue arisen due to poor water usage.

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.

In addition to the Primary Care Estates business as usual work plan SSL have continued to provide support for.

- 2 Mobile clinics
- 4 Community Red sites
- 2 Primary Care Urgent Treatment Centres
- Vaccination Centres across Birmingham and Solihull
- £500k PCN Strategy works
- £114k of work associated with the Winter Access Fund (Security), included the installation of 15 CCTV systems in various GP Practices in areas of high deprivation.
- Primary Care Capital Works
- Net zero Carbon projects
- GP lease renewal negotiations
- etc

Outpatient Dispensing Services – April 2022 – October 2022

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 27 externally reportable incidents from 113,740 dispensed. No service users were harmed as a result of these externally reportable incidents and all of them have been dealt with promptly.
- SSL implemented a Prescription Tracker which tracks our pharmacy performance (Please see Appendix D & E).
- SSL's outpatient dispensing service has slightly dropped in performance, this is due to known operational challenges across both the Trust and SSL pharmacy service. SSL are working alongside the chief pharmacist to resolve these challenges.
- SSL robot continues to deliver an accuracy of 99% on compliance aids,(see chart below):

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	June-22	July-22	Aug-22	Sep-22	Oct-22
99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance
SSL achieved £1.7m additional revenue compared to budget after 7 months of the current financial year. The additional Vaccine programme accounts for £0.7m of this number. The remainder, £0.9m, , is due to additional costs with the Trust, the majority of these additional costs are due to increases in utility costs and impact of the recent national pay award which has not been fully funded by the

government. We are forecasting our revenue to breach £28m by the end of the year. This is £3.9m ahead of budget and split £2m from External work and £1.8m from Trust work.

Its important to note, there is still huge uncertainty about increases in utility costs and difficult to forecast an outcome – our current forecast shows a potential increase of over £1m p.a. SSL is working with the Trust to look at options to increase the work on energy efficiency across the estate to help minimise the increase in utility costs.

HR Strategy/People Plan Staff

- SSL has now introduced a range of new HR policies which will apply to all SSL employees. The HR policy introduced with the most significant changes, is its Managing Attendance Policy, of which all Supervisors/Managers have attended a HR Workshop to ensure they are appropriately skilled.
- SSL HR Team have also rewritten it RMS/ADR process and looking to introduce a new quarterly check-in process to replace both systems. This currently sits with the Trust ESR and IT Team, who are completing an ESR template, for use by all SSL employees.
- SSL HR Team have liaised with the Operations Team and have identified a range of courses which operational personnel will be able to request via their RMS process. This will be positively marketed in quarter four onwards.

Resourcing and Reward

- Recruiting quality staff remains a high priority for SSL. We are experiencing the same recruitment challenges as the rest of the health system, with significant reduction in applications. To help to elevate this issue, SSL has engaged with iCan Program. The iCan program puts people who are coming back into the work place or have found it difficult with potential employers. Two SSL staff members attended and presented at the last iCan meeting to potential candidates. Our staff members explained what it was like to work for SSL, what does a domestic and catering assistant do in a health setting. We received positive feedback from all who attended and we had 30% applied for roles in SSL.
- SSL has also used HR Expert's, Salary Survey (Cendex System) and a separate Senior Management and Executive Survey, to positively identify where it sits in reference to external market across all employment roles. Tools have aided intelligent salary reviews where necessary to avoid loss of key personnel and inform pay review process.
- SSL agreed its annual inflationary increase inline with the Agenda for Change pay award, whereby all employees have received a £1,400 increase pro rated per annum, paid in September 2022.

Employee Engagement (Communications)

- SSL has throughout July/August undertook its second round of business briefing this year, with a focus on; Who is SSL ?; Our Services; Growth Opportunities, HR, and Finances. Business Briefing received positively by workforce.
- SSL has seen a positive increase in grievances because personnel feel more able to raise issues at business briefs and via EDI Advocates. A positive resolution to organisational issues is being found

- SSL has drafted and engaged with staff over monthly mood surveys to be launched and six topical pulse survey's which will be undertaken twice a year on; EDI, Media and Communications, Values, Leadership and Management, Training and Development, Health and well being.
- SSL's Recognition Scheme continues to go from strength to strength with second quarters nominees being a similar number to quarter 1.

Equality, Diversity & Inclusion

- SSL has held its second EDI forum, whereby the role of an EDI Advocate has been agreed and the number of advocates totalling 12 across the organisation currently, with new candidates being added.
- Training for Advocates will be delivered on the 28th and 29thNovember 2022.
- SSL has now commenced positively promoting the role and using EDI advocates to support in relation to grievances and disciplinary's. The role has positively influenced panels and allowed panels to consider a different perspective in relation to the presenting issues.

Business Development, Opportunities and Plans

Corporate, Property and Sustainability

- SSL will be developing further the 'Green Plan' for the Trust to include Scope 1,2 and 3 baseline data and targets
- SSL will be introducing both food waste recycling (sites with preparation kitchens) and a 'OPT in' waste recycling option for the Trust
- SSL have been working with National Express regarding the issue of free bus passes for all new SSL and BSMHFT starters – encouraging sustainable travel whilst at the same time giving the new starters the option of free travel
- SSL will be developing an EV charging point option for BSMHFT to consider during 2022/23. This will provide BSMHFT with all the information it should need to consider whether or not it intends to implement such charging points for staff / visitors / patients
- SSL are developing its 'fleet' to support BSMHFT Services by adopting Plug in Hybrid / All electric vehicles where it can and where costs and range permit
- SSL has managed energy procurement on behalf of BSMHFT and will be procuring all of its directly procured electricity from Zero Carbon sources for 2022/2023
- SSL will be leading in 2022/2023 a host of communications to staff in a vein to publicise the 'Green' agenda and get wider staff engagement and ownership
- SSL have secured an 8 Month contract with Birmingham St Marys and John Taylor Hospices to manage their facilities until April 2023.

Transport and Logistics

- Expansion of our warehouse and distribution facility and services. This will allow SSL the capacity to not only manage its current PPE but to also to allow for additional capacity and growth. This including but not limited to Laundry, Trust Clinical Uniforms provision and Expanding PPE provision in partnership with neighbouring Community Trust.

- Development of our Green Fleet - SSL are currently reviewing the fleet on behalf of the Trust (including whether Trust or SSL budgets / ownership / signage etc). The plan as per Greener NHS requirements being to move to hybrid / full EV vehicles as suitability / range and financial resources permit. At the current time there are 73 vehicles on the fleet.
- Possible expansion of our current patient transport service to provide a Secure Patient Transport service to the Trust and possibly other Trusts in the future.

ICS/ICO BSol Strategic Delivery

- SSL is currently reviewing our business structure to enable SSL to be a successful ICS partner in the future ICS structure.
- Expansion of our facilities managements and estates services and support to Primary Care.
- SSL is currently developing a project which may help to provide an initiative solution for future Clinical Dialogistic Centres
- We have been requested to support major BSol Project initiatives of Kingshurst, Meadway and North Birmingham (Gracechurch)
- In addition, SSL have been requested to support the ICS Green Strategy agenda, and have submitted proposals to deliver this service until the end of the financial year.

Governance and Assurance

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

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

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

SSL

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Appendix A – Financial Statement April 22 – October 22

SSL Financial Position	Annual budget	M7		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	12,827	7,482	8,128	646
Lease & Long License	2,507	1,462	1,547	84
Contract Management	2,231	1,301	1,130	(171)
Facilities Services	2,849	1,662	1,952	290
Grounds and Garden	290	169	157	(12)
PPE & Warehouse	118	69	93	24
Pharmacy	3,200	1,867	1,927	60
External Services - Head of Assets	95	55	180	125
External Services - STP	0	0	0	0
External Services - CCG Vaccine Pro	180	105	700	594
External Services - FM	0	0	14	14
Total income	24,296	14,173	15,826	1,654
Pay costs	(9,428)	(5,499)	(5,985)	(486)
Drug costs	(2,817)	(1,643)	(1,719)	(76)
Non pay costs	(6,024)	(3,514)	(4,485)	(971)
Clinical supplies costs	57	33	(5)	(38)
Total Expenditure	(18,212)	(10,624)	(12,195)	(1,571)
EBITDA	**6,084**	**3,549**	**3,632**	**82**
Depreciation	(3,336)	(1,946)	(1,946)	0
Interest Payable	(2,163)	(1,262)	(1,241)	21
Interest Receivable	0	0	0	0
Finance Lease	(379)	(221)	(219)	2
Profit / (Loss) before tax	**207**	**121**	**226**	**105**
Taxation	(380)	(222)	(224)	(2)
Profit / (Loss) after tax	**(173)**	**(101)**	**3**	**104**

SSL

NHS
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Appendix C/D: 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

Benchmarking Report for Outpatient Prescriptions

Team	Achieved to date/time Sept-22	Not Achieved to date/time Sept-22	Percentage Achieved to date/time Sept-22	Percentage Achieved to date/time Aug-22	Percentage Achieved to date/time July-22
Aston and Nechells Community Team	125		100%	95%	96%
Central Assertive Outreach	44	2	96%	96%	98%
East hub Older Adults	3		100%	100%	100%
East Assertive Outreach	40	2	95%	97%	91%
Handsworth AOT	31	1	97%	91%	90%
Kingstanding & Erdington CMHT	169	9	95%	98%	97%
Ladywood & Handsworth CMHT	122	5	96%	97%	98%
Longbridge CMHT	170	4	98%	93%	100%
Lyndon CMHT	72	4	95%	90%	100%
Newbridge Clinic	169	7	96%	98%	98%
Newington CMHT	53	7	88%	98%	100%
North Assertive Outreach	44	4	92%	89%	96%
North Hub Older Adults	20		100%	100%	100%
Reaside Community	108	6	95%	96%	96%
Riverside CMHT	12		100%	100%	92%
Small Heath CMHT	25	2	93%	95%	91%
Solihull Assertive Outreach Team	32	2	94%	92%	87%
Solihull Early Intervention Service	81	8	91%	98%	96%
South Assertive Outreach Team	34	4	89%	97%	94%
Sutton Coldfield Community Team	68	2	97%	95%	97%
The Homeless Team	9		100%	100%	100%
Warstock Lane CMHT	117	7	94%	91%	97%
West Hub Older Adults	6		100%	100%	100%
Yewcroft CMHT's	104	5	95%	93%	97%
Zinnia CMHT'S	259	20	93%	95%	95%
South Hub Older adults	4		100%	100%	100%
Wilson Lodge	5		100%	100%	100%
Grand Total	**1926**	**101**	**95%**	**95%**	**96%**

Benchmarking Report for Compliance aids

Compliance Aids	Achieved to date/time Sept-22	Not Achieved to Date/time Sept-22	Percentage Achieved to Date/time Sept-22	Percentage Achieved to Date/time Aug-22	Percentage Achieved to Date/time July-22
Aston and Nechells Community Team	20	3	87%	100%	95%
Central Assertive Outreach	12	2	86%	89%	93%
East Assertive Outreach	20	3	87%	94%	86%
Handsworth AOT	23	2	92%	87%	96%
Kingstanding & Erdington CMHT	18	2	90%	88%	90%
Ladywood & Handsworth CMHT	21	3	88%	86%	95%
Longbridge CMHT	37	6	86%	86%	97%
Lyndon CMHT	21	2	91%	92%	96%
Newington CMHT	19	1	95%	100%	100%
Newbridge Clinic	13	2	87%	86%	94%
North Assertive Outreach	18	3	86%	87%	95%
Reaside Community	26	4	87%	90%	91%
Small Heath CMHT				100%	100%
Solihull Assertive Outreach Team	13		100%	88%	100%
Solihull Early Intervention Service	9	1	90%	100%	100%
South Assertive Outreach Team	23	1	96%	88%	91%
Sutton Coldfield Community Team	4		100%	89%	100%
Warstock Lane CMHT	20	3	87%	86%	100%
Yewcroft CMHT's	9	1	90%	88%	92%
Zinnia CMHT'S	29	5	85%	82%	88%
Grand Total	**355**	**44**	**89%**	**89%**	**94%**

10.8. Questions from Governors and Public

10.9. Any Other Business (at the discretion of the Chair)

10.10. FEEDBACK ON BOARD DISCUSSIONS

11. RESOLUTION

The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

12. Date & Time of Next Meeting

1st February 2023, 09:00-12:30