Trust Board Part 1

Schedule Wednesday 29 September 2021, 9:00 AM — 12:30 PM BST
Organiser Hannah Sullivan

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
WEDNESDAY 29 SEPTEMBER 2021 VIA VIDEO-CONFERENCING

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

Staff Story 9:30 start for this item

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Declarations of interest	*Chair*	09.00	-	-
2.	Minutes of the previous meeting held on the July 2021		09.05	A	Approval
3.	Matters Arising/Action Log		09.10	A	Assurance
4.	Chair's Report		09.15	A	Assurance
5.	Chief Executive's Report	*CEO*	09.20	A	Assurance
6.	Board Overview: Trust Values	*Chair*	09.25	V	Assurance
	QUALITY				
7.	Integrated Quality Committee Chair Report	*L. Cullen*	10.10	A	Assurance
	PEOPLE				
8.	People Committee Chair Report	*P. Gayle*	10.30	A	Assurance
	SUSTAINABILITY				
9.	Finance, Performance & Productivity Committee Chair Report	*G. Hunjan*	10.40	A	Assurance
10.	Integrated Performance Report	*D. Tomlinson*	10.50	A	Assurance
11.	Finance Report	*D. Tomlinson*	11.00	A	Assurance
	GOVERNANCE & RISK				
12.	Reach Out Readiness to Proceed Assessment	*D. Tomlinson*	*11.20*	A	Approval
13.	Independent Assurance Report (ANHH)	*A. Hughes*	*11.50*	A	Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
14.	Guardian of Safe Working	*S. Muzaffar*	*12.20*	A	Assurance
15.	Questions from Governors and Public (***see procedure below***)	*Chair*		V	Assurance
16.	Any Other Business *(at the discretion of the Chair)*	*Chair*			-
17.	**SNAPSHOT REVIEW OF BOARD PERFORMANCE** **Were items appropriate?** **Were timings appropriate?** **Are there any items for inclusion on the action log?** **Are there any items to be disseminated across the Trust?** **Were the papers, clear, concise and aided decision making?**	*Chair*			-
18.	**RESOLUTION** The Board is asked to approve 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 • 27 October 2021			*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.

Staff Story 9:30 start for this item

1. Opening Administration:
Declarations of interest

2. Minutes of the previous meeting held on the July 2021

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING HELD 28th July 2021
VIA VIDEO CONFERENCING, MICROSOFT TEAMS

PRESENT:	Ms D Oum	-	Chair
	Ms S Bloomfield	-	Director of Quality & Safety *(Chief Nursing Officer)*
	Dr L Cullen	-	Non-Executive Director
	Mrs V Devlin	-	Executive Director of Operations
	Mrs R Fallon-Williams	-	Chief Executive
	Mr P Gayle	-	Non-Executive Director
	Dr H Grant	-	Executive Medical Director
	Mrs G Hunjan	-	Non-Executive Director
	Mr P Nyarumbu	-	Executive Director of Strategy, People & Partnerships
	Mr W Saleem	-	Non-Executive Director
	Mr D Tomlinson	-	Executive Director of Finance
IN ATTENDANCE:			
	Mrs A Tomlinson	-	Executive Assistant
GOVERNORS OBSERVING			
	Mrs M Johnson	-	Carer Governor

PRE-BOARD PRESENTATION – A SERVICE USER STORY

Katherine Allen introduced a service user from Ardenleigh Women's Service.

She spoke about her journey through mental health services for 12 years and expressed positively about the whole multidisciplinary team at Ardenleigh and the huge improvements and benefits of the new "blended model of delivery" which in particular had enabled her to have some input into her recovery journey. She highlighted her initial reluctance to engage in DBT and some of the challenges for her and other service users about making the transition from the "fantastic care" as an inpatient to making a successful transition, due to the anxieties, back into the community. She advised of the importance to continue to formulate the therapeutic care in the community to support service users in their transition and that a substance misuse buddy would be helpful. In conclusion, she described that being part of third sector organisation Anawim, and being part of Patient Experience Service User and Carers had positively impacted and changed her life for the better, and which had also been instrumental in supporting her recovery and transition.

The Chair gave thanks for her openness especially in relation to the transition and that she had powerfully demonstrated the importance of inpatient and service users being involved in shaping services and working with each other to support the delivery of services.

Ms S Bloomfield expressed her thanks and that it had been really helpful to receive the feedback in particular around transition. She advised that this had also been discussed at a recent risk review meeting, in particular with regard, to the anxieties of moving back into the community and what more could be done by the Trust.

Dr H Grant again gave thanks and said anything that could be shared would be really helpful. She recalled an example of transition of a patient when she had worked at Ardenleigh and following all the hard work by the service user of the importance to try and ensure that transition into the community was successful. Ms S Bloomfield and Dr H Grant expressed their keenness to meet the service user at Ardenleigh when they were due to visit in a few weeks' time.

Ms K Allen highlighted another service user, on the research team, who was undertaking the first service user led Quality Improvement project, to explore how the Trust could make transition and discharge more successful.

The meeting collectively gave an expression of their thanks and looked forward to seeing the service user again in the Autumn.

The service user and Ms K Allen left the meeting at this stage.

1. OPENING ADMINISTRATION AND DECLARATIONS OF INTEREST

The Chair welcomed Trust Governors and public who were observing the meeting.

Apologies for absence had been received from Professor R Beale, Non-Executive Director.

No Declarations of interest were noted to be considered by the meeting.

2. MINUTES FROM THE PREVIOUS MEETING & ACTION LOG

The Board members reviewed the minutes of the previous meeting held on 30th June 2021 and agreed that the minutes were a true and accurate record of proceedings with the following amendments:

- Page 8, Item 7.2 Freedom to Speak Up Report, paragraph 3 – *"S. Bloomfield confirmed that the case has been dealt with correctly and systems are in place for the management of cases"* - should read the next steps were being taken to resolve the case.
- P Nyarumbu should read P Nyarumbu.

3. MATTERS ARISING/ACTION LOG

No matters arising had been notified to the Chair.

The action log was reviewed and updated.

4. CHAIR'S REPORT

The report was received and noted.

5. CHIEF EXECUTIVE'S REPORT

Mrs R Fallon-Williams provided the highlights within the report. She began with an update with regards to clinical services. She advised whilst nationally COVID cases were reducing there was an increase in cases across Birmingham, which included the number of people entering hospital and Intensive Care and the system was on high alert. She thanked all staff for their hard work during the pressures and there was work being undertaken on the prioritisation plan for at least the next 8 weeks. She also noted there were number of joint working groups, in particular, out of area and access IAPT to tackle those constitutional standards.

The Trust was continuing to review the vaccination of colleagues with 79% of permanent vaccinated. Mrs R Fallon-Williams pointed out that staff were continuing to be supported and informed and using our values of having those conversations, and with bespoke pieces of work within the directorates that were not at 80% uptake.

Mrs R Fallon-Williams advised that of the CQC monitoring safety improvement plan was now in a monthly position, adding that. the previous meeting that month had been stood down on the basis of the assurances the Trust had provided to the CQC. The Board would continue to be updated and the plan was progressing well. She also drew attention to the expectation there will be a CQC inspection between now and the next quarter of the financial year.

Mrs R Fallon-Williams referred to the section within the report regarding the workforce and "keeping things safe" which currently was proving very challenging. She reported that a number of new measures had been introduced such as the daily staff huddle across all the operational directorates and redeployment across services and payment regimes were also being considered. She also advised as part of the regime, staff were being encouraged to have time out for supervision and peer support, in addition to asking those who were responsible for arranging meetings and attendees to consider if the meeting was needed over the next 8 weeks.

With regards to the finance position she reported that the system financial regime was required to be reset in terms of the criteria of funds that was expected and there was concern for the second part of the year which will continue to be reviewed.

Mrs R Fallon-Williams then referred to the progress of the work around equality diversity and inclusion in supporting the Trust becoming an anti-racism organisation. She commended those directorates that have had the opportunity to have the discussions and leadership development and taken the work forward independently. She advised that Mr P Nyarumbu was developing a relationship with NHSE and working with them to develop a design feature corporately and a Board for the Trust's work being supported.

On conclusion Mrs R Fallon-Williams was pleased to highlight the Liaison Diversion Service being awarded their “No Wrong Door” quality standard mark. She would also commend colleagues for enabling the Trust to receive the serious incident accreditation and noted that the Trust was one of a handful of Trusts in receipt of that accreditation.

Dr Cullen questioned with regards to staff safety and service users may develop COVID and how we deal with the possibility of infections. Mrs R Fallon-Williams advised that there had been isolated cases which had all been community acquired and commended colleagues continuing to be vigilant with regards to the guidance. She confirmed that there were currently four service user individual cases of COVID positive in different areas within the organisation which were traceable to the community and who were being isolated effectively.

In response to a query from Mrs G Hunjan, with regards to the COVID NHS app in order to maintain the safety of staff, Mrs R Fallon-Williams advised that the staff were advised to turn off the track and trace app off when they are coming in and out of work which was the national guidance. She reported that the number of absences of track and trace were relatively low compared to other Trusts and other national guidance locally were being considered which was now in place within the expectations across the system. She offered assurance that whilst cognisant of the fact there were reasons that staff could not and should not be at work

There was also a query with regards to “sniffer dogs” and the balance of care and therapy, Mrs R Fallon-Williams pointed out that this was a regime that had been within the Trust for some time and associated with the fact that in the local community there had been a rise of drug related issues and access to drugs had increased, the use of the regime was in place to support and take care of service users. Mrs R Fallon-Williams assured the Board that it was compassionately utilised and was also to develop service users with skills to overcome their addictions. Mrs V Devlin also provided assurance in particular, with regards to the Oleaster Unit where there had been some issues. She pointed out that staff were currently working with clinicians and security to support service users in a planned approach way, in particular if the dogs where to come on to the wards. Dr H Grant reported there had been an increase in drug related serious incidents with one PFD and there was a need for a balance between quality safety and therapeutic environments.

Ms S Bloomfield highlighted the need to thanked service users in this particularly difficult time especially if tested positively COID and those who were in isolation. She also remarked that following a recent site visit she had seen perfect isolation conditions and again extended her thanks to staff and service users.

Mr P Gayle referred to the work in the Memory Assessment Pathway and the IT specialist to develop an algorithm and how confident that the algorithm will not disadvantage service users, particular those, who have been waiting a long time. Mrs R Fallon-Williams advised it was at the development stage and this would be tested to ensure that it would not disadvantage service users.

The Board

- Received and noted the content of the report.

6. BOARD OVERVIEW: Trust Values

Dr H Grant was invited by the Chair to share her observations of Trust Values.

Dr H Grant began by thanking colleagues, in particular, executive and deputy colleagues, for covering her two weeks' annual leave in the last month. She acknowledged of the importance to recognise the difficulties by everyone to take time off over the last year and half due to the pandemic.

She went on to talk about the health and well-being of staff and that she had observed senior leaders giving daily consideration of how the organisation could support staff, in particular with regards to health and well-being recognising that staff were stretched and tired.

She reported that she had had the opportunity to meeting an expert by experience who has recently been appointed to the Quality Improvement Team. She advised that it had been interesting to hear of their challenges as an inpatient and how difficult they had found that experience, and of their empathy if they had been admitted during the COVID period. She was also interested to hear of their commitment and wanting to give something back to the Trust.

The meeting noted that Dr H Grant had recently become the Chair of the LGBT Trust Network. She advised one of the key discussions at the last meeting had been the objections at the Trust's participation in the Pride march from the organisers and other service providers. She reported there had been a unilateral strong feeling by the network to promote the rights of staff and service users in a positive way and should the march go ahead the network would strongly challenge the objections, recognising the multiple stigmas they continue to experience.

In conclusion Dr H Grant gave recognition to the Patient Safety Team for achieving the SIREN accreditation which was testament to their commitment and hard work. She also highlighted the work currently being undertaken by the Quality Improvement Team with the Academic Health Science Network, and the on-call work following the newly introduced evening and weekend calls, enabling people to come together to keep services safe; and commend staff for their commitment.

7. INTEGRATED QUALITY COMMITTEE CHAIR REPORT

Mr W Saleem presented his last report as committee chair to the Board.

He advised that the committee had particularly focussed on the CQC report where there had been acknowledgement of the hard work undertaken in relation to the action plan. He reported a positive development of the reduction of the CQC assurance meetings from weekly to monthly monitoring although he emphasised that this was a process of change which would require an in-depth understanding and continuous improvement process especially around MDT and care planning. He also highlighted the importance of a

consistent approach across the organisation and referred in particular to the safety huddles which had recently made a positive impact.

Mr W Saleem then reported that the Reaside SOC had been presented to the committee which had provided assurance of the quality and safety requirements, and which would also be embedded across the business planning process, and subsequently integrated into the OBC and FBC; both of which would come to IQC for final sign off at a future date.

The Board also noted that the IQC had been assured with regards to the governance, in particular the quality and safety agenda. He also reported that the committee a were assured on the work undertaken on the safety review on inpatient wards and the paperwork presented on the environmental and procedural and relational actions to support service users, would continue to be monitored by the IQC with regards to improvements, outcomes, and their impacts. The committee had also agreed that there would be one integrated report encompassing the CQC action plan and actions from the inpatient safety review in order that there would be a comprehensive overview.

In conclusion Mr W Saleem commented upon the presentation from QI which had provided the committee with reassurance that the QI methodology had been used in the response to COVID-19, and that further presentations on other projects such as the expert by experience would be received at the next meeting. He also advised that the integrated performance report was also considered but the metrics had not been reviewed in detail due to time constraints.

In response to the Chair's query the areas identified as gaps would be picked up following Mr W Saleem's departure, Mr W Saleem advised that he was confident that processes were in place for IQC to continue to monitor the progress that would need to be made, and reporting mechanism were also in place to provide assurance.

The Board

- Noted and took assurances from the update.

8. MENTAL HEALTH LEGISLATION COMMITTEE CHAIR REPORT

Mr P Gayle provided the main highlights of the report to the Board. He began be referring to the key points within the integrated report which include complaints and incidents and the CQC visit.

He noted the report overall had shown a 25% decrease in mental health incidents in quarter 1, which was the largest reduction that had been seen in unlawful detentions. The Board were informed that the committee felt assured that as the Trust continued to embed the new mental health legislation regulations, there would be further decreases in the Mental Health Act incidents in the future.

Mr P Gayle also advised that the committee were still awaiting receipt of the report following the CQC Mental Health Act visit.

The Board were informed that there were two areas of deficit noted by the committee with Mental Health Legislation compliance – the Trust Mental Health Capacity Act

assessments on admission and the Responsible Clinician not providing feedback from the Second Opinion doctors. Mr P Gayle advised that the committee had been assured that this matter had been addressed with reminding medics of their code of practice responsibilities. He also referred to the Mental Health Act data which showed no unusual activity or trends.

Mr P Gayle then drew attention to the CTO project and service evaluation and reminded the Board that this was a long-standing concern for the committee and for the Trust. He pointed out that there had been a high usage of CTOs which disproportionately affected black male service users within the Trust. He advised this was no different to similar Trusts across the country, but that no other organisation has undertaken a comprehensive detailed piece of work to produce what lies behind the CTO. The Committee were assured by the thorough process being undertaken by Dr H Grant and the team who will present their findings and conclusions at the Committee meeting in October 2021.

Finally he referred to COVID procedures and visiting procedures and that the committee felt the procedures needed to be received elsewhere due to the revised governance reporting arrangements. He also highlighted a major concern of the Committee of the reciprocal impact of the delays CQC SOAD provision and impact of treatment of patients waiting for the legal authority to do so.

Mr D Tomlinson sought clarification with regards to the reduction in mental health incidents which was reported as positive and to ensure that there are no inconsistencies with regards to general incident reporting. It was agreed that this would be reflected in the next report to the Board report.

Dr H Grant was invited to comment on mitigating situation of the Second Approved Doctors (SOADs). She advised that this was working with CQC and escalating in terms of the timeliness of SOADs seek a resolution and reviewing and monitoring if this was improving.

Dr H Grant referred to the CTO project and service evaluation which she noted was a national issue. She advised caution to undertake this review in a timely way and which would also require influence across the system. Mr P Nyarumbu noted the importance of liaising with the national networks as other organisations would go through this process and to learn from their experiences. In response to Mrs V Devlin ‘s query with regards to the appetite across the system to undertake this work, Dr H Grant noted her concern of the acceptance of the “status quo” as internally there appeared to be a lack of understanding of the complexities and that it was critical of a joint understanding of inequalities and inequities and of the broader system. It was agreed that the Board had a strong robust approach to develop with our partners and that it would be helpful for Dr H Grant to share the framework to understanding the meaning from various perspectives.

The Board

- Noted and took assurance from the update.
- Agreed that Dr H Grant would share the reference of understanding from various perspectives of the CTO.

9. MEDICAL DIRECTORATE ESCALATION REPORT – ANNUAL ORGANISATIONAL AUDIT

Dr H Grant presented the report and the key highlights. She referred to the annual appraisal report and associated appendices and noted that following the national guidance it had been agreed to make it much more straight forward and easier for people to engage and to reduce the requirements on both the appraiser and appraisees. She was keen for staff to engage in appraisal which is now more an informative process and conversation and will see a good level of appraisal compliance. We get back to appraisees to feedback what they need to improve as similar to revalidation. She referred to training for appraisee and appraisers, and regular quality audits. Job planning had been comprised over the last year due to COVID and the clinical demands on Clinical Directors, SAS doctors and Consultant Psychiatrists. Also reviewing the job planning policy and aligning it with over all with workforce planning and strategic objectives.

Dr H Grant concluded her report by noting the handbook which had been published by the GMC and although the Trust was not mandated to report against this, it had been considered good practice and subsequently a piece of work had been undertaken to identify an action plan to determine if standards were being met. Dr H Grant also provided an update with regards to the teaching academy and of the educating framework as the Trust were part of Aston medical school as well as Birmingham.

The Chair commented on how pleased she was to see the number activities that were ongoing and welcomed the report.

Mrs G Hunjan sought clarification of the job planning process and the timeline in terms of the responses and completing the process. Dr H Grant outlined the job planning process and that normally a job plan review would take place annually. She advised of the timescales which were currently under review in order to align with the Trust strategies. She also advised that as part of the process in terms of good practice, the Trust were due to introduce a job planning panel. The Board were made aware that timelines were not where they would want to be this year due to the pandemic which was similar to other organisations.

The Board:

- Noted the updates**.**

10. PEOPLE COMMITTEE CHAIR REPORT

Mr P Gayle brought a number of areas to the Board's attention. He reported there were three sub-groups that fed into the committee, and which was working extremely well.

The first sub-group Shaping Our Future Workforce had highlighted three key areas and were progressing the actions of the implementation plan. Mr P Gayle referred to the work supporting the increase in opportunities available for entry level jobs which was mentioned at the previous Board meeting. He advised that the committee had been partly assured as the analysis so far had highlighted that further work was required for the review of the Trust's staffing establishment and in creating opportunities for entry level roles.

Mr P Gayle went on to talk about the Transforming our Culture and Staffing Experience sub-group and referred to the graphs within the report. He highlighted that the deep dive data relating to assaults or harassment on staff by protected characteristics, the committee's view was that further work was needed in order to communicate with staff that incidents were recorded and in doing so would provide assurance. He also noted that the data quarterly details regarding current disciplinary cases which include ethnicity disability breakdown. He emphasised that whilst the data showed an improvement in this area, there was further work to be done to demonstrate continued sustainability to provide the Board with full assurance and importantly to give confidence to staff regarding changes in disciplinary process, particularly within protected characteristics groups.

With regards to KPIs, Mr P Gayle advised that the committee felt further work needed to be undertaken to strengthen assurance on actions specifically improvement on the rate of exit interviews, return to work interviews and fundamental training targets. He pointed out that a detailed pack was received by the committee on the quarterly measures which was outlined in the People Strategic Implementation Plan. He advised that the committee noted there were gaps in the some of the quarterly KPIs and further work had to be done to set the baselines as these KPIs were in the plan, and there had been a request for a clear timeframe for the development of this data set.

On conclusion, Mr P Gayle reported that the committee was provided with an ICS People Board update provided by Mrs R Fallon-Williams and were assured that they would continue to receive update reports on agreed priorities and actions being taken by the ICS People Board.

Mrs G Hunjan queried with regards to the disciplinary cases as to the consistency of processes and outcomes in particular for staff from a Black and ethnic minority background. Mr P Nyarumbu advised there was a need for a deeper understanding of why people enter into the process was and how the policy was applied. He reported that the committee was sighted on a quarterly basis, the number of cases and the progression but of the importance to protect confidentiality. He also reported at the last meeting the committee had received historic cases and the conclusion of those cases and these would continue to be monitored of how the process was applied and people's experiences.

In response to Mrs G Hunjan's question regarding the ICS strategy and of the commitment to increase the number of apprentices and volunteers and if there was any information with regards to the ICS's proposal within the system for people with long term disabilities in the community and if they would have access to apprentices and volunteers to support sustainability form them remain the community, Mr P Nyarumbu advised that following an analysis undertaken by the sub group, the committee had requested for a review of the establishment in order to support creating those. Mr P Gayle also noted that the disabilities element would also be tracked and reported to the board.

Mrs R Fallon-Williams queried the protected characteristics perspective as a board with a large number of people who were not prepared to make a declaration of their particular characteristics and if this was an opportunity for the Chair and Mr P Nyarumbu to send out a clear message to staff of the importance of making such a declaration and how this

could make a difference. Mr P Gayle advised that significant changes were being made and further work would be undertaken to appraise staff of the importance for Trust to have this information.

The Board:

- Noted the update.
- Endorsed the Terms of Reference.
- Agreed that the People Committee would undertake further work to clarify the reason for the Trust's request for staff to make a declaration.

11. FINANCE, PERFORMANCE AND PRODUCTIVITY REPORT COMMITTEE CHAIR REPORT

In the absence of Professor R Beale the Chair took the report as read and invited Mr D Tomlinson to give a brief overview of the report. Mr D Tomlinson highlighted the ICS Shared Services item which was for information and work was being undertaken internally. He also referred to the Terms of Reference and that these had been endorsed by the committee though a decision on a change of committee title had been deferred.

The Board:

- Approved the terms of reference and agreed to defer the change of title of the committee.

12. INTEGRATED PERFORMANCE REPORT

Mr D Tomlinson introduced the report and described the new format. He noted that there was a positive Performance Delivery Group meeting focussing on action orientated and flowing well into the committees.

The Chair had highlighted a number of comments in the report which could be taken to the committees. She referred to one query on page 1 and the board of the reporting cycles and requested this to be included at the start of the report. She went on to thank Mr D Tomlinson and the team that have made the changes which would stimulate the future board discussions.

The Board

- Noted the content of the report.
- Agreed that the reporting cycles would be included at the start of the report.

13. FINANCE REPORT

Mr D Tomlinson reported on the key highlights of financial performance to month 3 and advised that there was a £2.6m surplus year to date against a break even forecast. He noted that the overall STP position was more important than the Trust's individual results and that there is a risk of the elective recovery fund for the STP. However, the Trust's position remained positive mainly due to the non-recurrent slippage on recruitment against new investment. He noted this would be a non-recurrent gain and there were ongoing discussions with the STP how this was best managed collectively. He noted that

the six-month submission was for a break-even compared to the £1.6m deficit previously forecast but indicated there could be challenges in the second part of the year.

Mr D Tomlinson reported on the capital programme position and a final capital funding envelope of £10.3m because a further £700k has been provided by the STP. The Trust was performing well against the projections and working to complete all safety schemes.

On conclusion he referred to slide 119 within the report and the newly introduced system oversight framework which replaces individual organisations. This would feature in the new metrics used as part of the dashboard. He also advised that the committee welcomed a report on business development activity in terms of understanding what was coming through the system. He responded to a query from the Chair regarding agency spend, and although there was an increase this was mainly related to doctors and work is in hand to move this forward.

Mrs R Fallon-Williams asked whether there should continue to be a separate Finance report given progress with the integrated performance report. Mr D Tomlinson noted the importance of transparency but that the Finance report could be included within the reading room.

The Chair questioned the implications of H2 worsening. Mr D Tomlinson advised that the system is planning for CIPs of just over 2% which would imply a £5m per year saving for the Trust.

The Board

- Noted the content of the report.
- Agreed to further consider whether the Finance report should continue to be provided as a separate report to the Board.

14. MEDIUM AND LOW SECURE FACILITIES (Reaside) Strategic Outline Case

Mr D Tomlinson presented the Strategic Outline Case (SOC) for the development of a new hospital to replace Reaside, seeking approval and endorsement by the Board. He advised that the SOC had been ratified by the FPP and IQC following extensive engagement with clinicians in secure care management team and approval by the Inpatient Developments Project Board and the Capital Review Group.

The Board were informed that the next stage of the process would be for external review and approval and due to the value of £91m it would also require the Treasury and Department of Health review and approval with the expectation this would be by November 2021.

Mrs V Devlin was excited to see the SOC as there had been a lot of work with clinical leadership and service user engagement and felt assured. She highlighted a key point, which had been discussed at the Operational Management Team would be to ensure the communications as robust as possible and ensure that our communities, MPs, local Councillors were engaged for which a detailed communications plan had been developed.

Dr H Grant commented on the previous developments at Ardenleigh recommended to review the learning with regards to the environment in particular making it ASD friendly. She went on to talk about getting the clinical teams working in a very different way and strongly recommended that the clinical model was reviewed and stressed the importance of definitive MDT standards with an opportunity to build all the health and equalities together and transforming cultures. Ms S Bloomfield recognised there would be challenges but reiterated Dr H Grant's point of the opportunities in particular clinical pathways. She raised a minor concern to ensure the development of the workforce model had the right skill mix but need to be opened minded that this could change as the business case developed. She advised that herself, Dr H Grant in partnership with Mrs V Devlin and Mr D Tomlinson would need to be close to this to be able to assure the relevant committees that the new service would be a safe and innovative.

Dr L Cullen referred to the care pathway and how experts by experience were used in the different steps in the pathway and also the learning following ICCR transforming care work and for the directorates to share their learning experiences.

Mr P Gayle commended Mr D Tomlinson and the team as the SOC had been really informative and it was a great opportunity for the improvement of services for services users and staff.

The Board

- Approved the strategic fit within the context of BSMHFT.
- Approved the identification of the preferred option, Option A.
- Approved the commercial viability and feasibility of the programme.
- Noted the anticipated financial impact assessment on BSMHFT's financial standing.
- Approved the planned capital investment of £90.8m including VAT.
- Approved the Strategic Outline Business Case and progression to development of the Outline Business Case.

15. AUDIT COMMITTEE CHAIR REPORT

Mrs G Hunjan gave an overview of the key highlights from the report.

She began by referring to the internal audit outstanding reports relating to 2020/21 which had been presented to the committee and a further two due to come to the next meeting. She advised the meeting had reviewed the findings which had demonstrated compliance, noting the Capital Prioritisations processes had been strengthened as recommended at the last meeting.

The Board were informed with regards to the Annual Plan 21/22 and that the team had started their reviews, with the job planning review scheduled in quarter 1 being deferred to quarter 4 which had been agreed by Dr H Grant and the committee after consideration of the reasons for the delay.

The Counter Fraud annual assessment had been completed with an overall rating of green. Mrs G Hunjan highlighted that there were some areas where further work was required and the committee would continue to receive further updates on progress.

Mr G Hunjan was pleased to advise that external audit had concluded the VFM audit and the committee were advised there were no matters of concern. All audit certificates were due to be issued in the next few weeks. She thanked the Finance Team and those involved in ensuring that audits were completed within the timeframes.

Mrs G Hunjan then noted that the committee had endorsed the BAF and the proposed terms of reference for the Audit Committee.

Finally, Mrs G Hunjan advised that the Trust would be going out to tender for internal audit and counter fraud services as the current contract was due to expire in 2022. She advised that she and Mr D Tomlinson would be finalising the process, and the information would be shared with the Audit Committee members.

The Board

- Received and noted the content of the report.
- Reviewed and approved the Terms of Reference of the committee with a minor amendment to be explicit that *all the committee chairs were members of the Audit Committee*.
- Noted that the annual accounts would not be able to be laid before Parliament until later in the year, due to the national arrangement of the VFM, and therefore the AGM cannot be held any earlier than September 2021.

16. CHARITABLE FUNDS COMMITTEE CHAIR REPORT

Dr L Cullen provided a brief overview of the report. She provided feedback on the Committee and in terms of fundraising which has been really positive despite the pandemic and there had also been a lot of voluntary interest. There have been a lot of opportunities with regards to increasing the profile of the charity and working in partnership about mental health in communities, and the main discussion in particular was about the upcoming Commonwealth Games due to be held Birmingham in 2022 with the increase public awareness of mental health issues.

She advised that the charities' funds were stable and positive and the investments were making a good return and more importantly being invested ethically. Most of the funds have been from the membership of NHS Charities Together which had been developed by 'Sir Tom' during the pandemic. The focus of the meeting was on the future of the charity and investing and considered review that had been commissioned with the help of our partner charities. A member of staff within the Trust had done an excellent piece of work over the last few months meeting and hoping to bring a paper in September to consider our strategy in Caring Minds and if we want to invest to take the charity forward.

The Board

- Noted the content of the report.

17. BOARD ASSURANCE FRAMEWORK (BAF)

Mr A Hughes and colleagues, ANHH Consultancy joined the meeting.

The Chair welcomed Mr A Hughes and colleagues to the meeting and offered thanks for all their support. Mr A Hughes advised the BAF had been presented to the committees over the last few weeks and that there had been a process over several months and the Board were asked to consider the recommendations in the final section of the report.

He pointed out that the BAF was now a live document and would sit with the Company Secretariat. The new BAF reflected the Trust strategy, and the committees were aware of their respective roles against the risks included within the BAF.

The Chair highlighted some issues with the conversion of committee reports into the final paper which would require correction, but which did not detract from the work that had been undertaken.

Mr D Tomlinson reiterated for completeness that it had been agreed there was not a proposal to change the committee names at this stage which would need to be reflected as part of the BAF.

The Chair commented that she had made comments on the paper in terms of the controls and assurance and examples of the BAF, which does not need to be discussed in detail by the Board and does not take away the Board's ability to approve at this point as the BAF would be constantly amended and updated.

The Board

- Agreed that the proposal to change the committee titles would be deferred.
- Noted the content of the report.
- Approved the recommendations detailed within the report.

18. REACH OUT GOVERNANCE

The Board were provided an overview of the report which was seeking approval and a note of understanding the work programme for the next three months.

Mr D Tomlinson advised the proposed governance arrangements had been considered and endorsed by the committees. They would be kept under review with consideration to moving to a simplified version in time with the new committee reporting directly to the board rather than via IQC and FPP. He noted that the Trust would become the lead provider in the collaborative and distinguished between decision forming, decision making, assurance and decision taking as described within the framework. He noted one of the main concerns of NHSE remains around Learning Disability and Autism. He concluded that the final business case would come to board for final approval in September 2021 following approval by other organisations.

Mrs R Fallon-Williams thanked all involved in the work that had been undertaken and noted that the meeting with NHSE and the national team had demonstrated all the hard work.

Ms S Bloomfield recommended that IQC were kept appraised of the risks and the benefits but, at the moment would not anticipate any major concerns at the stage of final implementation.

Mr D Tomlinson summarised the risk and benefits share proposed for the adult secure component. The proposal is to move from the current arrangement that the Trust shares 56% of both risk and gain to 59%. The Midlands Partnership increases by about 1% which off sets a reduction with St Andrews. The impact of this for the Trust is approximately £18,000 and significant mitigation is in place. The Programme Board had endorsed this approach in principle and the Board was asked to approve it.

The Board

- Noted the content of the report in particular the endorsement by IQC and FPP in July 2021.
- Noted the understanding of the work programme for the next three months.
- Approved the governance principles to underpin the PC governance architecture.
- To receive a further update in September 2021.
- Approved the risk and benefit share as described by Mr D Tomlinson.

Mr A Hughes and colleagues ANHH Consultancy left the meeting at this stage.

19. BSOL MENTAL HEALTH PROVIDER COLLABORATIVE

Mr P Nyarumbu presented a report of the proposed approach to integration and collaboration within our system seeking approval of the proposals noted in the content of the report.

He advised that this work was in collaboration with Birmingham Women's and Children's Hospital and BSol CCG to develop the case for change. He noted the key proposals outlined for the next phase of the development of specific workstreams focussing on quality safety and outcomes, people, coaching and leadership, finance and contracting and transformation programmes. He reported that the BSol collaborative board was now in place and the associated governance within that.

Mrs R Fallon-Williams commented upon the quality of the consideration, reflection and involvement of so many people and was a fabulous piece of work which demonstrates how well the provider collaborative around mental health in Birmingham and Solihull could work.

The Chair highlighted the importance on the respect and how the voluntary sector was treated and asked the Board to consider and further reflect. Mr P Nyarumbu confirmed that this would be considered.

In response to a query from Mr W Saleem about the capability and capacity taking into consideration COVID and other provider collaborative, Mr P Nyarumbu provided assurance regarding this.

The Board

- Noted the contents of the report.
- Approved the guiding principles, commitments and next steps of each of the proposed workstreams.

- Approved the mandate of the Programme Board to oversee phase 3 of the programme in line with timeframes.

20. QUESTIONS FROM GOVERNORS AND PUBLIC

No questions for the Board were received from the Governors and public.

21. ANY OTHER BUSINESS

None raised.

3. Matters Arising/Action Log

4. Chair’s Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	29 September 2021
Author	Danielle Oum, Chair
Executive sponsor	Danielle Oum, 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. It has been a busy period, and I will limit this report to focus on just a few aspects of activity.

2. CLINICAL SERVICES

2.1 I am excited to have the opportunity to attend the Tamarind Centre next week to see the Elders project and meet staff from across the wards. Avoiding unnecessarily increasing infection risks was the right thing to do during the pandemic. However engaging with service users and colleagues is an important aspect of our role as Board members and so it is good that we are now able to restart Board member service visits, albeit on a smaller scale than envisioned.

3. PEOPLE

3.1 I enjoyed meeting Byron Currie, Deputy Director of People and Organisational Development, and understand his priorities for making sure basic HR functions are top notch, meeting the needs of customers (our staff):

- Strengthening the HR Business partner model
- Strengthening the capacity of clinical and operational leads to organisational culture
- Improving our ESR
- Embedding justice – so staff are treated fairly and feel confident
- Supporting equalities agenda so that all staff have a good experience

3.2 I was pleased to have my monthly meeting with Shane Bray, Managing Director of SSL, and gain a greater oversight of current developments and projects.

4. QUALITY

4.1 I was pleased to be able to meet with Anne Utley from NHS Provider who has agreed to support the Board development proposals over the coming months.

4.2 Participating in the Reducing Restrictive Collaborative session I was struck by the impact restrictive practice can have upon colleagues as well as patients. I was pleased to see the range of work underway to reduce levels of restraint and seclusion. It was also concerning to see the levels of inequalities in the application of restrictive practice and I look forward to the next planned session which will

focus on this.

4.3 I was glad to join a Schwartz Round and hear colleagues reflect on their experience of handling difficult situations.

5. SUSTAINABILITY

5.1 I was pleased to Chair the Old Age Consultant Psychiatrist interview panels and make an offer of appointment.

5.2 I met with Anne Utley from NHS Provider who has agreed to support the Board development proposals over the coming months

5.3 I attended the BSoL ICS Transition Committee to discuss the programmes of work underway to drive the system collaboration that will inform the commissioning and delivery of services across BSol.

6. COUNCIL OF GOVERNORS

6.1 Senior Independent Director
The Council received and approved the proposal for the appointment of the Senior Independent Director.

DANIELLE OUM
CHAIR

5. Chief Executive’s Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE'S REPORT**
Date	29 September 2021
Author	Roisin Fallon-Williams
Executive sponsor	Roisin Fallon Williams

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

Executive summary

My report to the Board this month provides context of the on going pandemic, the resultant pressures and challenges and our response to these. It also provides information on focused work 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'S REPORT

1. CURRENT PANDEMIC SITUATION

There are 3 confirmed positive patient cases, one on Tamarind (Myrtle) and 2 on Juniper (Sage). There are no suspected patient cases.
There are currently 310 (7.6%) staff off sick at present, with 97 Covid-19 related (2.3% of staff in total, 31% of staff sickne).

2. PEOPLE & ORGANISATIONAL DEVELOPMENT

Mandatory Vaccinations in Care Homes
The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 (the Regulations) were made on 22 July 2021 and will come into force on 11 November 2021. The Regulations require all persons working or deployed in a CQC registered care home (which provides accommodation together with nursing or personal care) in England to be fully vaccinated.

Two staff consultation meeting were held with affected colleagues and included consultation with Staff Side colleagues to advise individuals of the regulations and how this relates to their roles. Colleagues were also subsequently advised in writing of the temporary medical exemptions for COVID-19 vaccination for people working / deployed in care homes.

The Trust has reported the following data to the ICS:

How many staff in your organisation are covered by this legislation change?	Of those covered by this legislation change, how many are already fully Covid vaccinated?	Of those covered by this legislation change, how many have had a single Covid vaccine dose?	Of those covered by this legislation change, how many have had no Covid vaccine dose?
524	444	403	80

Further discussions and actions will take place with Clinical Leads and colleagues who have not had any vaccination to date, in line with the Action Plan previously agreed, to support individuals who will not be able to work in care home settings.

Staffing Levels
The vacancy rate decreased to 9.8% in August from 10% in July and is above the KPI target of 6.0%. Vacancy rates have fluctuated over the last 12 months with an overall increase in vacancies since April 2020 when vacancies stood at 7.8%.
There has been a 2% increase in vacancy rates between April and July, partially due to changes in the number of FTE budgeted posts following validation undertaken between the Finance system and ESR; additionally, the Long-Term Plan growth has also impacted on our vacancy factor. An additional 70 were added to our establishment over this period. August saw the first decrease in vacancy rate this financial year.
The People Committee has received updates on our new programmes of work associated with this and assurance on those already in train.
Whilst we have stood down the staffing huddles from daily we. Have retained these on a twice weekly basis to support safe staffing, workforce movements and additional

actions to enable safe service delivery

Anchor Employers Pledge - Entry Level Roles

The ICS People Board have identified an ambition to support more local unemployed people to access ICS wide jobs and have committed to initially contribute at least 100 jobs per annum for the next three years to be filled through the programme.
The target population will be unemployed people who live in wards where the claimant count rate is above the West Midlands Combined Authority (WMCA) area average rate.

The project will work proactively with relevant local authority teams and the voluntary and community sector to target communication and engagement activity aimed at engaging specific groups, for example:

a) Young people
b) Care Leavers
c) Ex-Offenders

This work is being undertaken. In conjunction with the ICSs Health Inequalities Board.

The initial approach will be to focus communication and engagement activity within priority areas and groups but not to exclude unemployed people from other areas of Birmingham and Solihull from applying. This approach will be reviewed as the programme progresses and in light of any future changes in labour market behaviour.

3. EQUALITY DIVERSITY and INCLUSION

The EDI function has been focussed on finalising its proposals in developing a programme of activity in becoming an anti-racist organisation and how we bring parity to workforce and health inequalities in our consideration. The proposal will include the Trusts current Workforce Race Equality Standard position, Workforce Disability standard position and the Gender Pay Gap.

We are currently planning our refreshed approach to Equality Impact assessments with support from regional partners.

In exploring the parity of service user and colleague experience we are scoping how and where the Patient and Carer Race Equality Framework intersects the workforce portfolio and how this connects with our Synergi Pledge, working on making those connections explicit.

Responsively we have facilitated a volunteers working group in response to the Afghan Refugee crisis, looking at how we can collectively better support and equip our staff and communities, this group meets monthly and will feed into OMT.

Since launching the Recruitment guidance earlier this year we have received feedback which we are now integrating into the guidance to enhance clarity and purpose.

In relation to our networks, the Allies group is being supported in exploring its purpose and approach with potential input from University West of England. Planning has

commenced for Black History Month which promotes the Theme of Proud to Be. The LGBT+ Network are being supported with the organisations Stonewall submission.

The Board will receive a paper at our November meeting setting out in more detail our work on EDI and Health Inequalities and our propped approach and areas of priority.

4. CLINICAL SERVICES

Secure Care and Offender Health

We are delighted to announce that we have two new ward managers at Reaside and Hillis Lodge who have taken up their posts this month.

An exceptionally good friends and family day has taken place at Tamarind with the theme of seeing each other again. Over 40 relatives attended with games, activities, a cocktail bar, and ice cream station.

On our Ardenleigh site, our Secure CAMHS service held a 'Prom' event which was really welcomed by our young people who gave great feedback about the event.

Acute and Urgent Care

The ensuite and bedroom door upgrade and replacement programme continues across acute care and is on track to deliver as forecast.

Work continues on the crisis transformation programme, the Birmingham Integrated Map is being used across the system and four system wide workshops have been arranged to support more organisations to take part in the pilot.
The crisis house specification documentation has now been completed for the crisis house procurement and is awaiting final executive sign off before procurement commences.

The Head of Nursing and AHP role has now commenced across Acute and Urgent Care, the role will support an improved focus on quality across the directorate, and a quality improvement programme is in development.

The numbers of S136's have increased significantly over the last two months, whilst the number of service users requiring a bed following S136 has decreased to below 35%. This increased use of S136 by the police is having a significant impact on the wider health system. A system wide meeting is being scheduled to take place in early October to look at this further.

Works continue to take place on the Urgent Care Centre. An early walk around has taken place to support with the operationalisation of the scheme. The MOU has now been completed between ourselves and Forward Thinking Birmingham (FTB) and is awaiting formal sign off. The building works remain on schedule with the building being handed over by the end of November.

Specialties

Acuity and demand levels continue. The Memory Assessment Service waiting list remains a concern, however as part of our recovery planning there is work internally and regionally to review pathways for dementia diagnosis and how best use can be

made of available resources.

As part of system wide integration of mental and physical health this month's communication of 'EI matters' which is circulated through the Early Intervention programme of the Birmingham Integrated care Partnership (BICP) features mental health and our ongoing work within EI. EI Matters- September 2021.pdf

Our recently established Increasing Access to Psychological therapies (IAPT) forum has agreed a work plan to promote a system partnership approach to enhance pathways and manage demand and capacity for IAPT Services.

Our Adult Eating Disorders service is part of the eating disorders provider collaborative. We are delighted that the collaborative has been shortlisted for the HSJ collaborative of the year award. Thanks are extended to all our Team BSMHFT colleagues and partners, who have contributed to this innovative work.

Integrated Community Care & Recovery (ICCR)
Teams continue to manage effectively through the current covid regimes, Steps 2 Recovery (S2R) Teams have struggled with covering all absences covid and non covid related however the Matrons, Team Managers and Clinical Service Manager have worked together with daily staffing meetings to redeploy staff to ensure services are as safe as is possible.

Implementation of the community transformation is now well under way with the transformation lead now in post. Posts continue to be advertised to support the development of the primary care, mental health service as well as new posts to Community Mental Health Teams (south initially) to bolster our complex Serious Mental health offer.

CQC (Care Quality commission) reports have been received for two of our S2R wards, overall, they have had very positive feedback. The team have worked on a response for the CQC for the areas of feedback that require attention.

Teams are being supported to utilise more frequently and consistently the unacceptable behaviour policy to ensure that on the occasions that colleagues are subject to abusive behaviour from our service users has consistent approach. All team are being requested to ensure all instances are entered on our eclipse system to enable the ICCR team to offer support to individuals personally and ensure the policy is applied.

5. QUALITY

Vaccination
The Covid vaccination continues to be available for colleagues to access as a first and second dose. We are now putting. In place plans for the COVID Booster across the Trust.

Flu
Flu vaccine clinics will commence within the trust on the 4th October.

6. SUSTAINABILITY

The Board will receive later in the meeting our financial report that will highlight the current financial position.

7. OTHER MATTERS

Amanda Pritchard appointed NHS Chief Executive
Amanda Pritchard has been appointed as the new Chief Executive Officer of NHS England.
She is the first woman in the health service's history to hold the post, which she will took up on Sunday August 1.

ICS guidance
Latest national update
Following the second reading of the Health and Care Bill in the House of Commons there has been a parliamentary recess. The Bill is still on course to pass into law by April 2022, with the committee stage expected in September 2021.
NHS England and NHS Improvement (NHSEI) has published new guidance on provider collaboratives, setting out expectations for how trusts should work together at scale within integrated care systems.
The guidance places an emphasis on providers' role in driving transformation and recovery within local health and care systems, following the success of mutual aid and other collaborative working arrangements before and during the COVID-19 response.
This guidance outlines minimum expectations for how providers should work together in provider collaboratives, offering principles to support local decision-making and suggesting the function and form that systems and providers may wish to consider.
The guidance offers flexibility for providers to lead the development of collaborative arrangements, including their membership and shared goals.

ICS constitution development - work continues in this area, with the iterative process for the development of the constitution needing to be completed in quarter 3 (Oct – Dec 21) 2021-22, ahead of submission for approval in quarter 4 (Jan – Mar 22). A detailed plan is currently in development.

8. NATIONAL ISSUES

NHS Provider The long-term need for continued government investment for mental health services
In the coming weeks, the chancellor will set out his spending plans for the next three years in the comprehensive spending review. We all know the public purse is under more pressure than ever before and that every part of the public sector has legitimate claims in light of the pandemic. In his decisions on mental health the chancellor has a real opportunity to build on investments to date which, despite the enduring care deficit in mental health, had started to improve services and experiences for mental health patients, and expand access. Mental health providers are not only expanding what they do, they are also making a wider contribution than ever before.

We need critical capital investment if we are to tackle the most immediate challenges facing the mental health estate. We need significantly more funding to recruit enough staff with the right skills. We need community services to be expanded to avoid

inpatient admissions and more beds to bring care closer to home. And we need extra investment to tackle the ever-growing backlog of care caused by the pandemic.

New briefing: the Case for Capital Funding

The government has announced that the NHS in England will be given an extra £500m of capital funding over the next six months for increased theatre capacity and technology, to support elective recovery. Other investments made over the past 18 months demonstrate a welcome acknowledgement from ministers that NHS facilities need investment.

For the full briefing please follow the link:

rebuilding-our-nhs.pdf (nhsproviders.org)

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Board Overview: Trust Values

QUALITY

7. Integrated Quality Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7**
Paper title	**INTEGRATED QUALITY COMMITTEE CHAIR REPORT**
Date	13 August 2021
Author	Linda Cullen, Chair of IQC
Board sponsor	Linda Cullen, Chair of IQC

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

Executive summary
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. Quality
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

REPORT FROM THE IQC COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

1.1 CQC Section 31 Improvement Plan Progress Report

The Executive Director of Quality and Safety (Chief Nurse) presented the report on the latest submission to the Care Quality Commission as part of our section 31 monitoring regime. She added The CQC have confirmed that we have now been 'de-escalated' from weekly monitoring. Monthly reporting will however continue for the foreseeable future.
The Committee were assured the overall position remains positive with continued audits and safety huddles in place.

The Executive Director of Quality and Safety (Chief Nurse) confirmed the Clinical Educator roles are being appointed too.

Chair's assurance comments:
Steady progress is being made within the key areas of relational and procedural security as well as the prioritisation of certain wards for alarm installation It was good to hear that CQC are also satisfied with our progress and have moved us to monthly reporting .
We will, however continue to keep a close focus on these areas especially in respect of minimum MDT standards and local team ownership and recognition of importance of these patient care and safety approaches .
The clinical educators' roles are an important investment in achieving our aims of continually improving staff and team understanding and learning of what good patient care should be like alongside learning from our service users

1.2 Responding to COVID -19

The Executive Director of Quality and Safety (Chief Nurse) confirmed there is a defined outbreak on Sage ward with three service use a- symptomatic. All are now testing negative, no concerns were raised.

The Committee were informed of small numbers of staff testing positive across the wards noting incidents remain low.

There was a detailed discussion regarding the guidance relating to isolating and the impact this could have on staff attending work.
The Executive Director of Quality and Safety (Chief Nurse) confirmed there are wider discussions taking place locally to agree adapting the guidelines to maintain safe risks. The committee highlighted the importance of equalities and need to consider the impact on populations trust wide.

Chair's assurance comments:

The committee was assured that staffing requirements continue to be actively managed during the ongoing pandemic by various measures such as the grand huddles and moving staff to areas of higher clinical need ,ongoing testing and supporting staff vaccination uptake.

1.3 SI Escalation

The Committee were appraised of a cluster of deaths at Reservoir Court including two inpatient deaths and one whilst on section 17 leave. The committee were assured processes are being followed with a rapid review on physical health and inpatient units being completed, the findings will be presented within next month's report.

Both the Executive Director of Quality and Safety (Chief Nurse) and Medical Director confirmed they are completing multi- disciplinary monitoring together including CPD, MDT, Clinical Service Strategy, and physical health as a priority.

Chair's assurance comments:
It will be useful to review the findings of the assessment of physical health procedures and approaches on the inpatient units at the next meeting in the light of the cluster of deaths we have had recently . It is well known that patients with severe and enduring mental illness have significant comorbid health conditions as well as shortened life expectancy compared to those without long term mental illness.
It was also encouraging to see a continued emphasis on effective multidisciplinary working and continuing professional development to support up to date and effective and safe practices

1.4 Learning from Deaths Quarterly Report

The Committee received the report and noted there will be a themed review into absconsions to ensure all risks are considered and monitored appropriately going forward. The Medical Director confirmed the Committee will maintain oversight.

The Medical Director confirmed the format of the report is being reviewed and will be updated for next month's meeting to ensure the baseline and progress is highlighted. The need to triangulate the data will be incorporated.

There was a detailed discussion regarding the need to reinstate clinical visits and it was agreed the process for Executive Directors, Non-Executive Directors ad Governors will be reviewed.

Chair's assurance comments: It will be important to conduct a comprehensive thematic review of absconsions to gain a greater understanding of the factors linked to these from a staff and ward as well as patient perspective . It will also be useful to include the learning from reg 28 reports from other trusts where death has occurred whilst patients have absconded from inpatient care settings.
I look forward to seeing the new format of reports at the next meeting which I anticipate will help us to see baseline data and then allow us to see progress and trends and variations from these as well as being able to compare and triangulate with other linked data
We also had an important discussion and about the benefits and risks of restarting clinical site visits and the importance of such visits in gaining assurance as well as visibility of senior leadership within the organisation .

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**7.1**
Paper title	**Chair's Assurance Report from the Integrated Quality Committee**
Date	29 September 2021
Author	Dr L Cullen - Non-Executive Director and Chair of Committee
Executive sponsor	Mrs S Bloomfield – Executive Director of Quality and Safety (Chief Nurse)

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

Executive summary
The IQC met on 22 September. The attached Assurance Report is provided by the Committee Chair for the attention of the Trust Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's IQC Agenda and to escalate any key issues to the Board.
Strategic objectives
Quality
Financial implications
None specific.
Risks
None specific.
Equality impact
None specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM IQC

1. ISSUES TO HIGHLIGHT TO THE BOARD

IQC met on 22 September 2021. Neither the Medical Director nor Chief Nurse were present, which meant that based on the established Committee Membership, the meeting was not quorate. The Committee Chair decided, however, that with the Chief Executive, Executive Director of Operations and Executive Director of Finance in attendance, there was still value in meeting, with the recognition that no votes could take place.

A summary of the key discussions is detailed below:

1.1 CQC Section 31 Improvement Plan Report

There is a monthly submission to CQC in terms of updates to this plan. The Physical Environment action plan has been updated to incorporate the programme for the installation of the bedroom doors alarm system in the prioritised wards. At a meeting on 6th September, updates were taken positively.

Reference guides and elearning have been developed to support staff around care planning. Key roles have been recruited to.

There is a delay in action to the closure of 2 beds on Reservoir Court, however, all actions within the physical environment action plan currently remain on track for completion. One bed has been closed on Reservoir Court but the other one will not be closed until the end of September.

Key stakeholders from each of the four operational service areas are developing a long-term 3 to 5 anti-ligature capital programme. This is now at the point where submissions have been received from directorates, working closely with estates.

Chair's assurance comments:
The Committee took significant assurance on physical environment and care planning and the agreed action plans in response to the Section 31 Notification.

1.2 Preparation for CQC Well-Led Inspection

The Trust is expecting a return visit from the CQC for a Trust wide inspection before the end of the financial year. It will include a range of core services as well as a Well-Led Review.

Whilst preparations for this inspection will be led by the directorate of quality and safety, this should be viewed as a whole Trust effort and staff operationally and corporately are expected to be on board to prepare.

The inspection will focus on the Trust's systems and processes of governance. This therefore requires the Trust to focus its preparations in two ways; to support services to prepare for the requirements of core service inspection and to prepare the board and senior leads for the well led element

Chair's assurance comments:
The Committee was reassured by confirmation that supporting developmental sessions for Board members will be put in place in terms of the Well-led element.

The Committee was assured that a communications strategy is being developed to inform staff of the process and that considerations are being made to review resources required in the run-up period to support the process and develop plans.

1.3 Responding to COVID

The Committee received a verbal update from the CEO in the absence of the Chief Nurse. Responses are as discussed in August. A Silver Level meeting has taken place and things have stabilised to a degree.

Chair's assurance comments:

The Committee was reassured that plans are in place to step down non essential services when required but currently pressure has eased.

1.4 SI Escalation

In the absence of the Chief Nurse, it was agreed that details will be circulated via email.

1.5 Integrated Performance Report including Quality Metrics

New quality goals have been adopted by the Integrated Quality Committee. Their introduction into the dashboard is under discussion. New sets of metrics are also being finalised for the other domains following approval of the Trust Strategy and will involve some transition.

New reporting cycles will be in place as previously agreed by the Board from January 2022.

Chair's assurance comments:

The IPR provided a significant data set that generated several questions on Convene. The Committee was reassured by the discussion that followed.

The Committee supported the proposal to develop the KPIs further and was assured by the process that has been followed and that a detailed plan with potential outcomes will be produced.

1.6 People Participation Experience and Recovery (PEAR) Presentation

Dr K Allen joined the meeting for this item. Participation and involvement are a significant thread of the Trust strategy. The Trust is required to meet the CQC's Well-Led Key Line of Enquiry into whether people who use services, those close to them and their representatives are actively engaged and involved in decision making to shape services and culture.

The approach taken has been to look at participation on a rights based model, incorporating the duty to provide opportunity for service users and their carers to become involved in a way that suits them.

Chair's assurance comments:

The Committee was assured by the approach to EBE, RA, the Family and Carer Strategy, the transformation of community mental health services, Peer support, and the draft EBE Reward and Recognition Policy.

The Committee was heartened to learn that Support Workers have been awarded a National Services Choice Award for breaking barriers.

1.7 Readiness to Proceed Assessment – Reach Out

1.8 Chair's Assurance Report from the Reach Out Commissioning Sub-Committee

Dr J Kenney- Herbert joined the meeting for these items. The Committee received the Readiness to Proceed Assessment, which had been significantly developed since it was last presented.

The Committee also received the Assurance Report from Reach out Commissioning subcommittee and noted that the Sub-Committee had reviewed the readiness in significant detail and that the recommendation was to go live.

Chair's assurance comments:
The Committee was significantly assured by the due diligence that had been undertaken regarding the quality and safety implications of the Reach Out Provider Collaborative. It was recognised that the state of readiness reflected a great deal of work by the Reach Out team. The Committee agreed to recommend to the Board of Directors that the devolution should go live on 1st October.

PEOPLE

8. People Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**8**
Paper title	**PEOPLE COMMITTEE**
Date	18 August 2021
Author	Phil Gayle
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, people and Partnerships

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

Executive summary
To provide the Board with an update relating to the people committee.

Reason for consideration
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. 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

ISSUES TO RAISE WITH THE BOARD

The People Committee met on 18 August 2021 and an exception report has been developed to update the Board.

This was a focused one-hour meeting. The committee would like to bring the following areas of discussion to the attention of the Board:

1 SHAPING THE FUTURE WORKFORCE

1.1 Shaping Our Future Workforce Sub group

The committee received any update from the subgroup. The People Strategic Priorities Implementation Plan has been reviewed and updated during w/c 9th August 2021. For actions which are under Shaping The Future Workforce section, out of the 43 actions, 2 actions have been completed, 26 actions were being progressed and the remaining 15 actions were not yet being progressed.

As part of the monthly Workforce KPI Dashboard circulation. The areas discussed included Bank and Agency Fill Rates, Turnover, Fundamental Training and Appraisals.

An update was received on two key areas. The Emergency Response Belt is up for review and the improved governance processes will be written into the policy and it was also greed that this training will be made mandatory. It was confirmed that going forward all mandatory training will be reviewed on an annual basis.

We were advised that further work is still being done to finalize the remote working policy. Staff Side highlighted that NHS guidance have been issued which come into effect on 13th September 2021, and staff will be able to make an unlimited number of applications for flexible working

An area of concerns was additional funding from the Trust to support more apprentice level/type roles (not levy).

The Trust is awaiting CCG sign off on several Workforce Plans. CCG authorisation will enable the Trust to recruit to associated vacancies. The Trust Finance Department is working this through, and an update will be provided to the People Committee in September 2021.

Chairs Reflections
The committee received the report and feedback on progress. The Committee were assured that the data and information presented did not raise any concerns or matters to bring to the Board attention.

2. TRANSFORMING OUR CULTURE AND STAFF EXPERIENCE

2.1 Workforce Partnerships update

The committee received an update on the current partnership workstreams namely:

- Staff Survey
- Policies
- Workstreams

The highlights included The People Strategic Priorities Implementation Plan has been reviewed and updated reflecting the period up to 30th July 2021. As there has been a very short period

between last reporting sizable updates are limited however progress continues. For actions which are under Transforming Our Culture and Staff Experience section, out of the 36 actions, 2 actions had already been completed (Ensure the Trust Behavioural Framework incorporates Just and Learning principles; Appoint a Wellbeing Guardian), 31 actions were being progressed and the remaining 3 actions were not yet being progressed. Of the 3 items not progressed 1 is not due until March 2022. The other 2 actions (relating to staff from minority ethnic backgrounds accessing senior roles, and also the introduction of carer passports) will be started by September but are within the due dates, the delays have been due to staffing shortages.

The newly appointed Chair of the Transforming Our Culture and Staff Experience sub-Committee stated that she would work with the Chair of the Shaping Our Future Workforce Sub Committee to ensure that both sub committees are aligned.

Chair's reflection

The Committee were assured on the progress made to date although we recognised the time period from the last meeting was quite tight in relation to the current data received. There were no significant points for escalation to the Board.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**8.1**
Paper title	**Chair's Assurance Report from the People Committee**
Date	29 September 2021
Author	Mr P Gayle - Non-Executive Director and Chair of Committee
Executive sponsor	Mr P Nyarumbu – Executive Director of Strategy, People and Partnerships

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

Executive summary
The People Committee met on 22 September. The attached Assurance Report is provided by the Committee Chair for the attention of the Trust 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.
Strategic objectives
People
Financial implications
None specific.
Risks
None specific.
Equality impact
None specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

The People Committee met on 22 September 2021 with a summary of the key applauded

1.1 Report from the Shaping our Future Sub-Group

The Sub-Group met on 14 September 2021. As a relatively recent forum it is still developing its method of operation.

The Sub-Group reviewed and updated the Five Year People Strategic Priorities Implementation Plan and confirmed that of the 43 actions, 2 have been completed, 26 are being progressed and 15 are not yet being progressed.

The Sub-Group continues to identify the most appropriate people KPI's which demonstrate that:

- Vacancies have reduced from 10.1% in July to 8.1% in August.
- Total sickness absence has reduced for 6.6% to 6,1% between July and August 2021.
- Return to Work interview completions have increased from 58.4 to 63%.
- The percentage of shifts filled by agency staff reduced from 9% to 7.4% within the period.
- The total number of shifts filled by bank staff increased from 14,700 to 16,000 during the period.
- Nursing vacancies have increased from 18.3% to 18.8% during the period. Work is underway to explore international recruitment capacity within the Trust and also work with system partners to develop different roles

The Sub-Group continues to co-ordinate the development of a Band 2-4 Staff Charter, which will make commitments to staff and be complete in October 2021.

The Learning and Development Team is creating an on-line induction programme, which will be completed in October 2021.

Chair's assurance comments:
The Committee applauded the work that had started and was assured that the key issues are being addressed. The Committee noted that the full scale of challenges is becoming clearer, including the level of temporary staff and the challenge of continuity of high-quality care, and attracting people to work in the Trust and city.

1.2 Transforming our Culture and Staff Experience Sub-Group

The Sub-Group met on 16 September 2021.

To support delivery of the People Strategic Priorities Implementation Plan the Sub-Group will be reviewing its Terms of Reference and establishing a progress report as a standing item on its Agenda.

The Sub-Group reported that anxiety, stress and depression remained the highest reason for sickness absence. Further work is being undertaken to identify any EDI or cultural trends.

The Band 5 nurse vacancy rate is at 34%, and feedback has highlighted feelings of lack of support and isolation in the workplace. The People Committee suggested that the Charter be extended to Band 5.

The Sub-Group approved the Corporate Training Induction Policy, the Dignity at Work Policy, and the Disciplinary Policy. Task and Finish Groups have been established to review the impact of the policies and to monitor their implementation.

The People Committee noted that the latest NHS People Pulse Survey results have seen a concerning reduction and negative shift compared to the NHS average. Long-term fatigue and concerns about quality of care are major things. The Committee noted that flexible working practices are an important consideration for staff.

Chair's assurance comments:

The Committee was reassured to learn that a communications piece of work is underway addressed to all staff and service users to reiterate the pressures on staff and the longer waiting times, following the Staff Survey.

The Committee supported the suggestion that the leadership team should be united behind the organisation on its cultural journey.

The Committee was reassured and encouraged to learn that a provider has been identified to deliver a senior leaders programme.

1.3 Safer Staffing Report

The Committee received the Safer Staffing Fill Rate Report for August 2021. The Deputy Director of Nursing reported that an escalation process has been established, which has resulted in a much more consistent approach.

Staffing huddles are now in place, which are proving a very productive process. The first range of staffing establishment reviews have started, using a clinical judgement tool. Further training is required to confirm the governance process for escalation.

Chair's assurance comments:

The Committee was encouraged to learn that the staffing huddles are working as they were introduced in response to some quality and safety concerns.

The Committee agreed that People Committee and IQC should work together over next 2 months to create a piece of triangulated evidence to understand the link between temporary staffing and costs.

The Committee was not fully assured by the level of information provided by the report and asked for this to be improved and the gaps in assurance be filled.

1.4 Disciplinary Policy

The Trust has developed a new Disciplinary Policy in line with recent NHSE/I guidance. The policy was received by the Transforming our Culture and Staff Experience Sub-Group and also approved for Board ratification by the People Committee. The Disciplinary Policy is attached to this paper for ratification by the Board and agreement to publish on the Trust website. A task and finish group will take responsibility for monitoring and reviewing the impact of the policy and to monitor its implementation.

Chair's assurance comments:

The Committee was assured that the policy had been developed through a rigorous process of co-production and engagement, and that it now fully reflected

the requirements of the guidance.

The Committee agreed to recommend its ratification by the Board.

1.5 KPI's and Integrated Performance Dashboard

The Deputy Director of Finance presented the emerging integrated performance report and dashboard. The report aimed to provide assurance on delivery of people KPI's, aligned to the shaping of our future workforce and transforming our culture and staff experience.

The Committee noted that there are financial implications linked to some of the performance, e.g., temporary staffing to cover vacancy rates and turnover, and sickness absence.

Chair's assurance comments:

The Committee was grateful to receive information in both graphic and narrative form and felt that this added to the level of assurance.

The dashboard remains a work in progress, but the Committee was increasingly confident of the information that was provided.

2.0 Recommendations

The Board is asked to:

- Note the contents of the report
- Agree to ratification of the disciplinary policy and publication on Trust website

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Birmingham and Solihull Mental Health NHS Foundation Trust

DISCIPLINARY POLICY

Policy number & Category:	**HR01**	**Human Resources**
Version Number & Date:	**9.1**	**Sept 2021**
Ratifying Committee:	**Transforming our Culture & Staff Experience Sub Committee**	
Date Ratified:		
Next anticipated Review:		
Executive Director	**Executive Director of Strategy, People and Partnerships**	
Policy Lead	**Head of People & Culture**	
POLICY AUTHOR *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT:

This policy outlines the approach to be taken by Birmingham & Solihull Mental Health NHS Foundation Trust (here in after referred to as the Trust), when dealing with incidents and matters of alleged misconduct and to identify the most appropriate way of dealing with such matters, so that we encourage improvement and learn lessons.

The policy provides clarification of the considerations which managers should give to an event and, if appropriate, what processes and employee's rights are applicable when dealing with such matters, to ensure matters are dealt with fairly and consistently and in a supportive manner.

This policy will apply to all Trust employees in respect of potential matters of misconduct, including medical employees.

POLICY REQUIREMENT: (see Section 2)

This policy outlines the procedures that must be followed to ensure that misconduct matters are dealt with in a fair and transparent way and provides practical guidance.

This policy:

- outlines the informal and formal procedure to be followed in respect of alleged misconduct
- outlines 'Just Culture' approach to Suspensions, Restrictions and Exclusion (Medical Staff)
- details disciplinary sanctions that can be applied and their duration
- makes clear the responsibilities of all employees in respect of this policy
- tell employees how to appeal a decision.

Contents Page

1. Introduction

1.1 Rationale (why)

Birmingham & Solihull Mental Health NHS Foundation Trust (here in after referred to as the Trust), requires high standards of professional behaviours/conduct from everyone and is committed to helping people improve and learn from mistakes. This policy is designed to ensure a fair, systematic and consistent approach is taken when an employee's behaviour or action is considered to be in breach of workplace rules or falls short of the expected standards.

We believe that it is important that we have a 'just culture' of openness, trust, learning and accountability. A culture where we learn from things that go wrong and where we have the confidence to raise concerns and report in a psychological safe space. When things go wrong, it is important that we consider how we respond to colleagues involved in the incident and how we minimise the negative impact and maximise learning by enabling a culture that instinctively asks: "what was responsible, not who is responsible". There will of course be situations where we must hold people accountable for undesirable conduct or performance and where formal action in line with this policy will be appropriate.

The policy provides clarification of the considerations which managers should give to an event and, if appropriate, what processes and employee's rights are applicable when dealing with such matters, to ensure matters are dealt with fairly and consistently and in a supportive manner.

An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are truly grounds for a formal investigation and/or for formal action. Would training for the employee, support, guidance or informal management be more appropriate and productive?

Where an employee's ability to do their job is affected by a lack of skill or knowledge, or ill health, this will be managed by following the Working Better Together Capability Process.

The policy has been developed taking into consideration the Advisory Consolidation Arbitration Services (ACAS) Code of Practice on disciplinary procedures and the Guide on Discipline and Grievances at Work. As well as taking into consideration good practice, NHS England and NHS Improvement recommendations and other reference information outlined in the Bibliography.

1.2 Scope (when, where and who)

This policy will apply to all Trust employees in respect of potential matters of misconduct, including medical employees. For misconduct relating to medical employees the Maintaining High Professional Standards should be also considered and this process is detailed within the ***Appendix 2 & 3.***

The policy does not apply to the following:

- Capability due to Performance Management Issues – Please refer to the Working Better Together Capability Process
- Capability due to Ill Health – Please refer to the Management of Sickness Absence Policy (HR03).
- Grievances - these should be addressed in accordance with the Trust's Grievance and Disputes Policy & Procedure (HR02)
- Bullying and Harassment concerns – these should be dealt with via the Trust's Dignity at Work Policy in the first instance. Where it is found that employees have breached the Dignity at Work Policy by using bullying, harassing or discriminatory behaviours these will then be addressed through the Disciplinary Policy, via a disciplinary hearing.
- Agency workers, work experience students, contractors and employees of other Organisations that are on site and volunteers.

1.3 Principles

We aim to treat all employees in a fair, effective, consistent and supportive way in relation to conduct matters and consider these matters promptly and impartially.

Our values, which will guide all of our actions and underpin our conduct are as follows:

It is the intention of this policy to support the delivery of these values by managers supporting our colleagues and applying these values in the application of this policy.

Treating people as individuals, based on their individual needs, is our commitment. Equality is not about treating everyone the same, as this will inadvertently disadvantage some, it is about being fair, creating an 'equal playing field' that supports individual needs going through this process. Employees who may fall under the criteria, legally defined under the Equality Act, will be particularly protected by our commitment to inclusion, diversity and equality, and in line with legislative requirements. All appropriate and reasonable steps will be taken to ensure that any individual who is subject to this Policy is treated in accordance with their specific needs.

2. The Policy

This policy outlines the procedures that must be followed to ensure that misconduct matters are dealt with in a fair and transparent way and provides practical guidance.

This policy:

- outlines the informal and formal procedure to be followed in respect of alleged misconduct
- details disciplinary sanctions that can be applied and their duration
- outlines 'Just Culture' approach to Suspensions, Restrictions and Exclusion (Medical Staff)
- makes clear the responsibilities of all employees in respect of this policy
- tell employees how to appeal a decision.

2.1 Policy Statement

Managers are responsible for ensuring their team is aware of the required standards of conduct and for bringing any concerns to the attention of employees at the earliest opportunity.

Managers should try to resolve minor matters of concern informally. If informal approaches do not bring about improvement or if misconduct is sufficiently serious, formal stages of this procedure should be followed.

Managers will ensure that all action taken under this policy and procedure is reasonable and proportionate. At an early stage, employees will be told why disciplinary action is being considered and they will be given the opportunity to respond to allegations before decisions about formal sanctions are taken.

Employees can be accompanied and represented, at a disciplinary hearing by a work colleague, trade union representative or other companion from any background, not acting in a legal capacity

Disciplinary cases will be treated sensitively and confidentially. Information will only be shared with those who have a legitimate right to be informed in accordance with Data Protection Act 2018 and the Common Law Duty of Confidentiality. Breaches of confidentiality by any party may result in disciplinary action. Standard Operating Procedures agreed between Human Resources and the Data Protection Office will be followed.

All managers who Chair or sit on hearing Panels must have appropriate and up to date training on

managing / chairing disciplinary cases. Such training should involve appropriate refreshers within three years of the hearing. A list of trained staff will be held centrally with the People Operations Team.

3. Procedure

The policy has 3 procedural stages:

1) Stage 1 – Informal
2) Stage 2 – Formal
3) Stage 3 - Appeal

In the implementation of this procedure there are also some factors which need to be considered and they are also outlined within this section of policy.

Handling of allegations of misconduct will be carefully assessed by the relevant manager, with HR advice, to decide if the matter can be managed informally where possible or whether there are grounds for further investigation and/or formal action

Managers/Decision-Making Group (DMG) should follow the steps in the 'Stop and Pause Decision Making Framework' ***Appendix 4***, when considering whether the issue/incident needs to be handled formally or can it be dealt with informally?

The Trust recognises that cases of minor misconduct are best dealt with informally and quickly. A quiet word is often all that is needed.

Supportive guidance to facilitate application of the procedure will be included in the DMG Framework and Manager's Toolkit.

3.1 Stage 1 - Informal

The informal stage allows employees and managers to resolve issues of minor misconduct informally at the first stage if it is appropriate; as part of day-to-day management. In many cases additional training, coaching and advice may be needed.

As the manager, have you asked yourself the following questions before deciding on the next step/s or requesting a DMG:

- Have you done a preliminary fact finding investigation to understand the situation well
- Does the conduct of the employee sit within the list of gross misconduct stated in the non-exhaustive list (par. 3.4.3)
- Was there any noticeable impairment to their judgement of competence at the time of the incident.
- Did the employee knowingly and/or unreasonably increase risk by violating known safety operating procedures/protocols.
- Would another similarly trained and skilled employee act in a similar manner (the 'James Reason substitution test').
- Have you maintained consistency and equity in dealing with the situation regardless of the employee's banding and/or protected characteristics.

3.1.1 Informal Meeting

Issues should be raised confidentially, on a 1:1 basis and in a supportive manner at the earliest opportunity shortly after the event and dealt with informally. This will be a two-way discussion, aimed at talking through shortcomings and encouraging improvement.

The aim of an informal discussion is to:

- Discover why the behaviour is happening? What has changed?
- advise the employee how they are demonstrating poor conduct or standards
- confirm that the employee understands the behavioural standards we expect

(refer to Everyday Behaviours Guide)

- help the employee make the necessary changes by setting objectives/standards within an agreed timescale
- discuss any support or training that may be needed, including flexi starting hours etc.
- agree how progress will be reviewed *(no more than 6 months)*
- set out the consequences of continued poor conduct or standards.

The meeting should be recorded using the Regular Management Supervision (RMS) form and a copy of the RMS form should be shared with the employee. Managers should keep brief notes of any informal action for reference purposes

3.1.2 Mediation

There are some minor conduct matters which may be resolved through mutual agreement of employees to mediation as part of informal resolution. This approach operates outside of any formal procedures and is voluntary. Mediation can be requested via the employee's line manager, HR, an Inclusion Advisor, Trade Union representative or via self-referral. The mediation self-referral form is Appendix 4 of the Dignity at Work Policy.

3.1.3 Restorative Just Culture

A restorative just culture aims to repair trust and relationships damaged following an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm. Incidents don't just harm the two parties involved. They also potentially harm/impact on are colleagues, teams, line managers, bystanders, families, and the Trust. Managers with support from HR should encourage staff to utilise the 'Restorative Just Culture Guide/Checklist' in ***Appendix 5***, to support the conversations or process.

3.2 Stage 2 – Formal

For unresolved minor misconduct, serious or potential gross misconduct it will be appropriate to consider the formal procedure. For medical colleagues this should be considered alongside the process outlined in ***Appendix 2 & 3.***

3.2.1 Fact Find

It is important that as soon as the line manager is made aware of a concern that is medium or high risk that there is a review undertaken of the whole of the incident through a fact find. This is an exploratory exercise to gather facts and gain an understanding of the situation that has occurred before making any decisions. All staff on duty should be asked if they know anything about the incident/event so that a full picture is obtained. It is not an attempt to prove the concern.

3.2.2 Decision Making Group (DMG)

To determine the action required a Decision-Making Group (DMG) should be arranged to consider the initial concerns and review the fact find. The purpose of the DMG is to ensure that all relevant matters are dealt with in a fair and consistent manner in line with Just and Learning Principles and ensure swift and proportionate action is taken to address the identified concerns. The DMG should utilise the 'Stop and Pause Just Culture Checklist', ***Appendix 6*** before a decision to formally investigate an incident/individual is made.

This checklist supports a conversation about whether a staff member involved in an incident requires specific individual support or some other intervention in order to work in a way that is safe and does not cause harm to patients or other staff/ the public. It stresses the importance of having informal conversations at the very beginning with a focus on fairness, openness and learning rather than formal investigations. The aim is to cultivate a culture of learning from an incident rather than seeking to blame or punish.
It offers a 'stop and pause' opportunity in which environmental, organisational, cultural and contextual factors can be considered.

The role, membership and process of the DMG is outlined within the DMG Framework in the Disciplinary Guidance and Toolkit.

3.2.3 48 Hour Holding Action

In exceptional circumstances it may need to be considered, if appropriate to send an employee home for up-to 48 hours. The employee's Staff Side/Union Representative will be advised, if applicable. This would enable an initial fact-finding to establish further information to provide fuller details for a DMG to assess and consider next steps.
All witness statements should be collated during this period, where possible to ensure the most appropriate and informed decision is made. This may also include seeking further guidance if suspension/exclusion or relocation should be applied.

This holding action may only be taken by an Associate Director or delegated Senior Manager and recorded to ensure that the necessary authority has been granted.

The 48-hour period may be extended further, in exceptional circumstances, to ensure we have obtained all of the initial fact-finding information required to make decisions on an informed basis. This also affords protection to the individual to ensure that we take the most appropriate action.

3.2.4 Suspension or Restriction of Practice (Referred to as Exclusion for Medical and Dental Employees – see Appendix 2)

Line managers can request employees to be suspended from duty, to be temporarily redeployed and/or placed on restricted duties, in order to safeguard individuals and/or the integrity of the potential disciplinary investigation. These interventions should be risk assessed and considered through a DMG, except where there is an immediate safety or security issue. Should the DMG come to view that they wish to suspend an employee the matter should be discussed and approved by the Deputy Director of People and Organisational Development, or by the Head of People and Culture. The employee's Staff Side/Union Representative will be advised, if applicable.

The DMG should utilise the 'Suspension Decision Tree', ***Appendix 7*** to inform discussions with the Deputy Director of People and OD on whether to suspended/exclude a member of staff.

Suspension would only normally be considered if there is a serious allegation of misconduct and will occur for the following reasons**:**

- To defuse a situation
- To prevent interference with the investigation and/or tampering with evidence, influencing witnesses and investigation
- To protect the organisation/the employee/s concerned
- To prevent causing a risk to the welfare of the service users and/or colleagues
- There is a risk to the employee themselves, property or patients
- The employee is the subject of criminal proceedings which may affect whether they can do their job.

Suspension is not a disciplinary measure or penalty; and is a neutral act without prejudice. This will be reviewed regularly (every 14 days) and the employee's personal well being will be a major consideration.

The employee will not be subject to any financial detriment during suspension; and will usually be paid based on 'normal' pay i.e. the pay the person would have received if they had been at work based on a 12 weeks reference period (leading up to the suspension), but will exclude pay for bank shifts. This will also include an average of the 12 previous week's enhancements and allowances

If an employee is suspended from their substantive post/role they will automatically cease to work on the Trust's Temporary Staffing (TSS) Bank until the suspension is lifted and to maintain confidentiality the information regarding the suspension will be given to TSS by the Suspending

Manager. Workers on TSS/Bank contracts will receive an average pay for the duration of their suspension, based on the average weekly pay/hours worked in previous 12 weeks prior to the decision/date of suspension.

Suspension without pay should only be considered in exceptional circumstances and will require authorisation from the Deputy Director of People & OD or Executive Director People, Strategy and Partnerships. Suspension without pay may occur for the following reasons (these are examples, and this list is not exhaustive):

- Frustration of contract – imprisonment
- Expiry of right to work in the UK
- Failure to renew statutory professional registration
- They have lost their entitlement to work under the Immigration and Asylum Act 1999

3.2.5 Alternatives to Suspension

Alternatives to suspension must be considered by the DMG, and could include the employee temporarily:

- being moved to a different area of the workplace
- changing their working hours
- being placed on restricted duties including having reduced access to Trust systems where appropriate
- working under supervision
- being transferred to a different role within the organisation (the role should be of a similar status to their normal role, and with the same terms and conditions of employment).
- Other meaningful activities that the individual could do should be actively explored. This could include working remotely from home, carrying out activities such as audits, supporting administrative duties, review/writing of policies and or procedures, research or teaching.

3.2.6 Communicating the Decision to Suspend and Supporting Employees

Every effort will be made for the manager to meet with the employee to inform them of the decision to suspend.

Employees can be accompanied by a trade union representative or companion when informed of suspension. However, the unavailability of a representative will not prevent suspension from taking place.

When a manager is considering the possible suspension of a member of staff prior to a DMG taking place, the manager should contact a trade union representative or an Inclusion Advisor via HR to advise them of the potential suspension.

The employee will be informed verbally of the suspension, and this will be followed up in writing within 3 working days. See ***Appendix 8.***

The letter will outline the requirements of the suspension including not attending work without prior agreement or discussing the case with any colleague other than their trade union representative or work colleague. Staff would be able to attend work to meet with their Staff Side/Union Representative, with prior agreement. Staff will not be able to take any voluntary, paid or unpaid employment with any other employer during suspension which your line manager has not already agreed to.

The manager communicating the decision to suspend will:

- Explain the reason/s for suspension and how long it is expected to last.
- Explain the employee's responsibilities during their suspension.

- Provide a point of contact (usually the line manager) that they can contact if they have any concerns.
- Agree *how and how often* they will keep in regular contact with the employee throughout.
- Give details about support from Employee Assistance Programme (EAP), including telephone counselling and Occupational Health. (PAM Assist, the Trust's confidential support service that can be contacted 24 hours a day on 0800 882 4102).
- If it is necessary to explain the employee's absence, the manager will discuss with the employee how they would like it to be explained to colleagues and/or patient
- Remind the employee that the suspension will be reviewed every 14 days and advise that the employee will receive an e-letter (or alternative) advising the outcome of the review, at the end of each 14-day period.,
- It is important to advise the employee of the evolving reasons for extending the suspension e.g. investigating officer carrying out investigation; investigating officer writing the investigation report.

3.2.7 Terms of the Suspension

The terms of the suspension, restrictions during suspension/exclusion and employee obligations will also include:

- not doing anything that could interfere with the investigation
- treating the matter confidentially
- seeking permission from the manager to contact colleagues
- if they wish to contact witnesses to support their case, they should do this via their manager or, if different, the manager dealing with the matter or their Trade Union representative or fellow colleague
- except for medical appointments and meeting with their staff side/union representative they must not visit Trust premises unless given permission by the line manager or a named deputy to attend for a specific purpose, e.g. a meeting a representative, an investigation meeting, a counselling appointment, a medical consultation
- the requirement to remain available between 9.00 am to 5.00pm, Monday to Friday, excluding public holidays, to attend meetings.
- Permission for any periods of absence, e.g. annual leave, must be requested in advance before annual leave is taken.
- If deemed necessary, the suspending manager may ask the employee to hand in Trust property such as keys, ID card, Trust mobile phone, bleep, laptop or any other mobile device at the time of exclusion. These will be listed and a copy given to the employee. The manager may also temporarily revoke remote access if in use or remove / restrict access to Trust systems by referral to the Data Protection Office. In these circumstances, the manager and employee must agree alternative methods of keeping in contact.
- A suspended person must not undertake any paid work during the hours for which they are contracted to work.
- People suspended for clinical / professional reasons must not undertake any work, paid or unpaid, without prior permission from the appropriate manager.
- Where an employee holds employment outside of the Trust and is suspended from the Trust, the employee is obliged to declare their alternative place/s of work and the suspension information may be shared with another employer, to safeguard service users/patients.

3.2.8 Timescales for Suspension

Suspension will be for the minimum time necessary and will be reviewed <u>every 14 days</u> and lifted when the reason for suspension no longer exists. Most investigations should be concluded within *four weeks of suspension*. Where this is not possible people should be informed that they remain suspended and told when the investigation is likely to be completed. This should be followed up in writing. Managers should make themselves available to meet employees to discuss the progress of the investigation.

Suspension and restrictions will be reviewed on a regular basis and amended and/or lifted via DMG, disciplinary meeting or hearing, where appropriate.

3.2.9 Investigation

If formal action is deemed necessary an investigation will be commissioned by the Commissioning Manager and *they* will identify an appropriate investigating officer/ manager, who has had no prior involvement and/or conflict of interest, in respect of the alleged incident/misconduct. The Commissioning Manager must ensure at the start of the process that the Investigating Manager will be available for the duration of the investigation, to avoid any delays in concluding the investigation. The Commissioning Manager will be responsible for drafting the terms of reference for the investigation and ensuring this is shared with the employee, their Staff Side/Trade Union Representative and Investigating Manager. *(See blank Terms of Reference Template in Toolkit)*

The People Operations Team will confirm an appropriate HR representative to support the investigation.

The investigation will involve interviewing the employee and all potential witnesses regarding the alleged misconduct and reviewing any other relevant information and documentation. The Investigating /Officer Manager will be responsible for writing an investigation report outlining the facts and findings of the investigation. The Investigating Officer/Manager is not responsible for reaching any decision/making any judgement on the evidence collected.

It is important to ascertain the investigating skills and experience that the potential Investigating Officer/ Manager has, prior to making the appointment. Commissioning Managers should seek to understand the previous experiences they may have of carrying out an investigation, and if they have received such training within the Trust or an alternative NHS organisation. An investigation *should ideally be completed within 40 workings* days of being commissioned and receipt of the terms of reference, however this may vary depending on the complexity of the case. *(See Sample Investigation Report incl. evidence matrix in Toolkit)*

The *report should be sent to the Commissioning Manager within 10 working days* following completion of the investigation (from date of last witness interviewed) and taken to a further DMG to determine the outcome and whether further action is required. There are various outcomes that could be considered including:

- There is a case to answer, and a disciplinary meeting or hearing should be convened.
- There is no case to answer and no further action required
- The case is partially upheld – the outcome could be that the case proceeds to a disciplinary meeting or hearing or other recommendations are made

The outcomes may involve further recommendations and/or potentially referral to DBS and professional bodies. *The employee will be informed of the investigation outcome, and this will be followed up in writing within 1 week of the DMG.*

3.2.4 Disciplinary Meeting

After completion of an investigation a written warning (first or final written warning) may be offered to the employee, if deemed appropriate, outside of a disciplinary hearing. This will only be considered where the employee has taken full responsibility for their actions and has accepted and acknowledged the case/allegations against them. This offer can only be considered at a DMG when reviewing the investigation findings and determining the outcome and whether further action is required. If the employee chooses not to accept the offer outside of a disciplinary hearing, then the matter will proceed to a formal disciplinary hearing.

3.2.5 Disciplinary Hearing

The disciplinary hearing should be arranged for as soon as possible after the completion of the investigation so as not to protract the timescale unnecessarily and taking into consideration the impact to the employee's wellbeing of the ongoing process.

An independent panel will be arranged consisting of a senior manager who will chair the meeting (who has had no prior involvement and/or conflict of interest, in respect of the alleged incident/misconduct), a HR representative and (where it is deemed appropriate) it may be necessary to call upon the expertise of a specialist who has expertise in that particular subject matter.

The Commissioning Manager must write to the employee concerned to advise them of the hearing giving them a minimum of 10 working days' notice of the date. Where there has been a protracted investigation the employee could be awarded extra time to develop/prepare their case. This should be requested and agreed in advance.

The letter must include key information:

- The allegations to be considered at the hearing
- Date, time and venue of the hearing
- Names of disciplinary hearing panel members
- Name of investigating manager who may be supported by a HR Representative
- Inform the employee of their right to be accompanied by a trade union representative or Trust work colleague
- Witnesses who will be called to attend by management and the right to call witnesses to support their case.
- Disciplinary hearing pack of information that will be relied on or referred to at the hearing
- The potential outcome e.g., whether gross misconduct leading to dismissal is a possible outcome
- Any reasonable adjustments that may need to be considered, which should be discussed with their Staff Side/Trade Union Representative prior to the letter being sent.

If after the disciplinary process has concluded it is established that the employee who is the subject of the disciplinary procedure has suffered any form of serious harm, whether physical or mental, this should be treated as a 'never event' and an immediate independent investigation should be commissioned and received by the Trust Board.

3.2.6 Disciplinary Sanctions

There are 3 levels of formal sanction that can be the outcome from the formal disciplinary process:

- First Written warning (Live for up to 12 months)
- Final written warning (Live for up to 24 months)
- Dismissal or Summary dismissal

There are circumstances where it is considered appropriate to take action short of dismissal and this will involve issuing a sanction of a final written warning alongside other actions for example downgrading.

The disciplinary warnings are intended to provide the employee with an opportunity to improve at each stage. The procedure should, therefore, usually be implemented in a sequential manner. However, the Trust reserve the right to move immediately to any sanction within the procedure, dependent on the seriousness of the alleged misconduct.

Employees need to be aware that a disciplinary sanction will impact their pay progression if they are approaching a pay step during the length of their disciplinary sanction.

3.2.7 Professional Bodies

Employees who are members of professional bodies are reminded that the Trust has a duty to report any incidence of possible professional misconduct and dismissals to the appropriate body who may investigate the case. Refer to the Overarching Fitness to Practice Policy (HR21) for further information.

3.2.8 Right to be Represented

Employees always have the right to be accompanied at formal disciplinary interviews or hearings, either by an accredited Trade Union/full-time TU regional/national official or a Trust work colleague, not acting in a legal capacity (e.g., lawyer).

3.2.9 Formal Proceedings against Trade Union Representative
Trade Union representatives are protected by the Trade Union Labour Relations (Consolidation) Act 1992 against any discrimination/unfair treatment that may arise due to their official duties. Before commencing any formal proceedings against a Trade Union Representative there is a requirement to discuss the matter with a Regional Full Time Officer with regard to any allegation. This will include establishing if the Trade Union Representative was undertaking their role responsibilities and duties as an accredited Trade Union Representative.

3.2.10 Inclusion Advisors
An employee may request for an Inclusion Advisor to be appointed to support with the investigation process and advise the investigation team or disciplinary hearing panel on any potential equality, diversity and cultural bias issues, particularly where unfair bias (conscious or unconscious) may have been identified. It is the right of the employee as to whether they wish for an Inclusion Advisor to be involved throughout the process. This is currently a running as a pilot programme and under evaluation at present.

3.2.11 Counter Fraud
Where fraud is suspected advice should immediately be sought from the Trust's Counter Fraud Service (CFS); prior to any information being discussed with the employee so as not to potentially jeopardise an interview under caution if required. The CFS will determine if the internal Trust process should be deferred whilst Counter Fraud investigate the matter or whether both can be run concurrently. Regular communication will be maintained to ensure availability of information and to agree next steps to both the Trust and CFS. Please refer to the Trust's Counter Fraud and Anti-Bribery Policy (CG 22).

3.2.12 Speaking Up

All staff are encouraged to speak up and raise concerns when things go wrong and to not be subjected to detriment as a result of doing so. For example, treatment that is disadvantageous and/or demeaning and may include being ostracised, given unfavourable shifts, being overlooked for promotion. The Trusts Freedom to Speak Up Guardians must be informed of any perceived or actual cases of detriment as a result of speaking up. Incidents will be escalated to the Lead Executive for Freedom to Speak Up (FTSU) and be viewed as serious misconduct if upheld.

3.2.13 Criminal Offences
Where an employee is arrested, cautioned, charged, convicted and/or subject to a police investigation they must inform their Line Manager as soon as practicable for whatever reason. Each case should be reviewed at a DMG and considered based on individual circumstances, including the nature of the offence, effect on the employee's suitability to do the job and their relationship with the Trust, colleagues, service users and those external to Trust and any sentence incurred. In the event that an employee/s are subject to a Police investigation it may be necessary for us to defer following the Trust internal investigation process until the Police have completed their investigations.

3.2.14 Safeguarding
All employees must ensure that all cases of actual or potential abuse are reported immediately to their Line Manager, in addition to the Trust's Safeguarding Team. The incident must be reported using the Serious Incident (SI) form through the Eclipse system.

If there is a safeguarding concern/s relating to another investigation (a complaint, disciplinary, or serious incident) such investigations may only occur once the concern has been confirmed by the safeguarding team. This process may involve the Local Authority Designated Officer (LADO) if it relates to a young person, or they are deemed to be a Person in a Position of Trust (PIPOT).

Please refer to Managing Safeguarding Allegations Concerning People in a Position of Trust Policy (HR37).

3.2.15 Conflict of Interest

It is the responsibility of all employees involved in the procedure to identify if they believe they have, or someone may have a conflict of interest in undertaking or participating in the procedure.

3.2.16 Electronic Recording

No employee at any time may record a meeting or conversation without the expressed permission of all parties involved. In the event of either management or an employee wishing to record a meeting or conversation, the minutes or recording must include informing of all parties that the meeting/conversation is being recorded and their agreement. Covert/secret recording is not permitted and may be deemed gross misconduct.

3.3 Stage 3 - Appeal

Following the disciplinary hearing, an employee may wish to appeal, against the sanction and/or findings or that the Disciplinary Policy was not applied appropriately.

If an employee wishes to pursue an appeal this should be put in writing to the Deputy Director of Workforce & Organisational Development and received within 10 working days from the receipt of the Disciplinary Hearing outcome letter. The appeal must include the grounds for the appeal.

A Disciplinary Appeal hearing will be arranged (ideally within 15 working days), and the appeal panel members will have had no prior direct involvement with the matter to be considered. An appeal hearing panel can increase a sanction, up to and including dismissal. The decision of the appeal hearing will be final and there is no further right of appeal. For more information, please refer to the Trust's Appeal Procedure.

3.4 Disciplinary Categories

There are three main categories for disciplinary matters; minor, serious and gross misconduct, which are detailed below. It is not possible to detail all types of misconduct which could give rise to disciplinary action and therefore the lists set out below must not be regarded as exhaustive or fully inclusive.

In considering misconduct and possible outcomes including sanctions, there are various factors which need to be thoroughly considered to ensure a just culture, including the context of the situation, as well as the employee's intent and mitigation. Therefore, an act of gross misconduct may not result in summary dismissal due to the circumstances surrounding the incident and possible where additional learning would allow improved conduct.

3.4.1 Minor Misconduct

These are matters that affect the conduct or behaviour of the individual, for example poor timekeeping or a small infringement of working practices.

3.4.2 Serious Misconduct

Where misconduct is confirmed or where the employee's conduct has not improved after either informal or formal action has been previously taken. For example, if the employee has received a previous first written warning, which is still in force further misconduct may lead to further disciplinary consideration.

Misconduct should be dealt with at the most appropriate level. If the manager identifies the required improvements are not reached within the agreed processes and timescales, then further disciplinary consideration may be given and discussed via a DMG.

Examples of serious misconduct include the following:

- Persistent repeats of minor issues
- Unauthorised absence

- Negligent loss/damage/misuse to Trust property
- Failure to adhere to Trust policies and procedures
- Abusive/obscene behaviour or language or gestures
- Ineffective/negative behaviour or attitude towards a members of staff as a result of 'speaking up' and/or 'raising concerns
- Failure to follow a reasonable management request
- Failure to maintain professional registration
- Breach of financial regulations
- Breach of confidentiality and data protection
- Health and Safety issues with the potential to cause harm to others
- Social Media making personal comments or engaging in activities within or outside work which could bring the Trust into disrepute.

(Please note this list is illustrative and not exhaustive).

3.4.3 Gross Misconduct

Gross misconduct is a serious breach of terms and conditions (written statement of contract) and is serious enough in its own right to irreparably and irrevocably damage the relationship of mutual trust and confidence that exists between an employee and employer.

If the allegations that have been made, when investigated are substantiated and upheld at a disciplinary hearing, this will normally lead to dismissal without notice or pay in lieu of notice (summary dismissal). This means the contract of employment will be terminated with immediate effect and the employee will no longer work for the Trust.

Examples of Gross Misconduct include the following:

- Persistent, serious or deliberate discrimination, harassment or incitement to discriminate (e.g., racism, homophobia etc)
- Harassment, sexual assault/indecency, physical violence/assault, verbal abuse or the threat of violence or bullying and harassment of any person by any means.
- Professional misconduct
- Theft, unauthorised removal of Trust property or unauthorised use, including the use of Smart Cards, ICT equipment, including any information obtained by such means
- fraud or deliberate falsification of records or trust documents
- malicious damage to Trust property
- Misuse of an employee's official position for personal gain. Significant breach of Standing Orders or Standing Financial Instructions
- Serious breaches or deliberate disregard of Health and Safety rules
- Being under the influence of alcohol or drugs whilst on duty *(Please refer to Managing the effects of Substance use in the Workplace HR Guidance)*
- Serious or persistent breach of terms and conditions of employment
- Serious insubordination
- Failure to disclose relevant information concerning past employment, including not declaring previous convictions, an accurate previous employment history, a personal relationship that may cause a conflict of interest within the workplace.
- Activities that bring the Trust into disrepute causing loss of faith in the employee including serious misconduct outside work
- Serious or gross negligence resulting in unacceptable loss, damage or injury; including compromising patient and/or public safety or significant financial material losses
- Frustration of contract, such as imprisonment (please note this will impact on pay)
- Vexatious allegation/s against a fellow employee or Trust Service User.
- Serious breaches of confidentiality and data protection
- Intentional serious breach of Trust policy or regulations or improper conduct in relation to job responsibilities

(Please note this list is illustrative and not exhaustive).

3.5 Confidentiality

When a potential disciplinary issue arises, all managers and employees must treat information with

the strictest confidence, also taking into account information governance controls. Any breach of confidentiality should be reported as an incident and may be regarded as misconduct and subject to disciplinary action. Please refer to the Trust's Confidentiality policy for further information.

3.5.1 Personal Data

Personal data released to the Investigating Manager must be fit for the purpose, not disproportionate to the seriousness of the matter under investigation. The investigation team should be familiar with the guiding principles of the General Data Protection Regulations and Data Protection Act 2018.

3.5.2 Patient Identifiable Information

Any documentation used or obtained to support a disciplinary investigation that contains patient identifiable information must be partially redacted. This includes personal data such as names, date of birth, RIO or NHS patient numbers. This is not an exhaustive list.

3.6 Staff Support

3.6.1 Health & Wellbeing

It is paramount that employees' health and wellbeing is considered throughout their involvement with informal and formal disciplinary procedures, whether they are subject to the complaint, making the complaint or a witness. We have a breadth of staff support available and the options for employees need to be considered individually depending on their circumstances and level and type of support required. The use of stress risk assessments can also assist identifying areas for support to help inform reasonable adjustments and solutions.

Where a conduct matter is identified it would be appropriate for the DMG to consider appointing a colleague to take on the role of being a wellbeing contact to provide support to employees who are going through these processes; checking on their welfare and to signpost them to the support available appropriately and confidentially (e.g., Employee Assistance Programme (EAP) including telephone counselling, Occupational health) for the duration of the process e.g. investigation and up to the hearing if required.

3.6.2 Psychological First Aiders/Mental Health First Aiders (MHFA)

Psychological First Aider support are available to support staff who have been impacted by stressful events, and could be feeling distressed or overwhelmed, anxious, disorientated and fearful as a result of being party/subject to a formal investigation process.

We have a number of staff who have been trained as psychological/Mental Health First Aiders across the Trust and other stakeholder organisations. This service is not provided by the HR Department and is a confidential and anonymous route for staff to access support.

Please contact the BSOL Staff Wellbeing Facilitator via e-mail paul.firth@nhs.net should you need support. You will be advised of the name and contact details of a MHFA or alternatively you may be contacted directly by the MHFA following receipt of your e-mail.

3.6.4 Communication

The Commissioning Manager will ensure a nominated point of contact is appointed for the employee during the procedure to address any issues or concerns. The point of contact and communication plan will be detailed within the investigation terms of reference (TOR).

Where there are delays in the investigation the Investigating Manager needs to advise the employee concerned in a timely, sensitive and compassionate manner.

4. Responsibilities

The following table outlines the responsibilities relevant to this policy.

Post(s)	Responsibilities
All Employees	• Ensure they are fully aware with the requirements of their role, standards of conduct, behaviours and policies aligned to their role. • Ensure that their conduct is aligned with Trust values and behaviours. • Cooperating in any investigations • Employees who are absent from duty due to sickness whilst involved in a fact finding/investigation have a responsibility to attend Occupational Health to assess fitness to attend an interview. • Informing the Investigating Manager of anybody whom they wish to be interviewed as part of the investigation.
Trust Board	• Overall responsibility for developing and maintaining an open, fair and consistent culture throughout the Trust, where disciplinary issues are dealt with fairly. • Awareness of employee relations KPI data reported via the Trust's People Committee • Review independent investigations into employees who have suffered any form of serious harm
Chair of the Trust	• Responsible for designating a Non-Executive Director 'the designated member' to oversee a doctor's case
Chief Executive	• Responsible for ensuring that a case manager is appointed for investigations into serious concerns involving doctors.
Non-Executive Director	• Where identified as 'the designated member' to oversee a doctor's case and ensure that momentum is maintained.
Medical Director	• Responsible (or a nominated deputy/senior manager) for acting as Case Manager in cases involving clinical directors and consultants • Responsible for appointing a case investigator for investigations involving doctors
Executive Directors	• Strategic accountability for ensuring there is compliance with this Policy and that it is applied in a fair and consistent manner. • To ensure the policy is implemented and cascaded throughout the Trust.
Service, Clinical and Corporate Directors	• To ensure the policy and procedure are implemented consistently within their services. • To ensure reporting Managers within their services comply with the requirements and follow the suspension process. • To ensure appropriate monitoring takes place and where necessary take accountability for ensuring that external agencies or professional bodies are notified in line with Trust responsibilities e.g., counter fraud, GMC
Line Managers	• To ensure that all new and existing employees are aware and understand the requirements for their job role, Trust values and the standards expected of them in relation to their conduct and behaviour at work. • Reviewing the incident, error or allegation and speak to HR to decide if informal resolution can be undertaken. • To ensure the employee's Health and Wellbeing is considered, reviewed and the correct support put in place. • Agree amount & form of contact with employees going through the procedure. • Ensure recommendations regarding employees are

	implemented fully and in a timely manner
Trade Union Representatives	• To work in partnership with management and HR to ensure conduct and behaviour is in line with our values and behaviours and employees are treated fairly and managed appropriately in line with the policy.
Inclusion Advisors	• Advise the disciplinary investigation team or hearing panels on any potential equality, diversity and cultural bias issues, particularly where unfair bias (conscious or unconscious) may have been identified. *(See IA role outline as part of toolkit for further information)*
Human Resources	• Responsible for providing professional HR advice and support to managers on applying this policy and procedure. • Involved in all formal stages of the disciplinary procedure. • To ensure the policy is reviewed regularly & updated in line with good practice and changes in legislation

5. Development and Consultation Process:

In the review of this policy the following key amendments have been made

Key Policy Amendments:		
DATE	**KEY AMENDMENT**	**WHOM**
June/July 2021	• Complete review of the policy to condense it to be an overview policy which will be supported by thorough detailed guidance and a toolkit. • All fraud matters to be referred to CFS in first instance and referenced the Trust's Counter Fraud and Anti-Bribery Policy (CG 22). • Reviewed and updated EIA on the basis of employee relations casework data • Reviewed misconduct categories following Trade unions feedback. • Crossed referenced with recently reviewed Dignity at Work Policy • Include reference to Restorative Just Culture, Guidance and Checklists • Expand on Suspension/Exclusion from Work	Rachel Morris (Senior HR Business Part

This is an outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation Summary		
Date policy issued for consultation	July 2021	
Number of versions produced for consultation	2	
Committees / meetings where policy formally discussed	**Date(s)**	
JOSC	14 July 2021& 24th August 2021	
PDMG	29 July 2021	
Transforming our Culture and Staff Experience	16th September 2021	
People Committee	22nd September 2021	
Trust Board	29th September 2021	
Where else presented	**Summary of feedback**	**Actions / Response**

Policy Review Group	Feedback received from staff networks and key stakeholders	Included
Staff Side Consultation Meeting	Feedback provided post meeting by Staff Side Chair	Included

6. Reference Documents

- Managing Safeguarding Allegations Concerning People in a Position of Trust (PIPOT) (HR37)
- Birmingham and Solihull Mental Health NHS Foundation Trust Everyday Behaviours Guide
- Counter Fraud and Anti-Bribery Policy (CG 22).
- Confidentiality policy (IG 01) (March 2021)
- Data Protection Act 2018
- Dignity at Work Policy (HR07)
- Equality Act 2010
- Grievance and Disputes Policy & Procedure (HR02)
- Management of Sickness Absence Policy (HR03)
- Managing the effects of Substance Use in the Workplace (HR Guidance Note 18)
- Maintaining High Professional Standards in the Modern NHS (December 2003)
- Overarching Fitness to Practice Policy (HR21)
- Pay Progression Policy *(New Policy – Reference TBC)*
- Procedure for Appeal Hearings (May 2014)
- Trade Union Labour Relations (Consolidation) Act 1992
- Working Better Together Capability Process
- Restorative Just Culture Checklist (Public Domain. By Professor Sidney Dekker)

7. Bibliography

- Advisory Consolidation Arbitration Services (ACAS) Code of Practice on disciplinary and grievance procedures (11 March 2015)
- Audio and Visual Recording by Patients and Staff Policy *(New Policy – Reference TBC)*
- Baroness Dido Harding, Chair for NHS Improvement letter to Trust Chairs and Chief Executives (May 2019)
- Corporate Records Retention Schedule
- Discipline and Grievances at Work – The ACAS Guide (July 2020)
- Equality, Inclusion and Human Rights Policy (HR 28)
- Fair to Refer - Reducing disproportionality in fitness to practise concerns reported to the GMC (June 2019)
- Media Policy (CG10)
- NHS Counter Fraud Authority website (https://cfa.nhs.uk/fraud-prevention/fraud-guidance)
- NHS England & NHS Improvement *'Sharing good practice to improve our people practices'* - 1 December 2020
- Professional Registration Verification and Monitoring Policy (HR05)
- Relationships at Work Policy - HR34
- Restorative Just Culture Checklist (Public Domain. By Professor Sidney Dekker)

8. Glossary

Abbreviations	Definition &/or Explanation
ACAS	Advisory Consolidation Arbitration Services
BAME	Black, Asian, Minority or Ethnic

CFA	Counter Fraud Authority
CFS	Counter Fraud Specialist
EAP	Employee Assistance Programme
GDPR	General Data Protection Regulations
MHPS	Maintaining High Professional Standards
PPAS	Practitioner Performance Advice Service (formerly National Clinical Assessment Service, NCAS)
RMS	Regular Management Supervision
TOR	Terms of reference

9. Audit and Assurance

Managers will demonstrate their knowledge and understanding of how to apply the procedures when managing issues of conduct arising in their area of work.

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations & Lead(S)	Change in Practice & Lessons to be shared
Employee Relations KPIs	Head of People and Culture	Employee Relations Casework Tracker & ESR Casework Tracker	Quarterly & Annually *(depending on KPI)*	People & OD Sub-Groups and People Committee	Senior People Partners (Operations)	Sharing lessons learned Feedback to Managers and People Team
Number of BAME staff involved in formal process and suspensions	Head of People and Culture	Employee Relations Casework Tracker & ESR Casework Tracker	Quarterly & Annually (depending on KPI)	People & OD Sub-Groups and People Committee	Senior People Partners (Operations)	Sharing lessons learned
WRES & WDES reporting	Head of Equality, Diversity & Inclusion	Employee Relations Casework Tracker & WRES & WDES reporting Templates	Quarterly & Annually (depending on KPI)	People & OD Sub-Groups and People Committee	HR & Equality, Diversity & Inclusion	Sharing lessons learned
Professional Lead Casework Reporting	Senior People Partners	Casework Tracker	Monthly	Monthly via email to Professional Leads (Medical, Nursing & PIPOT)	Senior People Partners (Operations)	Sharing lessons learned Feedback to Managers and People Team

Casework Review Meetings	Head of People & Culture or delegated to Senior People Partners	Casework Tracker	Weekly	HR Casework Review & Discussion	Senior People Partners (Operations)	Sharing lessons learned

Monitoring

The Deputy Director of People & OD will monitor the effectiveness of the policy using information from the following sources:

- Exit Interviews & Staff Surveys
- Staff Support Questionnaires
- Feedback from Employee Tribunal Cases/Proceedings
- ER Casework
- Inclusion Advisors

This will be reported on a quarterly basis to People Committee

Appendix 1
Equality Analysis Screening Form

Title of Proposal	**Disciplinary Policy**		
Person Completing this proposal	Rachel Morris	**Role or title**	Senior HR Business Partner
Division	Corporate	**Service Area**	People & Culture
Date Started	March 2021	**Date completed**	July 2021

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

The Disciplinary policy outlines the approach to be taken by us when dealing with incidents and matters of alleged misconduct and to identify the most appropriate way of dealing with such matters, so that we encourage improvement and learn lessons.

The policy provides clarification of the considerations which managers should give to an event and, if appropriate, what processes and employee's rights are applicable when dealing with such matters, to ensure matters are dealt with fairly and consistently.

The policy outlines responsibilities including those of Managers, employees and Trade Union Representatives and provides clear procedures and processes that are to be followed.

Who will benefit from the proposal?

This policy will apply to all Trust employees in respect of potential matters of misconduct, including medical employees.

The policy will not apply to Temporary Staffing Solution (TSS) and agency workers, work experience students, contractors and employees of other Organisations that are on site and volunteers.

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**			Although this protected characteristic is not currently monitored, going forward it will be incorporated into the Employee Relations Casework Tracker. It is anticipated that there will be no impact on employees due to their age as the policy ensures that all employees should be treated in a fair,

				reasonable and consistent manner irrespective of age.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability		**X**		Recent employee relations data shows 6.45% disabled colleagues have been subject to a formal disciplinary procedure in last 12 months (Jul'20 – Jun'21). The impact of the previous policy has been mitigated with the implementation of Decision-Making groups which mean that no one person makes a decision on how to proceed where a misconduct issue arises. Further investigation skills and Maintaining High Professional Standards (MHPS) training is being arranged across the Trust for 2021. In line with our ongoing commitment to ensure Inclusion principles are an integral part of any formal disciplinary process the use of the Inclusion Advisors will ensure continued review of equality, diversity and cultural bias issues is maintained throughout the entirety of the process. Therefore, it is anticipated this will reduce the impact on employees as a result of Disability as the policy ensures that all employees should be treated in a fair, reasonable and consistent manner.
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**			Although this protected characteristic information is collated it is not currently reported on. It is anticipated that there will be no impact on employees due to their gender as the policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of gender.
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**			Although this protected characteristic is not currently monitored, going forward it will be incorporated into the Employee Relations Casework Tracker. It is anticipated that there will be no impact on employees due to their marriage or civil partnership as the policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters. Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**X**			Although this protected characteristic is not currently monitored, going forward it will be incorporated into the Employee Relations Casework

				Tracker. It is anticipated that there will be no impact on employees due to pregnancy or maternity as the policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their pregnancy or maternity. The Trust will provide the necessary support and reasonable adjustments for any employee who is pregnant or on maternity, paternity or adoption leave and this may include pausing the procedure for a temporary period of time.
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 in relation to pregnancy and maternity?				
Race or Ethnicity		**X**		Recent employee relations data shows that in the last 12 months (Jul'20 – Jun'21) out of 31 formal disciplinary cases, 14 cases related to colleagues from Black, Asian and Minority Ethnic background (45.16%). The impact of the previous policy has been mitigated with the implementation of Decision-Making groups which mean that no one person makes a decision on how to proceed where a misconduct issue arises. Further investigation skills and Maintaining High Professional Standards (MHPS) training is being arranged across the Trust for 2021. In line with our ongoing commitment to ensure Inclusion principles are an integral part of any formal disciplinary process the use of the Inclusion Advisors will ensure continued review of equality, diversity and cultural bias issues is maintained throughout the entirety of the process. Therefore, it is anticipated this will reduce the impact on employees as a result of Race or Ethnicity as the policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of Race or Ethnicity.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training do 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**			Although this protected characteristic is not currently monitored, going forward it will be incorporated into the Employee Relations Casework Tracker. It is anticipated that there will be no impact on employees as a result of their religion or belief as the policy applies to all employees irrespective of their religion or belief. The policy is written to ensure all employees are treated in a fair, reasonable and consistent manner. As required appropriate arrangements will be made to ensure that the religious or spiritual care needs of employees are met, and the necessary specialist advice sought with the support of the Operational Human Resources team where necessary.

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**			Although this protected characteristic is not currently monitored, going forward it will be incorporated into the Employee Relations Casework Tracker. It is anticipated that there will be no impact on employees as a result of sexual orientation as the policy applies to all employees irrespective of sexual orientation and is written to ensure all employees are treated in a fair, reasonable and consistent manner.
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 protected characteristic is not currently monitored, as the data is not currently collected in ESR. It is anticipated that there will be no impact on Trans employees or employees in Transition as a result of this policy as the policy applies to all employee and is written to ensure all employees are treated in a fair, reasonable and consistent manner.
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**			The policy is written in a manner to ensure that an employee's rights to Dignity and Respect are reinforced and maintained during the Disciplinary process. It also ensures that the vulnerable people in our care are appropriately safeguarded from harm.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e., Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
		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?
The operational human resources team regularly provides training and guidance for managers on the application of the Trust's Disciplinary policy and is arranging specialist MHPS training in 2021. For all training delivered we utilise formal evaluation mechanisms which help to inform future training decisions. Alongside this we actively encourage and promote this training amongst managers who are new to their role, less experienced or for whom we believe there may be an issue in relation to confidence, proficiency or a requirement for knowledge refresh.
How will any impact or planned actions be monitored and reviewed?
Review formal evaluation feedback and revise training offer accordingly. Employee Relations casework KPIs will be monitored through the Trust's People Committee which currently incorporate casework by ethnicity and disability.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact on other people as a result of their personal protected characteristic?
All employees will be treated equally, and we will take into account and provide the appropriate adjustments for the protected characteristics of each individual. The policy has been developed to ensure all employees are treated in a fair, reasonable and consistent manner. The policy ensures that an employee's rights to equality of opportunity and treatment are reinforced and maintained during the Disciplinary process. It also ensures that the vulnerable people in our care are appropriately safeguarded from harm.
Please save and keep one copy and then send a copy with a copy of the proposal to the Head of Equality, Diversity & Inclusion at bsmmhft.hrsupport@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.

Appendix 2

Disciplinary Investigation & Exclusion Procedure for Medical Staff
(In conjunction with Maintaining High Professional Standards in the Modern NHS)

1. INTRODUCTION

In December 2003, the Department of Health issued the document Maintaining High Professional Standards in the Modern NHS, a framework for the initial handling of concerns about doctors and dentists. This procedure is in line with the above document and describes the local procedures for handling concerns about a doctor's conduct and follows best practice guidance.

Concerns about a doctor's conduct can come to light in a wide variety of ways, for example:

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff.
- Review of performance against job plans, annual appraisal, revalidation
- Monitoring of data on quality of care.
- Complaints about care by patients or relatives of patients.
- Information from the regulatory bodies i.e., Lapse in professional registration.
- Litigation following allegations of negligence.
- Information from the police or coroner and court judgments.

All Doctors who are involved in a disciplinary procedure, whether as case managers, investigators, hearing officer, the doctor being investigated or being called upon to give information, have a responsibility to ensure that they work in a spirit of co-operation, and comply with the requirements of the Equality, Inclusion and Human Rights policy, to support and assist in a timely investigation. Employees have a responsibility to ensure that they co-operate fully with all aspects of the procedure.

Any allegation/concern has the potential to cause lasting damage to a doctor's reputation, career prospects and a potential loss of confidence in the care provided by the Trust. Therefore, the Trust has a duty to take any concerns relating to a doctor's practice seriously and manage them consistency, fairly and in line with MHPS requirements to ensure these are effectively resolved. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action.

Informal resolution should be considered in the first instance for less serious problems. Concerns about the capability of doctors in training should be considered initially as training issues and the Postgraduate Dean should be involved from the outset.

For all serious concerns the Chief Executive, Chair of the Trust and Medical Director have responsibilities which are outlined in section 4 of the policy. All serious concerns relating to the practice of a doctor must be brought to the attention of the Medical Director who will be required to work with the Deputy Director of Workforce and OD to receive the necessary HR advice. There will be a requirement to convene a multi professional Decision-Making Group in order to support the decision-making process regarding the appropriate course of action.

When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. There is an opportunity to engage with the local GMC Liaison Officer for the Trust on an early basis regarding any initial concerns to establish whether these potentially meet the threshold for referral and/or receive additional advice about any other relevant considerations. At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body,

whether or not the case has been referred to the Practitioner Performance Advisory Service (PPAS). Consideration should also be given to whether the issue of an alert letter should be requested. In such circumstances the Case Manager must liaise with the Medical Director and the Deputy Director of Workforce and OD prior to any final decisions being made.

The GMC will discuss with the PPAS whether any immediate action is needed by the GMC or whether the PPAS's consideration should continue.

At any stage of the handling of a case consideration should be given to the involvement of the PPAS. PPAS is an assessment and advisory support service whose role is to assist in the management of concerns relating to a doctor's practice. They offer a range of services which include the below

- Immediate telephone advice, available 24 hours
- Advice, then detailed supported local case management
- Advice, then supported local clinical performance assessment
- Advice, then detailed PPAS clinical performance assessment
- Support with implementation of recommendations arising from assessment
- Understanding the issue and investigation

Upon making contact with PPAS it is important to ensure that you have sufficient information available to clarify what has happened, the nature of the problem or concern and outline the potential impact on service delivery or patient care of the concerns which have been highlighted and the options available to manage this risk which may include movement to an alternative role, restricted duties, temporary exclusion or other relevant action as appropriate.

PPAS will then be able to offer advice and support on what the way forward should be and support you in considering whether restriction of practice or exclusion is required. There will be an ongoing requirement to keep PPAS regularly informed of progress in relation to the management of concerns where an issue has been notified to them relating to a doctor's practice.

Once the investigating report is received there may be a requirement for PPAS support in matters relating to a doctor's performance. This may be where there are difficulties which are serious and/or repetitive. That means performance falling well short of what doctors could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk. Alternatively, or additionally, problems that are ongoing or (depending on severity) have been encountered on at least two occasions. In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. PPAS may advise on this, but further direction should be taken from the Deputy Director of Workforce and OD.

A practitioner undergoing assessment by PPAS must co-operate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the PPAS assessment is complete. Failure to co-operate with a referral to the PPAS may be seen as evidence of a lack of willingness on the part of the doctor to work with the Trust on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the parties and may necessitate disciplinary action and consideration of referral to the GMC.

The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator must.

- formally involve a senior member of the medical staff where a question of clinical judgement is raised during the investigation process, must ensure that

safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible.

- Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how, within the boundaries of the law, that information should be gathered.
- Must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.
- Must ensure that a written record is kept of the investigation, the conclusions reached, and the course of action agreed by the Deputy Director of Workforce and Inclusion with the Medical Director.
- Must assist the designated Board member in reviewing the progress of the case.

The case investigator does not make the decision on what action should be taken nor whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied.

At any stage of this process, or subsequent disciplinary action the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or lay representative of the British Medical Association, British Dental Association or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

The case investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.

If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another NHS body should be invited to assist. The case manager has the right to request for a further DMG to be convened if they require any professional advice to assist them in making this decision and/or whether they require support in identifying a suitable external professional advisor. There may be other discrete circumstances in which the case manager may require further support. In the event this is the case there may be a need to convene an additional DMG process as appropriate to be determined under the direction of the Medical Director and associated Non-Executive Director.

The case investigator should complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 days. The report of the investigation should give the case manager sufficient information to make a decision whether:

- There is a case of misconduct that should be put to a conduct panel.

- There are concerns about the practitioner's health that should be considered by the Trusts relevant occupational health service.
- There are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Service.
- Restrictions on practice or exclusion from work should be considered.
- There are serious concerns that should be referred to the GMC
- There are intractable problems, and the matter should be put before a capability panel
- No further action is needed.

1.1 Confidentiality

The Trust must maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust should only confirm that an investigation or disciplinary hearing is underway.

2. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

In this part of the framework, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC to suspend the practitioner from the register pending a hearing of their case or as an outcome of the fitness to practise hearing.

The Trust must ensure that:

- Exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered.
- Where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than 4 weeks at a time.
- All extensions of exclusion are reviewed, and a brief report provided to the Chief Executive and the Board.
- A detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

2.1 Managing the Risk to Patients

When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor in training the postgraduate dean should be involved as soon as possible.

Exclusion of clinical staff from the workplace is a temporary, precautionary measure and not a disciplinary sanction. Exclusion from work ("suspension") should be reserved for only the most exceptional circumstances.

2.2 Purpose of Exclusion

The purpose of exclusion is:

- To protect the interests of patients or other staff; and/or
- To assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

Alternative ways to manage risks, avoiding exclusion, include:

- Medical or Clinical Director supervision of normal contractual clinical duties.
- Restricting the practitioner to certain forms of clinical duties.
- Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling.
- Sick leave for the investigation of specific health problems.

3. THE EXCLUSION PROCESS

Under the Direction, The Trust cannot require the exclusion of a practitioner for more than 4 weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further 4-week period of exclusion is imposed. Under the framework the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

3.1 Key features of Exclusion from Work

- An initial "immediate" exclusion of no more than 2 weeks if warranted.
- Notification of the PPAS before formal exclusion.
- Formal exclusion (if necessary) for periods up to 4 weeks.
- Advice on the case management plan from the PPAS.
- Appointment of a Board member to monitor the exclusion and subsequent action.
- Referral to PPAS for formal assessment, if part of case management plan.
- Active review to decide renewal or cessation of exclusion.
- A right to return to work if review not carried out.
- Performance reporting on the management of the case.
- Programme for return to work if not referred to disciplinary procedures or performance assessment.

3.2 Roles of Officers

The Chief Executive of the Trust has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The case should be discussed fully with the Chief Executive, the Medical Director, the Deputy Director of Workforce and OD, the PPAS and other interested parties (such as the police where there are serious criminal allegations or the Local Counter Fraud Specialist (LCFS)) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a DMG. The authority to exclude a member of staff must be authorised by the DMG.

The Medical Director, Non-Executive Director and Chief Executive will need to ensure they are satisfied that any exclusion and/or restriction to practice is absolutely necessary and has been regularly reviewed and in place for the minimum period of time.

3.3 Role of Designated Board Member

Representations may be made to the designated Board member in regard to exclusion, or investigation of a case. The designated Board member must also ensure that time frames for investigation or exclusion are adhered to.

3.4 Immediate Exclusion

An immediate time limited exclusion may be necessary for the purposes identified above following:

- A critical incident when serious allegations have been made; or
- There has been a break down in relationships between a colleague and the rest of the team; or
- The presence of the practitioner is likely to hinder the investigation.

Such an exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact the PPAS for advice and to convene a case conference.

The manager making the exclusion must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of 2 weeks away at which the practitioner should return to the workplace for a further meeting. The case manager must advise the practitioner of their rights, including rights of representation.

3.5 Formal Exclusion

A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a DMG, whether there is reasonable and proper cause to exclude. PPAS must be consulted where formal exclusion is being considered. If a case investigator has been appointed, he or she must produce a preliminary report as soon as is possible to be available for the DMG. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

The report should provide sufficient information for a decision to be made as to whether:

- The allegation appears unfounded; or
- There is a misconduct issue; or
- There is a concern about the practitioner's capability; or
- The complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.

Formal exclusion of one or more clinicians must only be used where there is a need to protect;

A) The interests of patients or other staff pending the outcome of a full investigation of:

- Allegations of misconduct,
- Concerns about serious dysfunctions in the operation of a clinical service,
- Concerns about lack of capability or poor performance of sufficient seriousness that it is warranted to protect patients; or

B) The presence of the practitioner in the workplace is likely to hinder the investigation.

Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

When the practitioner is informed of the exclusion, there should where practical, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g., further training, referral to occupational health, referral to the PPAS with voluntary restriction).

The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g., exclusion from the premises and the need to remain available for work) and that a full investigation or what other action will follow. The practitioner and their companion should be advised that they may make representations about the exclusion to the designated board member at any time after receipt of the letter confirming the exclusion.

In cases when disciplinary procedures are being followed, exclusion may be extended for 4-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion should still only last for 4 weeks at a time and be subject to review. The exclusion should usually be lifted, and the practitioner allowed back to

work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred to the PPAS for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of 4 week "renewability" must be adhered to.

If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion, inform Health Education England in relation to doctors in training and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

3.6 Exclusion from Premises

Practitioners should not be automatically barred from the premises upon exclusion from work. Case managers must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

3.7 Keeping in contact and availability for work

As exclusion under this framework should usually be on full pay, the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continue to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would be given 24 hours’ notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g., abroad without agreement).

The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments and take part in Continuing Professional development (CPD) and clinical audit activities with the same level of support as other doctors in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

3.8 Informing other Organisations

In cases where there is concern that the practitioner may be a danger to patients, the Trust has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans and where appropriate in a declaration of interests’ form. If there is no information available through this route the Case Manager must ascertain whether the individual is working in any other capacity outside of the Trust and there is an obligation for the individual practitioner to provide this information. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where the Trust has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

Where the case manager believes that the practitioner is practising in other parts of the NHS

or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the Director of Public Health or Medical Director of NHS England consider the issue of an alert letter.

3.9 Informal Exclusion

No practitioner should be excluded from work other than through this procedure. Informal exclusions, such as 'gardening leave' must not be used by the Trust as a means of resolving a problem covered by this framework.

4. KEEPING EXCLUSIONS UNDER REVIEW

4.1 Informing the Board

The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed. It should, therefore:

- require a summary of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible.
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended.

4.2 Regular Review

The case manager must review the exclusion before the end of each 4-week period and report the outcome to the Chief Executive and the Board. This report is advisory, and it would be for the case manager to decide on the next steps as appropriate. The exclusion should usually be lifted, and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse, and the practitioner will be entitled to return to work at the end of the 4-week period if the exclusion is not actively reviewed.

It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed.

Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

The Trust must take review action before the end of each 4-week period. After 3 exclusions, the PPAS must be called in. The information below outlines the various activities that must be undertaken at different stages of exclusion.

4.3 Exclusion Review Process

Stage	Activity
First & second reviews *(& reviews after the third review)*	Before the end of each exclusion period (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to Chief

	Executive and the Board. • Each renewal is a formal matter and must be documented as such. • The doctor must be sent written notification on each occasion.
Third review	If the doctor has been excluded for 3 periods: • A report must be made to the Chief Executive: ➢ Outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative. ➢ And if the investigation has not been completed a timetable for completion of the investigation. • The case must formally be referred to PPAS explaining: ➢ Why continued exclusion is appropriate ➢ What steps are being taken to conclude the exclusion at the earliest opportunity • PPAS will review the case and advise the NHS body on the handling of the case until it is concluded.
6 months review	If the exclusion has been extended over 6 months, • A further position report must be made by the by the Chief Executive to NHS England indicating: ▪ The reason for continuing the exclusion. ▪ Anticipated time scale for completing the process. ▪ Actual and anticipated costs of the exclusion PPAS and NHS England will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The Trust and the PPAS should actively review those cases at least every 6 months.

4.4 The Role of the Board and Designated Member

The Trust Board has a responsibility for ensuring that these procedures are established and followed. It is also responsible for ensuring the proper corporate governance of the Trust, and for this purpose reports must be made to the Board under these procedures.

Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.

The Trust Board is responsible for designating one of its non-executive members as a "designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process.

This member's responsibilities include:

• receiving reports and reviewing the continued exclusion from work of the practitioner

- considering any representations from the practitioner about his or her exclusion
- considering any representations about the investigation

5. RETURN TO WORK

If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be and any monitoring arrangements to ensure patient safety.

6. PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

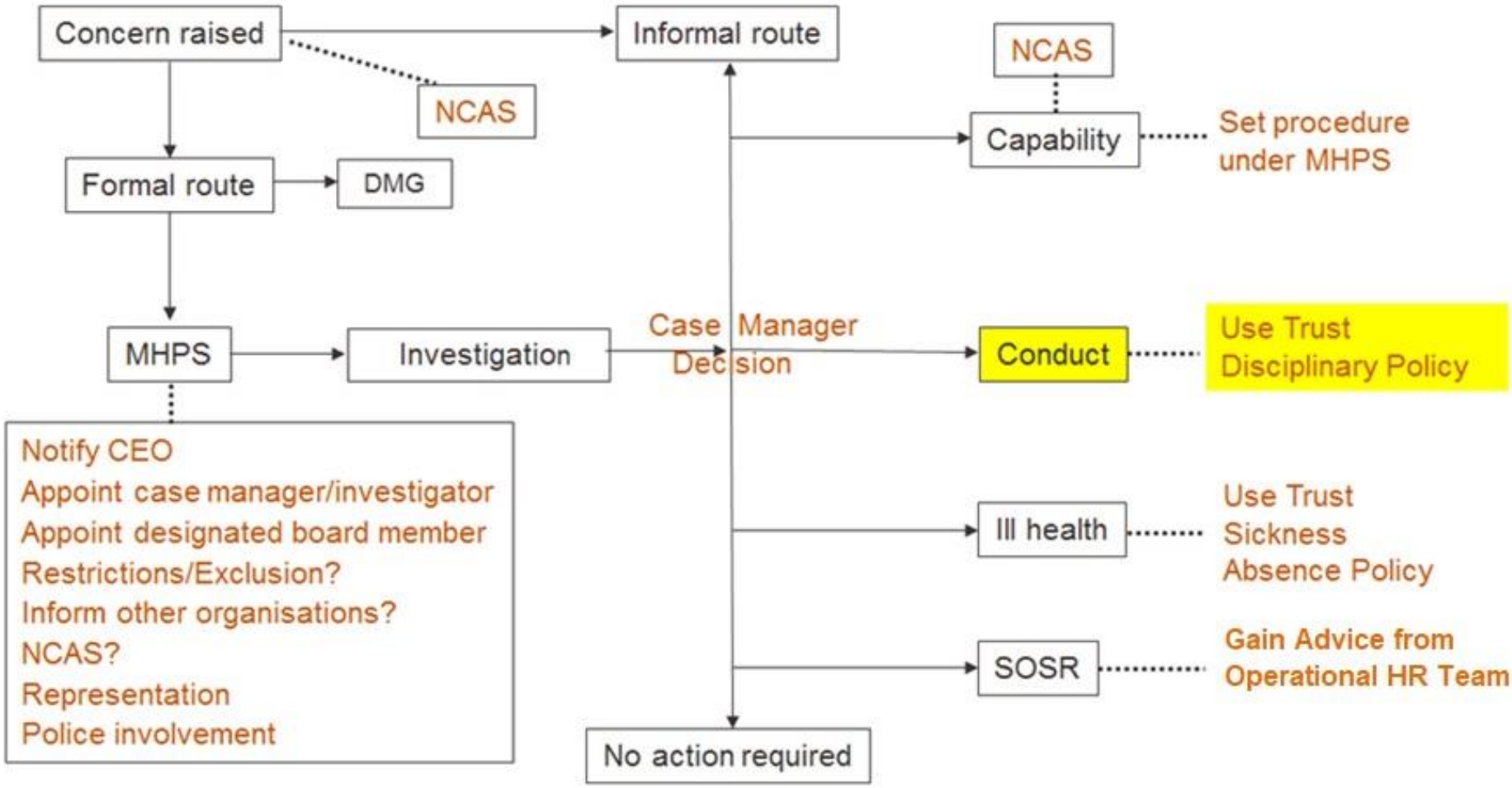
1. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organisational failures or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

2. The National Patient Safety Agency (NPSA) was established to coordinate the efforts of all those involved in healthcare to learn from adverse incidents occurring within the NHS. In particular, the NPSA aims to facilitate the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety.

3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues and should be dealt with in line with Part 4 of MHPS which provides specific guidance on how to apply this. In first instance advice should be obtained from the Operational Human Resources department about how to progress the management of any identified issues or concerns.

Appendix 3

Basic Process Flowchart of Maintaining High Professional Standards



TEMPLATE FOR BRIEFINGS TO CASE MANAGER (MEDICAL STAFF)

Birmingham and Solihull Mental Health NHS Foundation Trust

To:	(Case Manager)
From:	(Case Investigator)
Date:	(Date)
Case No:	(No.)
Name of Doctor under Investigation:	(Name of Doctor)
Update No:	(Reports to be submitted 2 weekly)

SUSTAINABILITY

9. Finance, Performance & Productivity Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9**
Paper title	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	18 August 2021
Author	Russell Beale - Non-Executive Director
Executive sponsor	

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

Executive summary
The Reaside and Highcroft Stakeholder Engagement plans over the next few months were discussed and agreed *The ongoing work of the BAF was reviewed.* *The financial plan for the Trust and the resultant changes from system-wide working were reviewed and agreed.* *The proposal for greater detailed reports as part of the Integrated Performance Report were agreed.*

Reason for consideration
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. Sustainability
Financial implications
Not applicable for this report
Risks
Financial risk relating to Reach Out provision is significant: management, mitigation and governance is still being worked on.
Equality impact
Reach Out programme assists us helping all sectors of the community.
Our values
Committed Compassionate Inclusive

REPORT FROM THE FPP COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Finance, Performance & Productivity Committee met on the 18 August 2021 with a summary of the key discussions being detailed below:

1.1 Month 4 2021/22 Finance Report

The Deputy Director of Finance presented the month 4 Finance Report for 2021/22 consolidated Group position is a surplus of £3.2m year to date. This is mainly due to non-recurrent slippage on recruitment against new investment. The financial plan for the first half of 2021/22 (H1) was re-submitted on 22 June 2021, with a planned break-even outturn.
Planning guidance for the second half of the year (H2) is expected in mid-September with submissions due in November.
The Capital position at month 4 year to date group capital expenditure is £0.6m, this is £0.4m less than plan. The total capital programme for 2021/22 is £10.3m.
The cash position is £34.2m.

Chair's assurance comments: We note the lack of guidance from the centre which is causing some uncertainty, but the finances are being managed within sensible expectations. The current finances are in a satisfactory position with good cash positions.

1.2 Integrated Performance Report

The Director of Finance confirmed the new Quality goals have been adopted by the Integrated Quality Committee. Their introduction into the dashboard will take a little while. New sets of metrics are also being finalised for the other domains following approval of the Trust Strategy.

The key issues noted were:

- IQC - Staff and patient assaults, prone restraints, commissioner reportable incidents, falls
- FPP – Out of area bed use, IAPT, financial position and CIP
- People - Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness; also the divergence in performance between different teams.

Chair's assurance comments: We are having a deeper dive into these figures shortly, once the dashboard is updated. Concerns are still there around recruitment, and e discussed possible CIP and noted actions on those.

1.3 Committee Name

All member considered the proposals to change the committee name and after deliberations agreed to maintain the current name and review this in six months' time.

Chair's assurance comments: Current name felt to be the best of the options; review in 6 months.

1.4 Hot Topics

Chair's assurance comments: None that didn't come up in the meeting

1.5 Committee Forward Plan

The Director of Finance presented the Committee forward plan and agreed the need to include the Reach Out Business Case and Highcroft SOC.

Given the current anxieties regarding the H2 guidance it was agreed this would be monitored on a quarterly basis to ensure the Committee has full oversight of the expenditure, digital strategy and compliance plans.

Chair's assurance comments: Noted and agreed.

Overall: effective meeting with discussion of key points, a range of opinions and questions for the exec, with coherent and strong answers.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.1**
Paper title	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	22 September 2021
Author	Gianjeet Hunjan - Non-Executive Director
Executive sponsor	Dave Tomlinson- Executive Director of Finance

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

Executive summary

The Reach Out readiness to proceed documentation was reviewed in detail and approved for submission to Trust Board.
Financial position noted with mitigations in place for associated risks.

Reason for consideration

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report

Risks

Financial risk relating to Reach Out provision is significant: management, mitigation and governance is still being worked on.

Equality impact

Reach Out programme assists us helping all sectors of the community.

Our values

Committed
Compassionate
Inclusive

REPORT FROM THE FPP COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Finance, Performance & Productivity Committee met on the 22 September 2021 with a summary of the key discussions being detailed below:

1.1 Month 5 2021/22 Finance Report

The Deputy Director of Finance presented the month 5 Finance Report for 2021/22 and reported the consolidated Group position as a surplus of £2.6m year to date. This is mainly due to non-recurrent slippage on recruitment against new investment. The financial plan for the first half of 2021/22 is a break-even outturn. Planning guidance for the second half of the year (H2) is subject to change.
Capital position at month 5 year to date Group capital expenditure is £1.1m, this is £0.7m less than plan. The total capital programme for 2021/22 is £10.3m.
Cash position is £37.6m.

Chair's assurance comments:

In relation to Capital, during September the Capital Review Group had been considering the next steps for utilizing the remaining envelope. The current finances are in a satisfactory position with good cash balances.

1.2 Integrated Performance Report and Detailed Report to include deep dive with additional operational input

The Associate Director of Performance and Information confirmed the new sets of metrics are being finalised for the other domains following approval of the Trust Strategy. Given this, the report this month does not include all the new metrics.

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

- IQC - Staff and patient assaults, prone restraints, commissioner reportable incidents, falls
- FPP – Out of area bed use, IAPT, financial position and CIP
- People - Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness; also the divergence in performance between different teams.

Work to reduce waiting times and the enhanced digital offer were noted and welcomed.

Chair's assurance comments:

We heard of the proposals to achieve zero Out of Area bed use by September 2021, with additional beds being procured. However the complexities involved meant the discussions with NHSE are ongoing.
In relation to IAPT services, we heard this was reviewed by the Performance Delivery Group during September. Additionally, a system wide forum has been set up together with support from the National IAPT team to work on an integrated approach to IAPT services across BSoL.

1.3 Information Governance Report

The Associate Director of Performance and Information presented this report. Following a governance review, it has been agreed quarterly reports will be submitted to the Committee for oversight and assurance.

The Committee were appraised on the current pressures and salient points were noted as:

- Training standards have not been met to the 95% compliance rate for Information Governance training. This is largely due to TSS staff. People Committee will review the data in detail.
- Internal audit confirmed all other areas are compliant
- Data security toolkit was launched in July 21, IGSG Lead is managing the challenges
- 2021/22 toolkit submission is due end of September and will include an improvement plan
- One serious incident reported to ICO, awaiting formal feedback

Chair's assurance comments:

We heard that compliance with Information Governance training had not been met for a second successive year. Actions being taken to achieve compliance were discussed, with future updates being provided to the Committee.

1.4 Readiness to Proceed Assessment – Reach Out

The Committee were given a detailed presentation on the Readiness to Proceed Assessment for Reach Out.
The Committee were assured all risks have been mitigated and will be reviewed closely on a regular basis.

The Committee endorsed the proposal with risks recognised.

Chair's assurance comments:

We had received the assessment of readiness to proceed, discussed the risks and were assured about the arrangements in place for Commissioning responsibilities. The Committee endorsed the proposal.

1.5 Revised Terms of Reference

The Director of Finance highlighted the updated membership for the Committee and agreed the Committee will meet at least eight times per year.
Revised version will be submitted to Trust Board for final approval.

Chair's assurance comments:

The revised version as highlighted was agreed for submission to Trust Board.

1.6 Reach Out Commissioning Sub-Committee Chairs report

The Committee noted the Chairs report and were assured the Sub-Committee had reviewed the proposal in detail and acknowledged the associated risks and mitigations.
The risk register is being developed to ensure full assurance can be given going forward.

Chair's assurance comments:

We heard from the Reach Out Commissioning Sub-Committee Chair and were assured this way of reporting to FPP worked well.

1.7 Committee Forward Plan

The Director of Finance presented the Committee forward plan and noted the dates may be subject to change.

The Committee agreed the forward plan will be updated and reviewed at next months meeting.

Chair's assurance comments:

Overview of the meeting was positive, with appropriate discussions of some big issues, together with a significant amount of details. Positive feedback from all in attendance.

10. Integrated Performance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10**
Paper title	**INTEGRATED QUALITY COMMITTEE CHAIR REPORT**
Date	29 September 2021
Author	Linda Cullen, Chair of IQC
Board sponsor	Linda Cullen, Chair of IQC

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

Executive summary
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. Quality
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

REPORT FROM THE IQC COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

1.1 CQC Section 31 Improvement Plan Progress Report

The Executive Director of Quality and Safety (Chief Nurse) presented the report on the latest submission to the Care Quality Commission as part of our section 31 monitoring regime. She added The CQC have confirmed that we have now been 'de-escalated' from weekly monitoring. Monthly reporting will however continue for the foreseeable future.
The Committee were assured the overall position remains positive with continued audits and safety huddles in place.

The Executive Director of Quality and Safety (Chief Nurse) confirmed the Clinical Educator roles are being appointed too.

Chair's assurance comments:
Steady progress is being made within the key areas of relational and procedural security as well as the prioritisation of certain wards for alarm installation It was good to hear that CQC are also satisfied with our progress and have moved us to monthly reporting .
We will, however continue to keep a close focus on these areas especially in respect of minimum MDT standards and local team ownership and recognition of importance of these patient care and safety approaches .
The clinical educators' roles are an important investment in achieving our aims of continually improving staff and team understanding and learning of what good patient care should be like alongside learning from our service users

1.2 Responding to COVID -19

The Executive Director of Quality and Safety (Chief Nurse) confirmed there is a defined outbreak on Sage ward with three service use a- symptomatic. All are now testing negative, no concerns were raised.

The Committee were informed of small numbers of staff testing positive across the wards noting incidents remain low.

There was a detailed discussion regarding the guidance relating to isolating and the impact this could have on staff attending work.
The Executive Director of Quality and Safety (Chief Nurse) confirmed there are wider discussions taking place locally to agree adapting the guidelines to maintain safe risks. The committee highlighted the importance of equalities and need to consider the impact on populations trust wide.

Chair's assurance comments:

The committee was assured that staffing requirements continue to be actively managed during the ongoing pandemic by various measures such as the grand huddles and moving staff to areas of higher clinical need ,ongoing testing and supporting staff vaccination uptake.

1.3 SI Escalation

The Committee were appraised of a cluster of deaths at Reservoir Court including two inpatient deaths and one whilst on section 17 leave. The committee were assured processes are being followed with a rapid review on physical health and inpatient units being completed, the findings will be presented within next month's report.

Both the Executive Director of Quality and Safety (Chief Nurse) and Medical Director confirmed they are completing multi- disciplinary monitoring together including CPD, MDT, Clinical Service Strategy, and physical health as a priority.

Chair's assurance comments:
It will be useful to review the findings of the assessment of physical health procedures and approaches on the inpatient units at the next meeting in the light of the cluster of deaths we have had recently . It is well known that patients with severe and enduring mental illness have significant comorbid health conditions as well as shortened life expectancy compared to those without long term mental illness.
It was also encouraging to see a continued emphasis on effective multidisciplinary working and continuing professional development to support up to date and effective and safe practices

1.4 Learning from Deaths Quarterly Report

The Committee received the report and noted there will be a themed review into absconsions to ensure all risks are considered and monitored appropriately going forward. The Medical Director confirmed the Committee will maintain oversight.

The Medical Director confirmed the format of the report is being reviewed and will be updated for next month's meeting to ensure the baseline and progress is highlighted. The need to triangulate the data will be incorporated.

There was a detailed discussion regarding the need to reinstate clinical visits and it was agreed the process for Executive Directors, Non-Executive Directors ad Governors will be reviewed.

Chair's assurance comments: It will be important to conduct a comprehensive thematic review of absconsions to gain a greater understanding of the factors linked to these from a staff and ward as well as patient perspective . It will also be useful to include the learning from reg 28 reports from other trusts where death has occurred whilst patients have absconded from inpatient care settings.
I look forward to seeing the new format of reports at the next meeting which I anticipate will help us to see baseline data and then allow us to see progress and trends and variations from these as well as being able to compare and triangulate with other linked data
We also had an important discussion and about the benefits and risks of restarting clinical site visits and the importance of such visits in gaining assurance as well as visibility of senior leadership within the organisation .

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**All Committees and Board**
Agenda item	**10**
Paper title	**Integrated Performance Report**
Date	29/9/2021
Author	Richard Sollars, Deputy Director of Finance Rob Grant, Interim Associate Director of 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:

New Quality goals have been adopted by the Integrated Quality Committee. Their introduction into the dashboard will take a little while. New sets of metrics are also being finalised for the other domains following approval of the Trust Strategy.

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

- IQC - Staff and patient assaults
- FPP – Out of area bed use, IAPT, eating disorders, CPA (Care Programme Approach) 12-month reviews, new referrals not seen, financial position and CIP (Capital Improvement Plan)
- People - Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness. Also the divergence in performance between different teams

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 Report

Context

New Quality goals have been adopted by the Integrated Quality Committee. Their introduction into the dashboard is under discussion and will take a little while. New sets of metrics are also being finalised for the other domains following approval of the Trust Strategy and will involve some transition.

We will move to new reporting cycles as previously agreed by the Board from January 2022. We will continue to report the overall Trust position and overall performance to the first meeting following the month in question but supplement this with a triangulated, more detailed thematic review to provide more insights and intelligence into what's happened, the consequences and planned improvements. As an example, in September the Board would receive aggregate performance information regarding August supplemented by a more detailed analysis of July's performance.

Performance in August 2021

The key performance issues facing us as a Trust have changed little over the last six 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 has significantly impaired our ability to eliminate use of out of area beds. There have been good reductions over the last four months, but the figure has now increased to 652 occupied bed days (10 patients)
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. While this has deteriorated as a result of COVID, the divergence between individual teams is of concern:
- **Financial position and CIP** – Financial control totals have only just been set for 2021/22 and we are still developing plans. We have thus yet to identify savings, but are currently performing better than plan as a result of delays in recruitment against additional funding for new services

Quality

- A new set of Quality goals have been approved by IQC. Their introduction into the dashboard will take a little time and the removal of some old ones has impacted on the old positions
- The reported level of physical assaults on service users and staff has substantially risen this month
- Levels of prone and physical restraint remain at low levels
- Incident reporting levels have reduced
- **Key concerns: Staff and patient assaults**

Performance

- The level of Out of Area Patients remains the main concern. The national requirement was for this to be eliminated by April, but this was renegotiated to September. The figure for August has risen to 652 occupied bed days (21.0 patients),
- IAPT patients seen within 6 weeks of referral has fallen eleven months in succession to 32%, the lowest position in entire reporting period (65 months since Apr-16). It reflects large number of staff vacancies (12% - 17.5 WTE)

- Compliance with eating disorder waiting time targets has plummeted though there was only 1 urgent service user and 4 routine.
- The % of service users on CPA having a formal review in the last 12 months remains a worry at 89%
- New referrals not seen within 3 months are of concern and have increased in month to 2,322, the highest level since Feb-21
- **Key concerns: Out of Area, IAPT seen in 6 weeks, Eating disorders, 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
- Sickness levels have reduced to 6.6% but remains the second highest since Feb-21. Variation: Medical directorate 0.6% v Older People 9.9%
- Return to work interviews improved to 63%, but still well below target of 85%. Variation: Urgent Care 20% on 10 people v Tamarind 92% on 25
- Shift Fill is at 82.9%, the lowest level since Feb-21, against a standard of 95% - the main issue is Secure (75%), which has the highest number of requested shifts (5,874 out of a total of 16,084, the highest requirement since Jan-21)
- Fundamental training at 91.2% is at its second highest level since Apr-20 but remains below the 95% standard with temporary staffing a particular issue (57% for IG training, lowest level since this has been separately analysed). Variation: Medical directorate 77% on 169 people v NAIPS 96% on 165.
- Appraisals up to 82.4% but still significantly below pre-COVID levels and target. Variation: Psychology 45% on 29 v CMHT 93% on 246
- Rolling 12-month turnover and agency expenditure continue to be better than plan
- Vacancies remain high at 10% (416.2 WTE)
- **Key concerns: Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness**

Sustainability

- The financial result to August is better than plan with a YTD surplus of £2.6m against a planned breakeven, as a result of delays in recruitment against additional funding for new services. In month position is £0.6 overspend against planned breakeven Savings plans are yet to be set for 2021/22. No savings have been identified as yet
- Cash and property standards remain well above target
- Cap Ex performance against plan remains a little down in month as a result of delays at start of year in agreeing capital programme, expected to catch up
- Information Governance position improved overall, but still held back by training of temporary staff
- **Key concerns: CIP under achievement impacting adversely on Operating Surplus, uncertainty regarding national financial ask**

Integrated Performance Report

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Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

* **Performance: IAPT seen in 6 weeks worsen**
* **People: Continues to be adversely affected by COVID**
* **Quality: reported incidents**

Division: A: All

A: All

August-2021

Performance

CPA 7 day FU	91.0% ↓
CPA with Formal Review last 12 mths	89.2% ↓
Data Quality Maturity Index (DQMI)	97.4% ↑
Delayed Transfer Bed Days	1007
Delayed Transfer, percent of bed days	6.2%
Eating disorders routine	75.0% ↓
Eating disorders urgent	0.0% ↓
First episode psychosis	100.0%
IAPT into recovery	56.2% ↑
IAPT seen in 18 weeks	91.6% ↓
IAPT seen in 6 weeks	31.7% ↓
Out of Area Bed Days	652
Referrals over 3 mths with no contact	2322 ↓

People

Bank & Agency Fill Rate	82.9% ↓
Fundamental Training	93.4% ↓
Rolling 12m Turnover	9.5% ↑
Staff Appraisals	81.5% ↓
Staff Sickness	6.1% ↓
Staff Vacancies	9.7% ↓

Quality

Absconsions and Failures to Return	17 ↑
Commissioner reportable incidents	2
Community suicides	0
Duty of Candour	1 ↓
Falls resulting in harm	0
Homicides	0
Incidents resulting in harm	14.8% ↑
Inpatient suicides	0
Never Events	0
Patient Assaults / 1000 OBD	3.3
Pressure Scores	2 ↓
Prone restraints/ 1000 OBD	2.9
Reported incidents	1991 ↓
Staff Assaults / 1000 OBD	5.5

Sustainability

CAP Ex	£427k
Cash	£37,630k ↑
CIP	£0k ↓
Info Governance	88.2%
Monthly Agency	£441k ↑
Operating Surplus	£555k
Property	98.5% ↑
SOF rating	2 ↓

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

compassionate inclusive committed

Integrated Performance Dashboard

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
CPA 7 day FU	95.00	95.8%	95.1%	94.7%	93.8%	90.0%	91.0% ↓
CPA with Formal Review last 12 mths	95.00	88.1%	88.3%	88.5%	88.6%	89.1%	89.2% ↓
Data Quality Maturity Index (DQMI)	95.00	98.2%	98.2%	98.6%	98.5%	97.4%	97.4% ↑
Delayed Transfer Bed Days		825	797	922	997	1232	1007
Delayed Transfer, percent of bed days		5.2%	5.1%	5.7%	6.4%	7.8%	6.2%
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	75.0% ↓
Eating disorders urgent	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	0.0% ↓
First episode psychosis	60.00	100.0%	80.0%	100.0%	100.0%	85.7%	100.0%
IAPT into recovery	50.00	55.5%	59.2%	55.1%	55.5%	52.3%	56.2% ↑
IAPT seen in 18 weeks	95.00	100.0%	99.2%	94.7%	97.1%	93.1%	91.6% ↓
IAPT seen in 6 weeks	75.00	45.1%	41.8%	36.7%	34.3%	32.9%	31.7% ↓
Out of Area Bed Days		1029	643	664	566	572	652
Referrals over 3 mths with no contact		2292	2227	2256	2167	2146	2322 ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* **IAPT seen in 18 weeks and IAPT seen in 6 weeks**
* **New referrals not seen in 3M - down to 2,322 performance standard not yet agreed**
* **CPA 12 month review - standards under discussion**

SOME CONCERNS

* None

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Staff Vacancies	6.00	7.9%	8.2%	9.5%	10.0%	9.9%	9.7% ↓
Staff Sickness	4.28	5.3%	5.3%	5.3%	6.0%	6.6%	6.1% ↓
Staff Appraisals	90.00	80.8%	80.8%	82.6%	82.5%	81.6%	81.5% ↓
Rolling 12m Turnover	11.00	8.9%	8.9%	9.2%	9.5%	9.5%	9.5% ↑
Fundamental Training	95.00	90.7%	91.3%	92.0%	93.3%	93.2%	93.4% ↓
Bank & Agency Fill Rate	95.00	88.6%	89.3%	88.8%	86.3%	83.8%	82.9% ↓

Top Line Commentary (Trust level)

KEY CONCERNS

* **Fundamental training at lowest level**
* **Sickness rate is increasing**
* **Appraisals remain very low**

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division: A: All

A: All

Measure	Latest Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Absconsions and Failures to Return	0.00	7	15	25	22	15	17 ↑
Commissioner reportable incidents	0.00	10	3	7	4	7	2
Community suicides	0.00	4	0	1	0	0	0
Duty of Candour	0.00	0	0	0	0	1	1 ↓
Falls resulting in harm	0.00	1	0	0	1	0	0
Homicides	0.00	0	0	0	0	0	0
Incidents resulting in harm	0.00	16.6%	16.8%	16.4%	12.2%	15.8%	14.8% ↑
Inpatient suicides	0.00	0	0	0	0	0	0
Never Events	0.00	0	0	0	0	0	0
Patient Assaults / 1000 OBD	0.00	2.8	2.1	2.0	1.9	1.5	3.3
Pressure Scores	0.00	4	1	0	1	3	2 ↓
Prone restraints/ 1000 OBD	0.00	5.8	4.6	4.5	2.7	2.2	2.9
Reported incidents	0.00	1947	1818	1932	2025	2235	1991 ↓
Staff Assaults / 1000 OBD	0.00	4.5	3.4	4.2	4.8	4.8	5.5

Top Line Commentary (Trust level)

KEY CONCERNS:

* **Reported incidents**

SOME CONCERNS:

* Absconsions and failures to return

NO CONCERNS:

All other metrics on or close to target

	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**

Division

A: All

A: All

Measure	Latest Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	
CAP Ex		£3,693k	£55k	£334k	£88k	£176k	£427k	
Cash	27,709,244.44	£28,803k	£28,160k	£28,642k	£27,830k	£34,188k	£37,630k	↑
CIP		£319k	£0k	£0k	£0k	£0k	£0k	↓
Info Governance	100.00	91.7%	80.1%	88.6%	92.5%	86.6%	88.2%	
Monthly Agency		£478k	£405k	£366k	£462k	£478k	£441k	↑
Operating Surplus		£707k	£315k	-£1,116k	-£1,776k	-£651k	£555k	
Property	95.00	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	↑
SOF rating	3.00	3	3	3	2	2	2	↓

Top Line Commentary (Trust level)

KEY CONCERNS:

* **Surplus, Cash, SOF figures artifically boosted by COVID - Surplus slightly better on mid-year forecast**
* **Removal of top-up funding exposes underlying performance**
* **CIP will be an issue when national funding regime returns to normal**
* **SOF remains at 'normal' position**

SOME CONCERNS: IG held down by poor compliance by temporary staff

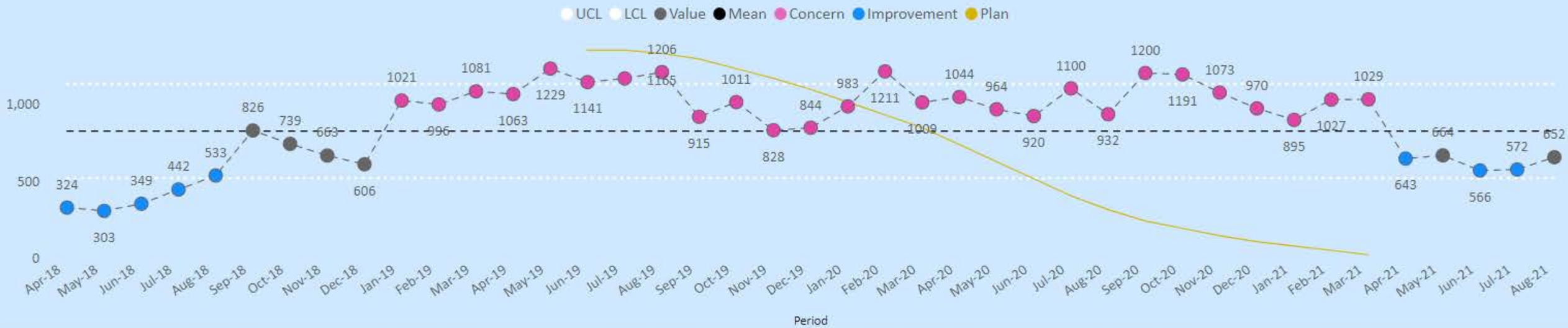
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	1029	643	664	566	572	652
B: Acute and Urgent Care	1029	643	664	566	572	652

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 has been sustained in May - July with a slight increase in August to 652 days. There were a total of 19 new out of area placements in August.

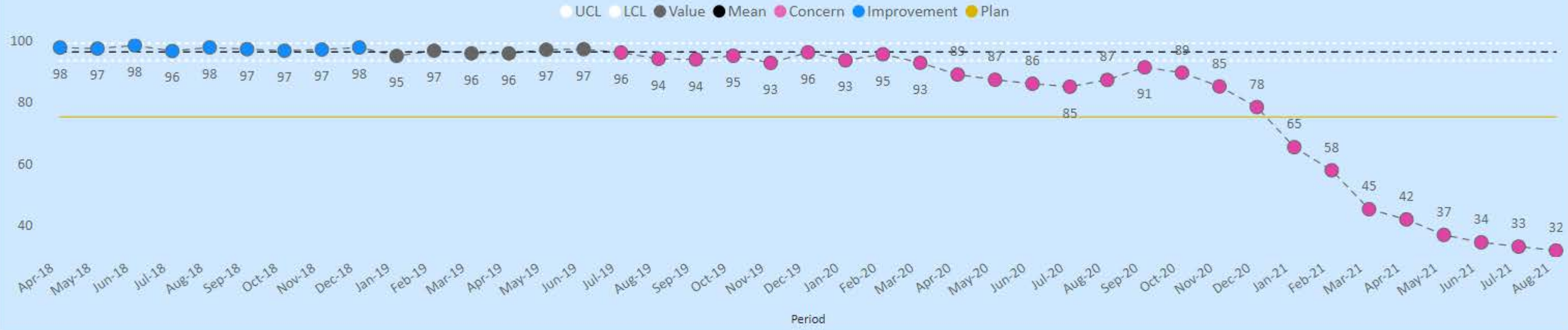
A revised target has been agreed with NHSE/I to reduce OOA bed usage to zero by the end of quarter 2 (September 2021).

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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	45.1%	41.8%	36.7%	34.3%	32.9%	31.7%
E: Specialties	45.1%	41.8%	36.7%	34.3%	32.9%	31.7%

Commentary

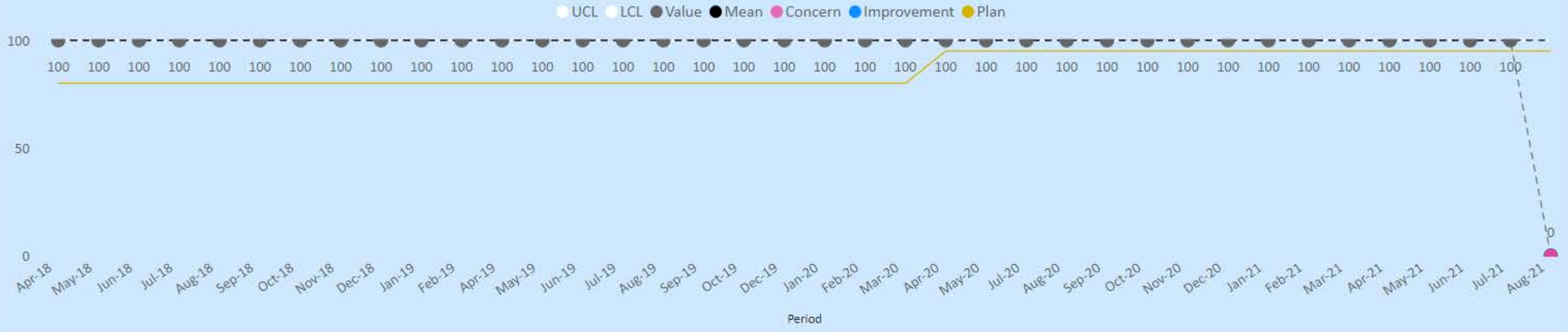
Performance has been on a reducing trend since March 2020 and remains well below the 75% target at 30.80% and outside control limits.
The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in a timely way. The majority of contact with service users remains via telephone and this is not always the most suitable form of contact.

Birmingham and Solihull Mental Health NHS Foundation Trust

Eating disorders urgent

Divisions

Statistical Process Control (SPC)



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

Division	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
C: ICCR			100.0%			
E: Specialties						0.0%

Commentary

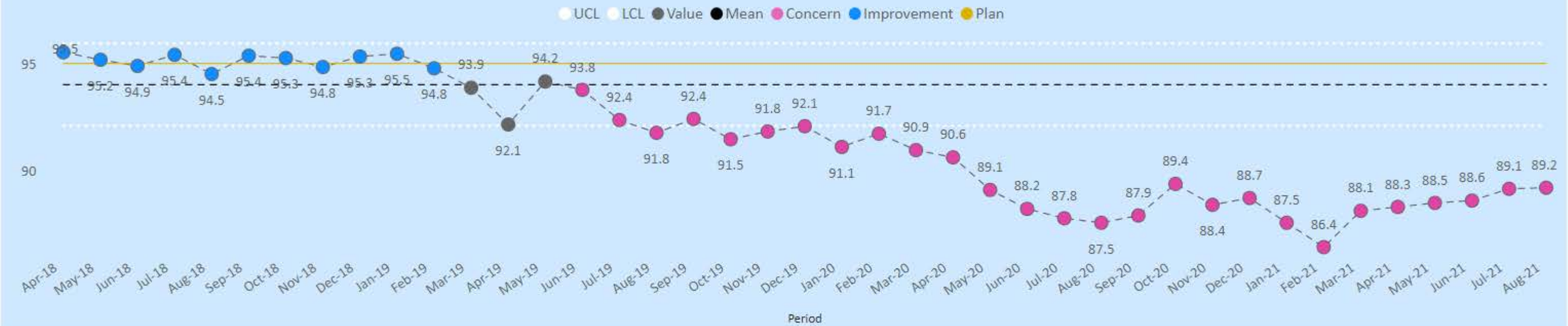
Consistently meet and exceed the national target of 7 days for urgent referrals (95%). This is a very small volume service for the Trust demonstrated by August 2021 performance being at 0%. This is due to only one patient being referred to the Barberry service, however the service user chose to defer the appointment offered and agreed to a later date due to personal circumstances resulting in this breach of the target.

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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	88.1%	88.3%	88.5%	88.6%	89.1%	89.2%
B: Acute and Urgent Care	8.1%	16.7%	66.7%	50.0%	33.3%	50.0%
C: ICCR	88.5%	86.9%	88.6%	86.8%	87.5%	89.3%
D: Secure Serv & Offender Health	97.8%	97.9%	99.1%	98.5%	98.2%	98.3%
E: Specialties	77.7%	77.0%	77.3%	77.2%	75.6%	78.7%

Commentary

Performance has consistently declined over the last year and has been outside the control limits since July 2019. The rate has been sustained at an average of 89% since April 21. Adult CMHT account for 57%, older adult CMHT for 4%, secure services for 12% and AOT for 20%.

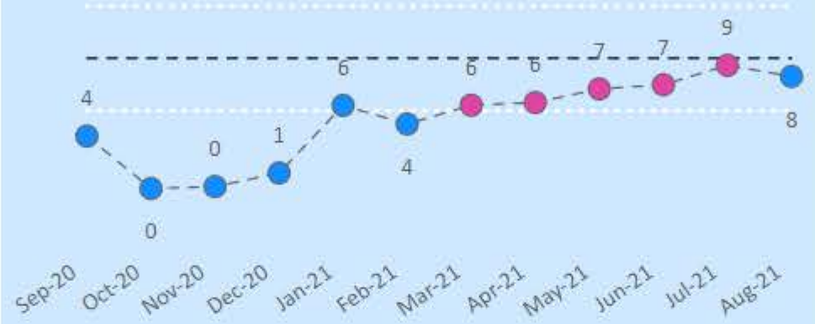
Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Vacancies

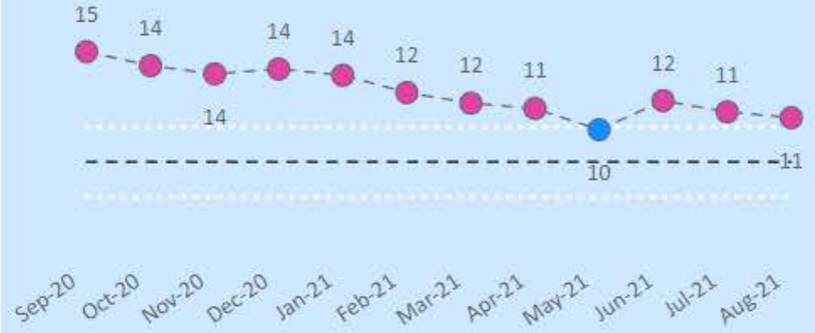
Trust level

A: All

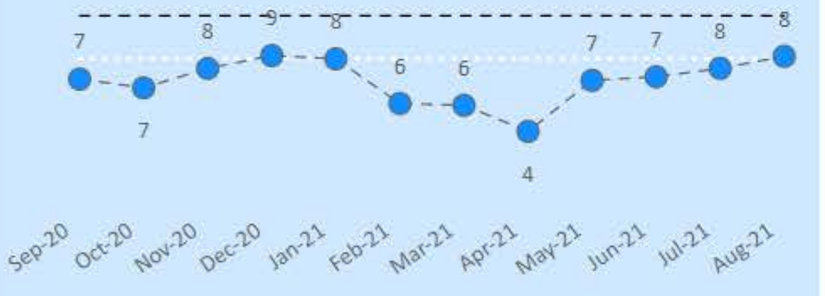
B: Acute and Urgent Care



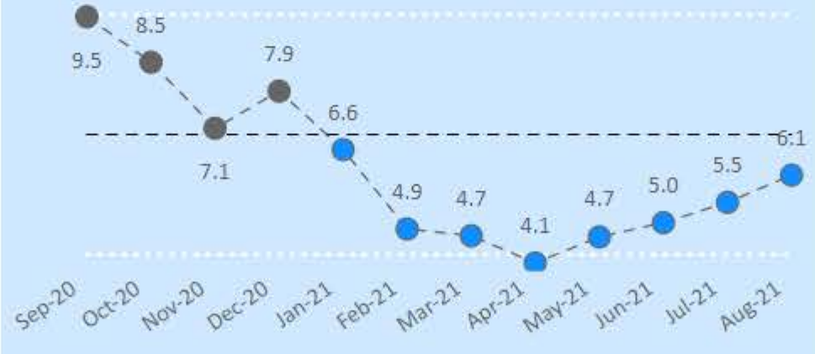
C: ICCR



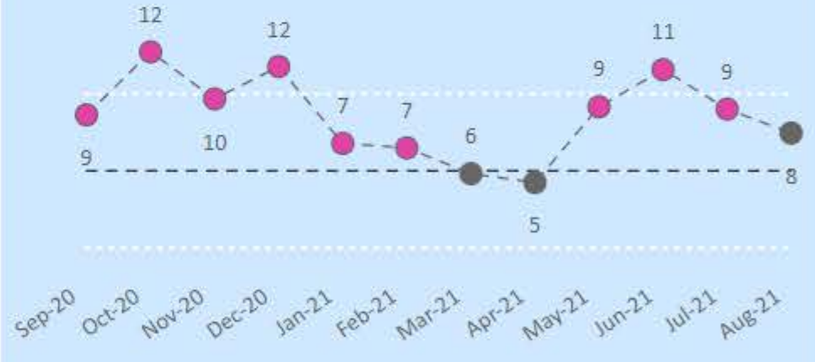
D: Secure Serv & Offender Health



E: Specialties



F: Corporate



Key

UCL LCL Value Mean Concern Improvement

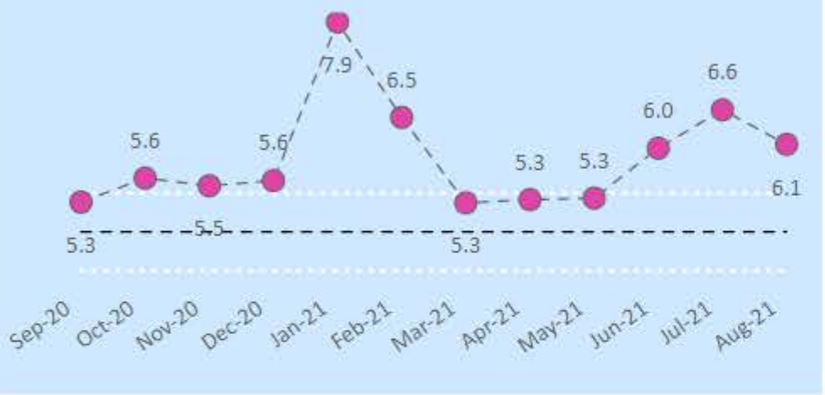
compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

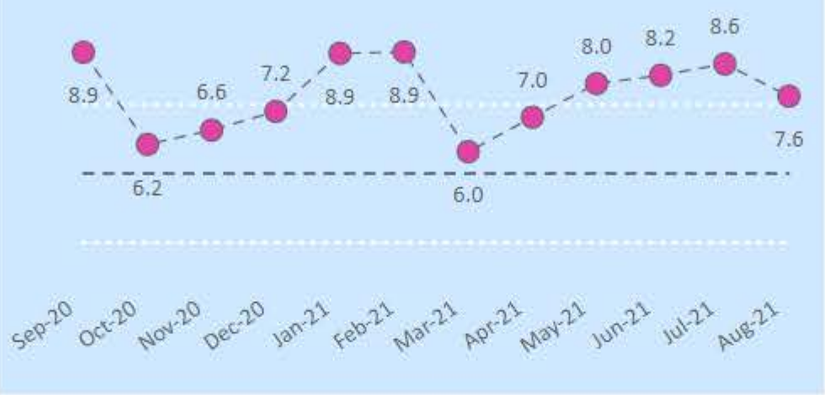
Staff Sickness

Trust level

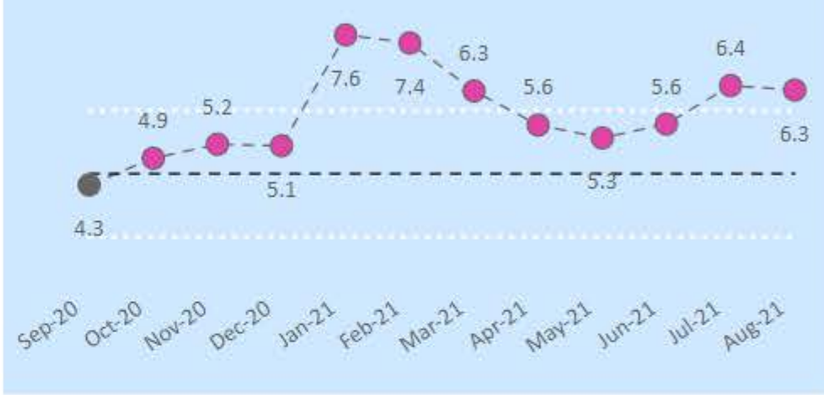
A: All



B: Acute and Urgent Care

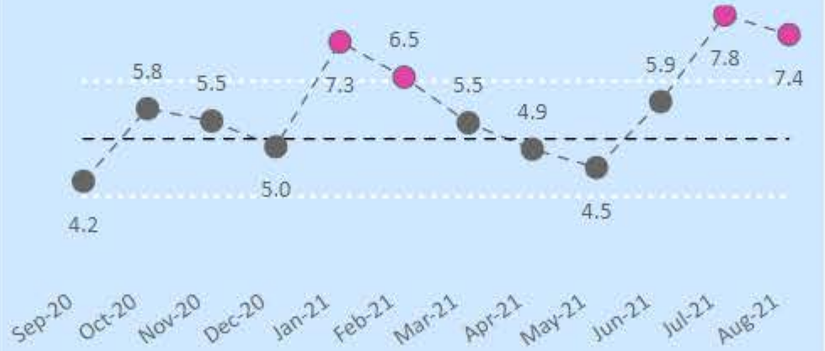


C: ICCR

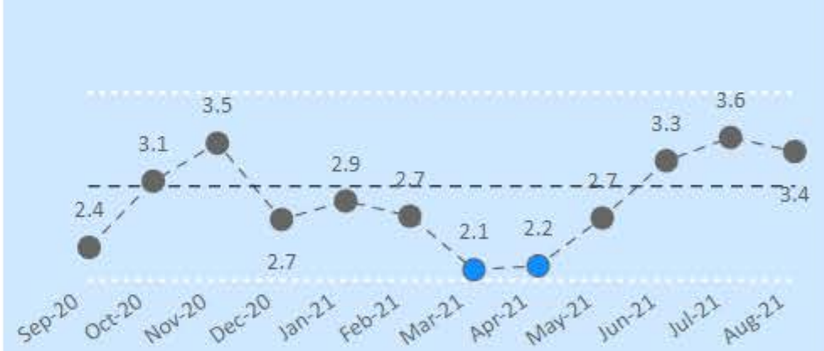


D: Secure Serv & Offender Health

E: Specialties



F: Corporate



Key

UCL LCL Value Mean Concern Improvement

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

CIP

Divisions

Statistical Process Control (SPC)

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

Division	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	£319k	£0k	£0k	£0k	£0k	£0k

Commentary

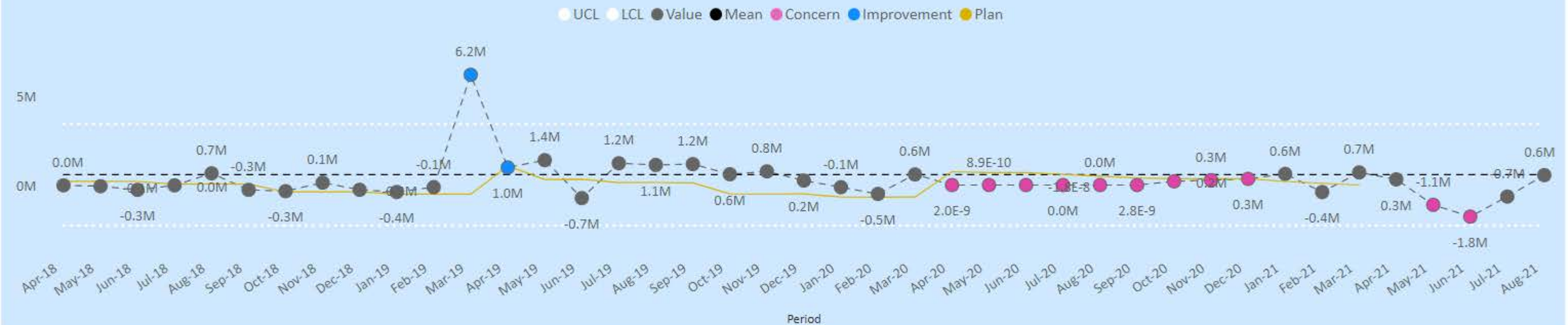
There are no CIP plans yet developed for 21/22

Birmingham and Solihull Mental Health NHS Foundation Trust

Operating Surplus

Divisions

Statistical Process Control (SPC)



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

Division	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	£707k	£315k	-£1,116k	-£1,776k	-£651k	£555k

Commentary

YTD surplus of of £2.6m v plan of breakeven

Birmingham and Solihull Mental Health NHS Foundation Trust

Cash

Divisions

Statistical Process Control (SPC)

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

Division	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	£28,803k	£28,160k	£28,642k	£27,830k	£34,188k	£37,630k

Commentary

Cash is up to £37.6m, down on Feb-21 (£52.5m), but up £11m since May-21 and still well above acceptable levels (18m)

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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A: All	£3,693k	£55k	£334k	£88k	£176k	£427k

Commentary

Monthly spend taking time to catch up, given delay in agreeing capital programme, YTD spend of £1,081k v plan of £1,772k

11. Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**11**
Paper title	**Month 5 2021/22 Finance Report**
Date	29 September 2021
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

Executive summary & Recommendations:

Revenue position
The month 5 2021/22 consolidated Group position is a surplus of £2.6m year to date. This is mainly due to non-recurrent slippage on recruitment against new investment. The financial plan for the first half of 2021/22 (H1) is a break-even outturn. Planning guidance for the second half of the year (H2) is expected in mid-September with submissions due in November.

Capital position
Month 5 year to date Group capital expenditure is £1.1m, this is £0.7m less than plan. The total capital programme for 2021/22 is £10.3m.

Cash position
The month 5 Group cash position is £37.6m.

Reason for consideration:

Update on month 5 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 Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Linked to existing BAF2_0012
Equality impact assessments:
N/A
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 2021 to 31st August 2021

Month 5 financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	H1 Budget *Revised June '21 NHSEI submission* £'000	YTD Position Budget £'000	YTD Position Actual £'000	YTD Position Variance £'000
Income				
Healthcare Income	143,980	119,976	120,601	625
Other Income	7,502	6,259	7,328	1,069
Total Income	**151,482**	**126,235**	**127,929**	**1,694**
Expenditure				
Pay	(109,400)	(91,167)	(91,728)	(561)
Other Non Pay Expenditure	(21,949)	(18,257)	(19,493)	(1,236)
Drugs	(2,959)	(2,466)	(2,667)	(201)
Clinical Supplies	(570)	(475)	(206)	269
PFI	(5,198)	(4,332)	(4,277)	55
Unallocated Budgets	(3,263)	(2,719)	-	2,719
EBITDA	**8,142**	**6,819**	**9,559**	**2,740**
Capital Financing				
Depreciation	(4,042)	(3,368)	(3,417)	(49)
PDC Dividend	(1,182)	(985)	(982)	3
Finance Lease	(2,183)	(1,819)	(1,826)	(7)
Loan Interest Payable	(631)	(527)	(527)	0
Loan Interest Receivable	49	40	0	(40)
Surplus / (Deficit) before taxation	**152**	**160**	**2,807**	**2,647**
Profit/ (Loss) on Disposal	40	-	-	-
Taxation	(192)	(160)	(160)	-
Surplus / (Deficit)	**0**	**0**	**2,647**	**2,647**

Month 5 2021/22 Group Financial Position

The month 5 2021/22 consolidated Group financial position is £2.6m surplus year to date. This is mainly due to non-recurrent slippage on recruitment against new investment.

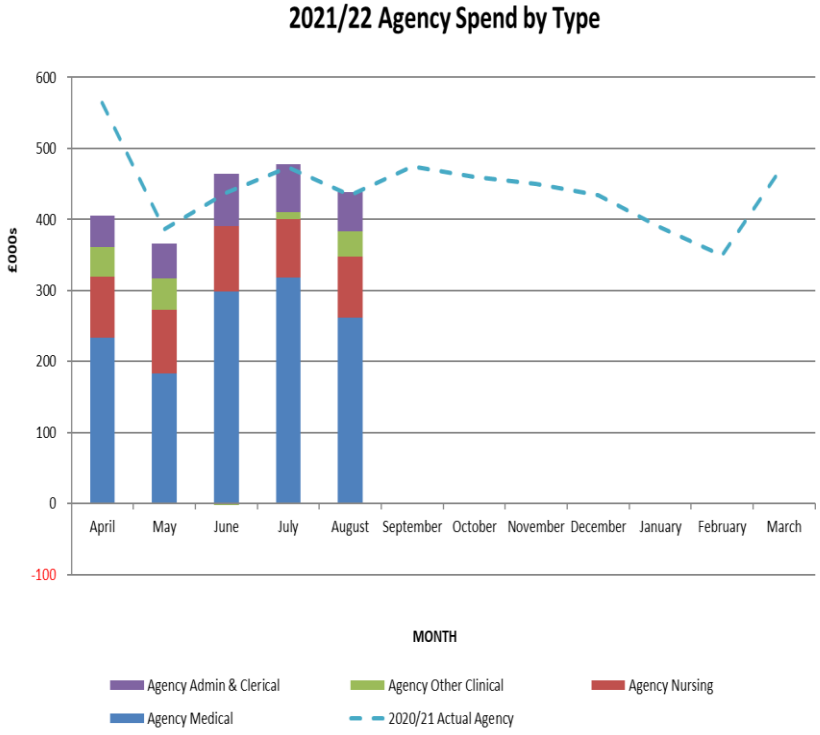
H2 Plan – current indications

It is expected that H2 planning guidance (to cover October 2021 to March 2022) will be issued mid to late September, with system and Trust submissions due in November.

Agency expenditure

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 YTD
Agency Spend (£000s)	405	366	462	478	439							2,151
NHSEI Ceiling (£000s)	501	501	501	501	501	501	499	499	499	499	499	2,506
Net (£000s)	**96**	**135**	**39**	**23**	**63**	**501**	**499**	**499**	**499**	**499**	**499**	**355**

Agency Medical	234	183	298	318	261							1,294
Agency Nursing	86	91	92	82	87							438
Agency Other Clinical	42	44	(2)	10	36							130
Agency Admin & Clerical	44	49	74	68	55							289
Agency Spend (£000s)	**405**	**366**	**462**	**478**	**439**	**0**	**0**	**0**	**0**	**0**	**0**	**2,151**



Agency spend decreased from £478k in July to £438k in August; this is £4k more than agency spend in August 2020. Year to date expenditure is £2.2m, this is £355k below the estimated NHSEI year to date ceiling.

Agency controls are in place to ensure that spend remains below target:

- Rapid, substantial recruitment to the bank took place in 2020/21 in response to COVID-19 which has greatly increased bank capacity and this recruitment is continuing in 2021/22.
- There are a number of bank staff currently unable to work in areas which require AVERTS due to an under-resource in AVERTS training capacity however, as more individuals complete their training, bank capacity is increasing. Two core skills trainers that can deliver ELS, AVERTS and CRAM have been recruited and started in August 2021 (one permanent and one FTC) which will increase training capacity. Guidance has been produced on where and how staff can work dependent on previous training whilst they are awaiting AVERTS training and those who have completed alternative restraint reduction courses are fast tracked on to one day AVERTS updates where appropriate.
- In response to significant staffing pressures, HCA over-recruitment was stood back up for Q4 of 2020/21 and we are currently over establishment for HCAs– the HCA over-recruitment initiative has reduced HCA agency spend.
- Work continues with operational areas to convert long term agency into substantive offers of employment Trust-wide.
- Recruitment plans continue to be developed and reviewed with each service to address clinical vacancies and recruit to additional posts identified through the Long Term Plan expansion requirements and the 2021/22 Spending Review Funding.
- The Workforce Transformation workstream continues to focus on upskilling our workforce, additional workforce supply, new roles and new ways of working and retention to address high levels of substantive vacancies.
- Following the pilot of MHOST in 2020/21, work is continuing with the tool to roll out a bi-annual establishment review process.
- The Trust continues to run processes to ensure the staffing impact of COVID-19 is minimised to help prevent heavy reliance on agency workers. A review of the staffing impact of long covid has been undertaken.
- The Workforce Initiatives Group (previously the Redeployment Group) is meeting weekly to respond to urgent workforce pressures and recruitment blockers that arise and to progress initiatives to drive up workforce supply and availability.
- There is a new CIP for temporary staffing costs which will aims to provide a compliant flexible workforce, a decrease in expenditure, an increase in bank fill rates, a reduction in unfilled shifts and overall demand and recruitment programmes to attract high quality bank and substantive staff.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - Final 31-Mar-21 £m's	NHSI Plan YTD 31-Aug-21 £m's	Actual YTD 31-Aug-21 £m's	NHSI Plan Forecast 31-Mar-22 £m's
Non-Current Assets				
Property, plant and equipment	186.5	180.1	184.2	183.2
Prepayments PFI	1.6	1.4	1.9	1.4
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	-	-	(0.0)	-
Deferred Tax Asset	0.1	(0.0)	0.1	(0.0)
Total Non-Current Assets	188.1	181.4	186.2	184.5
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	9.7	7.4	12.3	7.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	27.7	37.6	19.8
Total Curent Assets	38.9	35.5	50.2	27.6
Current liabilities				
Trade and other payables	(29.4)	(29.0)	(35.5)	(28.0)
Tax payable	(4.4)	(4.4)	(4.3)	(4.4)
Loan and Borrowings	(2.7)	(2.7)	(2.6)	(2.7)
Finance Lease, current	-	-	-	-
Provisions	(1.2)	(0.7)	(1.2)	(0.7)
Deferred income	(13.2)	(11.2)	(14.9)	(11.2)
Total Current Liabilities	(50.9)	(48.1)	(58.4)	(47.1)
Non-current liabilities				
Loan and Borrowings	(29.5)	(28.4)	(28.4)	(27.3)
PFI lease	(49.3)	(48.7)	(48.7)	(47.7)
Finance Lease, non current	-	-	0.0	-
Provisions	(2.4)	(1.8)	(3.4)	(1.8)
Total non-current liabilities	(81.3)	(78.9)	(80.5)	(76.9)
Total assets employed	94.9	90.0	97.5	88.1
Financed by (taxpayers' equity)				
Public Dividend Capital	110.5	110.5	110.5	110.5
Revaluation reserve	27.5	24.6	27.5	24.6
Income and expenditure reserve	(43.1)	(45.2)	(40.5)	(47.0)
Total taxpayers' equity	94.9	90.0	97.5	88.1

SOFP Highlights

The Group cash position at the end of August 2021 is £37.6m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 5 to 6.

Current Assets & Current Liabilities

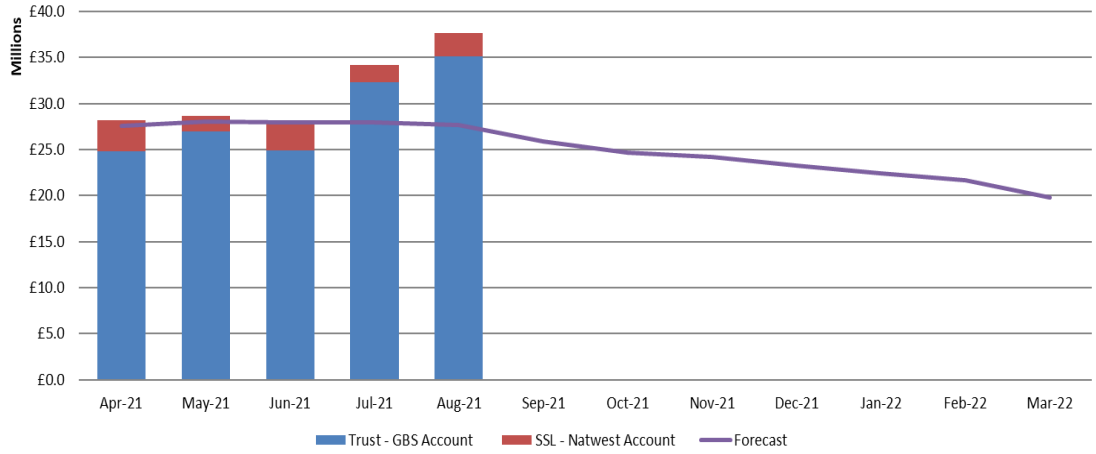
Ratios

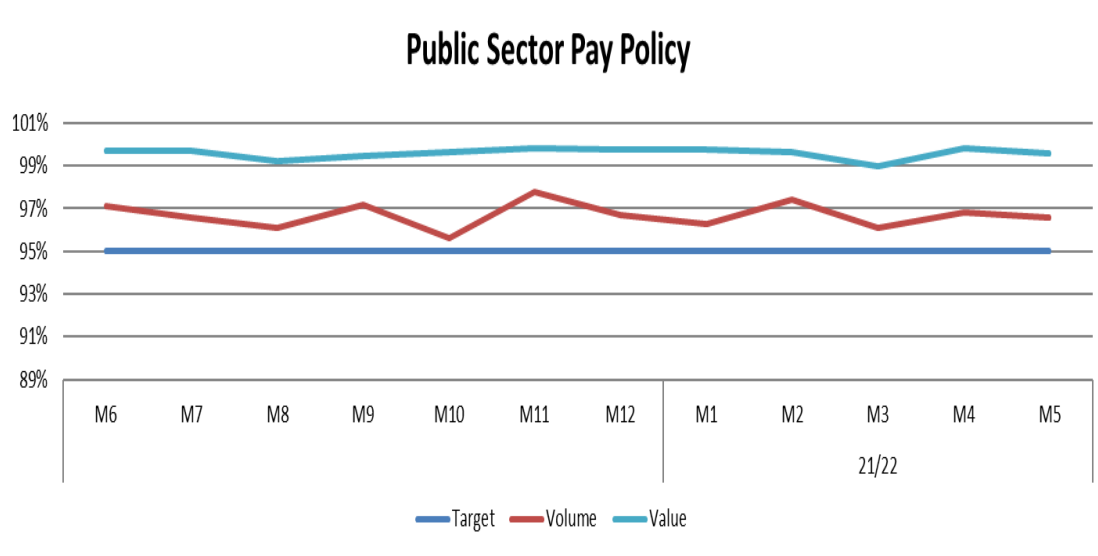
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	50.2
Current Liabilities	-58.4
Ratio	0.9

Current Assets to Current Liabilities cover is 0.9:1 this shows the number of times short-term liabilities are covered.

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of August 2021 is £37.6m.

As per the financial regime introduced as a result of the pandemic, the majority of our NHS contracts are being paid on a block basis. We are awaiting formal H2 guidance but it is expected that the block income arrangement will continue for the second half of the financial year with a reduction applied for general efficiency.
The cash forecast currently remains in line with the original annual plan as submitted to NHSEI, with a year end cash forecast balance of £19m. We will re-forecast once we have received the H2 settlement, recognising H1 recruitment slippage against new investment.

Better Payments

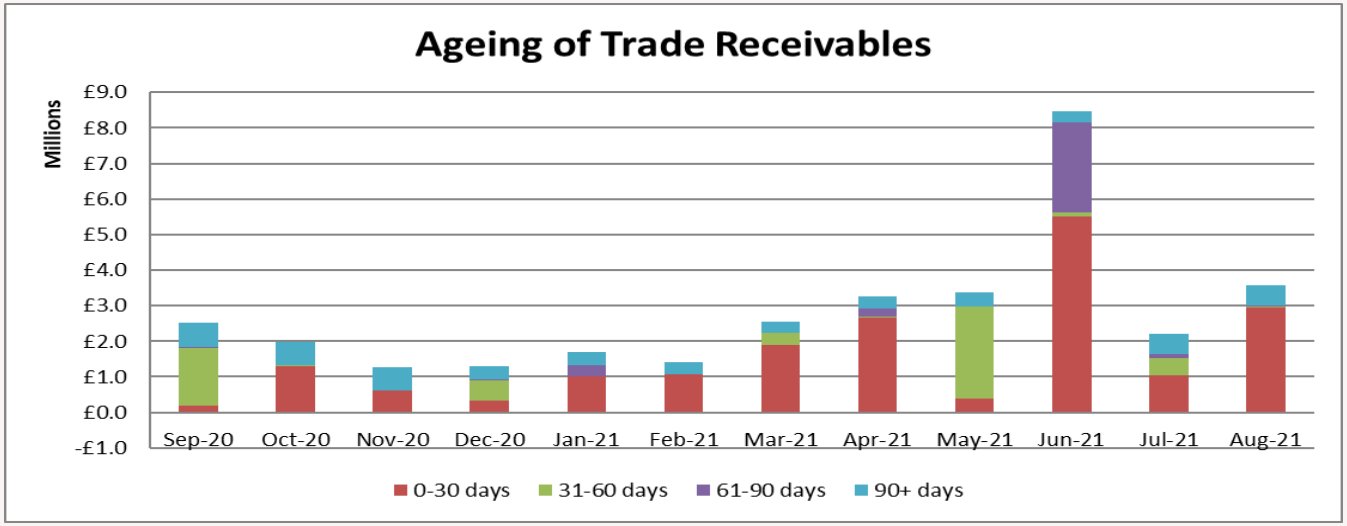
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

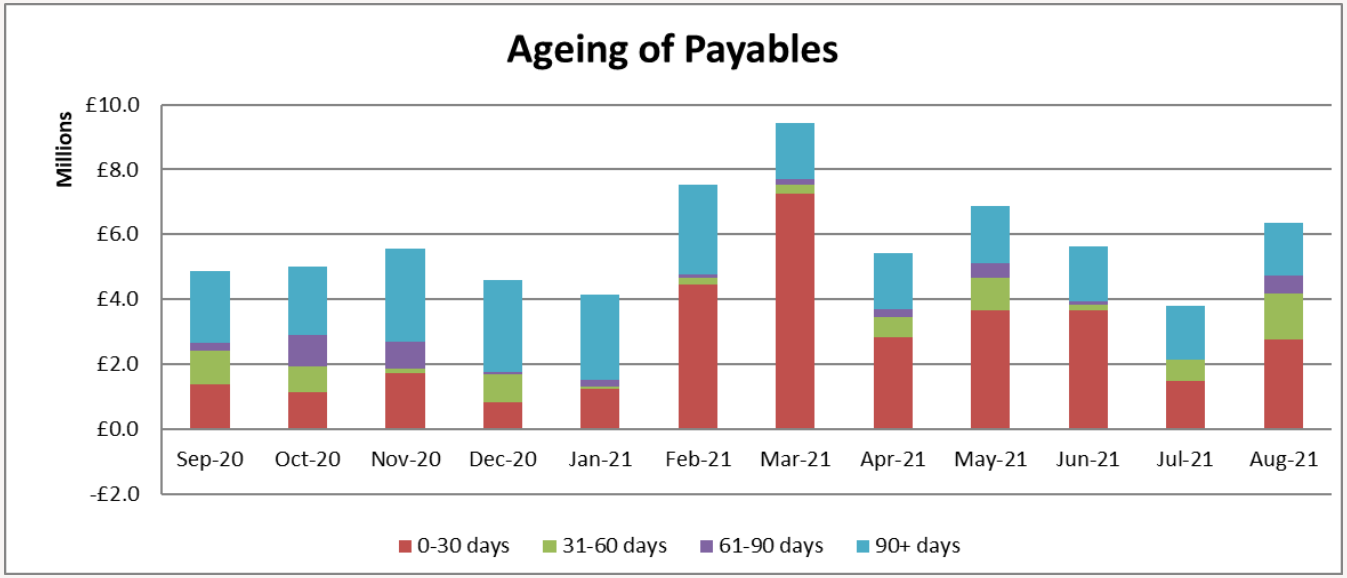
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables

The overall receivables position reduced significantly last financial year mainly due to provider to provider arrangements under the COVID-19 financial regime which is continuing in H1. The focus is to maintain this position as far as possible and escalate to management, STP and other partners where necessary for urgent and prompt resolution.

Receivables :

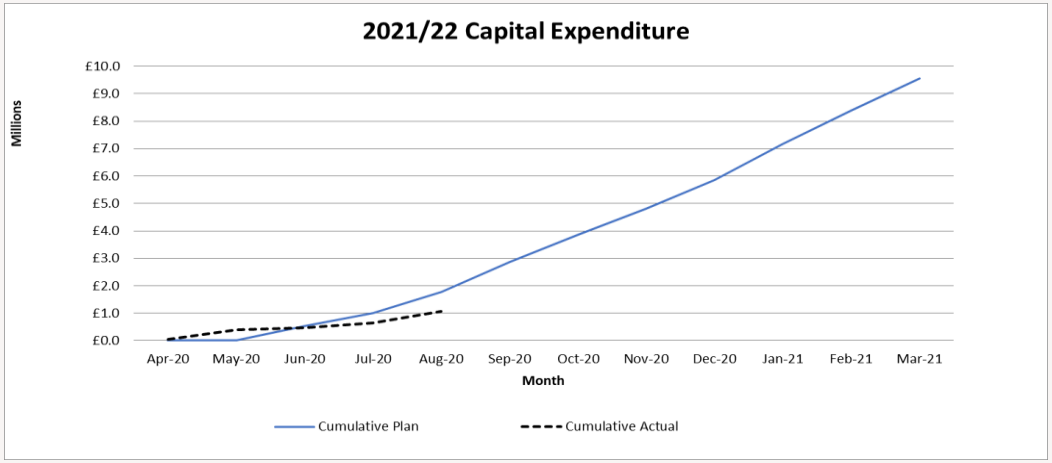
- **0-30 days** -increase is due to a £2m invoice to BSOL CCG which payment was received on 01/09/2021 and a further £464k to SSL which is still outstanding
- **Over 90 days-** BSOL CCG £249k relation to year-end balances. Escalated to management internal & external and a partial payment has been received to date.

Trade Payables:

- **0-30 days**-BWCH £1.3m relating to the Priory contract & B'ham Community P2P Q1 £1m
- **Over 90 days-** NHS Property Services £466k– Awaiting lease agreement to be finalised to enable/facilitate payment. The Estates Dept are working with NHS Property Services to resolve this matter (DoF is aware of the position).
- Non-NHS Suppliers (40+) £1.0m – accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in September 2021.

Month 5 YTD Capital expenditure behind plan

Capital schemes	Total 2021/22	YTD plan	YTD actual	YTD variance
	£'m	£'m	£'m	£'m
Pre committed - major schemes c/f from 20/21- Urgent Care Centre	1.2	0.6	0.5	0.0
Pre committed - minor schemes c/f from 20/21	0.3	0.0	0.0	0.0
Pre committed - Ardenleigh Women's seclusion suite	0.5	0.0	0.0	0.0
Total Door Sets phase 1 and phase 2	4.4	0.4	0.3	0.1
Stautory Standards & Backlog Maintenance	1.8	0.2	0.2	0.0
ICT	0.8	0.3	0.0	0.3
Newington refurbishment	0.5	0.0	0.0	0.0
Risk Assessments - to be allocated	0.8	0.2	0.0	0.2
TOTAL	10.3	1.8	1.1	0.7



Month 5 Group Capital expenditure

Month 5 year to date Group capital expenditure is £1.1m, this is £0.7m less than plan.

£0.3m underspend year to date relates to slippage on ICT capital schemes (business cases approved at August Capital Review Group). £0.2m underspend relates to risk assessments.

£3.4m was originally allocated to risk assessment work in the capital plan. The SSL capital team produced estimated programmes and cost plans for phase 2 risk related works, totalling £1.8m for 2021/22 as supported at July CRG. It was agreed that a further £0.5m door set works would be brought forward from 2022/23, leaving £1.1m to be allocated for risk assessment works. Other priority schemes were discussed at the Operational Management Team meeting in July, however, no formal plan has been agreed to date. Business cases totalling £0.3m (for replacement boilers and critical assets) were approved via August Capital Review Group, leaving £0.8m to be allocated. To be reviewed at September Capital Review Group to determine next steps for utilisation of the remaining envelope.

Major schemes

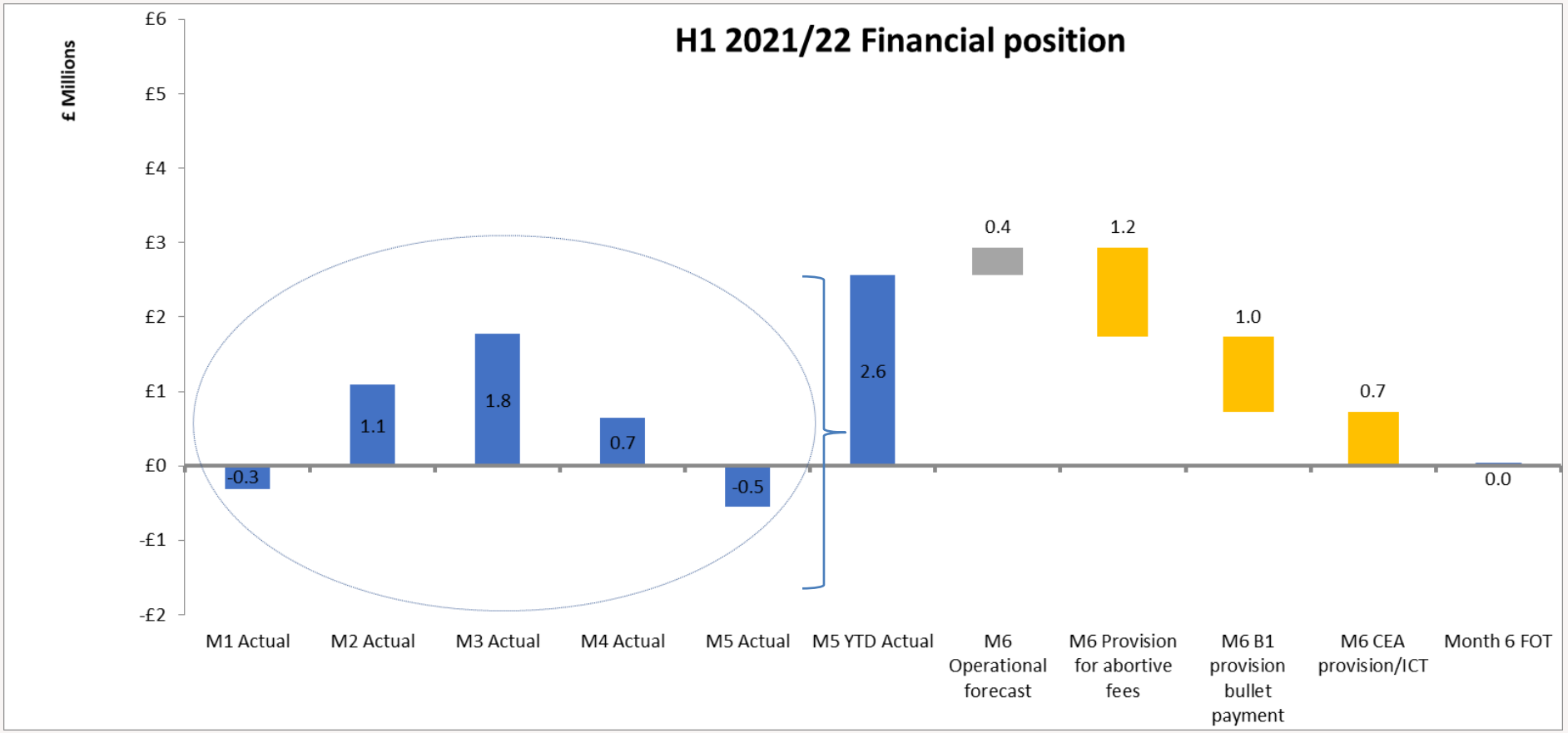
Expressions of interest were submitted to DHSC for the Highcroft & Reaside redevelopment schemes. We await confirmation on feedback and next steps following submission.

Birmingham and Solihull Mental Health NHS Foundation Trust

Financial Planning & Run Rate overview

For Private FPP

H1 2021/22 Forecast outturn



Run Rate

Current	Monthly run rate £'000
BSOL CCG	12,541
Other CCGs	2,209
NHS England	6,146
NHS England Prison	771
Patient Activity Income	1,155
Other Income	388
Research Income	106
Training Income	807
System reserve	993
COVID income	519
Substantive	-15,900
Bank	-1,934
Agency	-429
Apprentice Levy	-67
Clinical Supplies	-66
Drugs	-534
Consultancy	-112
Non Pay	-3,466
PFI	-855
Capital Financing	-1,350
Disposals	0
Corporation Tax	-32
Year End Revaluations	0
Net Surplus/(Deficit)	**888**

Working ahead of the publication of H2 planning guidance and as a way of determining the scale of savings target required for future years, we have completed a review of the underlying run rate.

2021/22 run rate is currently at £0.9m surplus per month, mainly supported by additional monthly funding of £1.5m provided as part of the H1 funding envelope (system reserve and covid income) and slippage in recruitment against new investment. We are awaiting guidance for H2 and therefore the level of any additional top up funding for the remainder of the financial year is unknown. If this were to cease, and with new investment expenditure ramping up, there could be a significant impact on underlying run rate, moving the position from a surplus to a deficit of circa £1m per month worst case.

Net Surplus/(Deficit) 21/22	Monthly £'000	Annualised £'000
	888	10,656
Remove System Reserve Income	-993	-11,915
Remove COVID Income	-519	-6,229
Revised (Surplus)/Deficit	**-624**	**-7,488**
Remove new investment income	-844	-10,129
Remove new investment expenditure (current av)	480	5,760
Revised Surplus/(Deficit)	**-988**	**-11,857**
Add new investment margin - SDF Rec	79	949
Corporate Infrastructure expenditure	-125	-1,500
Revised Surplus/(Deficit)	**-1,034**	**-12,408**

Financial Planning Arrangements H2 2021/22 and beyond

At a briefing for NHS Chief Finance Officers and Finance Directors on 9/9/21, NHSEI provided an overview of the financial arrangements for H2 (October 2021 to March 2022).

H2 Financial Arrangements

- H2 system financial envelopes and planning guidance will be issued mid-September, with submissions due in November 2021.
- H2 envelopes will be based on H1 (April to September 2021) envelopes.
- H2 envelopes will be uplifted for inflation, the most significant increase will relate to the 2021/22 pay award (see below for further detail).
- Block income arrangements will continue as per H1.
- In H2 there will be an increased efficiency requirement. A general efficiency of 0.82% will be applied to all block payments. A further targeted reduction will be applied to system enveloped based on distance to Financial Improvement Trajectory (FITs)
- Covid allocations will reduce by circa 5%
- H1 and H2 will be treated as a single financial period, with organisations expected to achieve financial balance for the year as a whole.

2021/22 Pay Award

On 21 July 2021, the government announced a 3% pay award for NHS staff, comprising agenda for change staff, career and staff grades, consultants and Speciality and Associate Specialist doctors not switching to new contracts. It excludes any staff already covered by a multi-year pay deal and very senior managers (VSMs).

H2 funding for pay award

In month 6, we will pay the actual cost of the pay award uplifts and the backpay (from April 2021) through the September payroll. Our expected annualised cost increase is circa £5m. Income will be accrued in month 6 to offset the cost of the pay award so that there is a nil bottom line impact in month. As part of the H2 financial regime outlined above, month 7 system envelopes will be uplifted to account for additional recurrent costs of the pay award as well as a non-recurrent adjustment for backpay. Distribution of the system pay uplift funding across partners will need to be agreed as part of system H2 planning.

Key events	Possible timings
H2 2021/22 settlement confirmed	Sept 2021
H2 2021/22 planning	Sept – Nov 2021
2022/23 preparatory work: • Review NHS block payments and system top-up baselines	By Nov 2021
Spending review outcome	Dec 2021
2022/23 planning	Jan – Mar 2022

Financial planning 2022/23

Financial planning guidance for 2022/23 is expected by the end of the calendar year, with submission of the annual plan in March 2022. It is anticipated that the current block income arrangements introduced in 2020/21 as part of the Covid-19 response, will be removed and potentially replaced by a new aligned payment and incentive (API) system. NHSEI are currently running engagement events before finalising the system to be introduced. Under the current proposals, payments to providers would consist of a fixed element to cover an agreed level of activity and a variable element to reflect quality of care and any differences in actual activity levels compared to plan.

GOVERNANCE & RISK

12. Reach Out Business Case

Meeting	**Trust Board**
Agenda item	12
Paper title	**Reach Out Lead Provider Collaborative Readiness to Proceed Assessment**
Date	29th September 2021
Author	Ebru Oliver Jeremy Kenney-Herbert Richard Sollars
Executive sponsor	Dave Tomlinson

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

Executive summary & Recommendations:

The Trust will assume its Lead Provider role and take the responsibility of the Adult Secure Care income budget of c£138m (£116.6m mental health and £21.6m LDA) on 1st October 2021. The decision formally needs to be taken by the Trust Board for go-live, and this paper presents the readiness to proceed to enable Board to make the final decision.

The Board is recommended to:

- Note the progress made since March 2021 to become Lead Provider of Adult Secure Care Services (Mental Health, Learning Disability and Autism)
- Approve the Final Reach Out Business Cases (adult secure and learning disability and autism secure care)
- Note the financial due diligence completed and approve the final allocation
- Approve the Final Reach Out Partnership Agreement
- Note that LDA Partnership Agreement will be completed later in this calendar year
- Note that LDA Risk and Gain Share will be agreed upon completion of discussion regarding exceptionally high cost packages
- Note the quality due diligence completed and approve the Quality Assurance and Improvement Framework
- Approve that Trust enters into formal Lead Provider contract discussion with NHSE
- Approve 'Go-Live' on 1st October

Reason for consideration:

The Trust is on track to become the Lead Provider for West Midlands Adult Secure Care Services from 1st October taking on the commissioning, financial and quality oversight responsibilities.

The last approval step requires formal sign off of the Business Case, Partnership Agreement and Risk and Gain Share Agreements by Provider Collaborative Partner and Lead Provider Boards.

This paper sets out the Trust's readiness to fulfil its Lead Provider responsibilities and formally

to assume its role.

Previous consideration of report by:

- Commissioning Sub-Committee on 16th September 2021
- FPP Committee on 22nd September 2021
- IQC Committee on 22nd September 2021

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)*

BSMFHT is the largest mental health provider and under the terms of the Risk and Gain Share is liable for 59% of any financial risk. The Board is asked to note these are mitigated through inclusion of a number of reserves. The financial environment of Provider Collaboratives allows for the carry forward of surplus and deficits between years giving further reassurance that any financial risk should not unduly impact on the BSMFHT financial position in any one year.

In terms of risks regarding learning disability and autism budgets and risks associated with it, Coventry and Warwickshire Partnership Trust Board have confirmed the acceptance of the financial model and the allocation. There remains the need to progress discussions regarding exceptionally highcost packages and the conclusion of the risk and gain share discussions between Coventry and Warwickshire Partnership Trust (CWPT), Midlands Partnership Foundation Trust (MPFT) and Birmingham Childrens Hospital (BCHCT).

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

There are no new risks associated with delivery of the Trust's strategic risks.

Equality impact assessments:

Not applicable as this paper seeks approval for devolution and provides position statement for 'go live'.

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

Throughout the development of business cases, significant level engagement and coproduction activities took place with staff and service users.

In the development of the governance frameworks, partnership agreement, quality assurance and improvement framework, the affected stakeholders (Partners) were fully engaged and contributed to the development of key protocols and processes.

West Midlands Adult Secure Care Provider Collaborative
Lead Provider Devolution Readiness Assessment

1. Situation

1.1. The Trust, through Reach Out Provider Collaborative, is taking on devolved responsibilities for commissioning of adult secure mental health, learning disabilities and autism services across the West Midlands from NHS England Specialised Commissioning on 1st October 2021, subject to the final Trust Board approval on 29th September 2021.

1.2. The purpose of this paper is to present for approval and to formally establish the Provider Collaborative as the Lead Provider of specialist services for West Midlands patients.

1.3. The paper provides a summary of the work undertaken in relation due diligence and to highlight risks and how these will be mitigated.

1.4. The paper also provides overview of the due diligence carried out and assurance that the Trust is able to fulfill its duties as the Lead Provider and discharge its commissioning, contracting, quality assurance, performance oversight and financial management and control responsibilities.

2. Background

2.1. The Trust Board received an update regarding progress and achievements of the Collaborative, and the Lead Provider roles and responsibilities and set-up including the outstanding issues and risks in its February 2021 meeting.

2.2. The role of the Lead Provider is fivefold:

- Undertaking strategic planning and service development
- Contractual, financial and informational oversight
- Clinical oversight and quality assurance
- Workforce planning and development
- Ensuring that the ambitions and the targets set out in the Long Term Plan for Learning Disability and Autism inpatient cohorts are achieved.

2.3. The Board was provided with information about the outstanding issues in relation to the integration of learning disability and autism cohorts, challenges and risks in regards to financial baseline offer, the establishment of the commissioning infrastructure (hub) and finalisation of the Collaborative and Trust's governance framework to enable the Trust to discharge its duties.

2.4. Significant progress has been made since March, and issues described in detailed at the last update report have now been resolved.

2.5. It has been agreed that Coventry and Warwickshire Partnership Foundation Trust will act as the Lead Partner, working with West Midlands learning disability and autism inpatient service providers and the wider system partners (Transforming Care Partnerships) under the banner of 'West Midlands LDA Alliance'. The Alliance will develop the regional strategy, oversee the financial sustainability, define quality standards and support the commissioning and quality assurance of services, in order for the BSMHFT to discharge its Lead Provider duties.

3. Readiness Assessment

3.1. Provider Collaborative Business Cases

Go Live Status	GREEN

The Collaborative's business cases (appendix 1 and 2), as required by NHS England devolution process, have been developed in partnership between providers, staff, patients, carers and system partners.

A single strategic framework setting out vision, objectives and priorities, a clinical model and an outcomes framework have been adopted by mental health and learning disability providers across West Midlands to minimise unwarranted variation, improve quality of services and achieve better patient experience and outcomes.

The business cases are providing the basis for setting commissioning and contract intentions and service transformation and quality improvement priorities.

The business cases have been approved by the Executive, Clinical and Operational Leadership Teams of Providers and are currently in the process of formally being approved by Partners' Trust Boards.

An oversight and assurance reporting framework will be in place to monitor the progress made to achieve the strategy set out in these business cases, and an annual report will be produced to outline performance against the strategic objectives.

The Partnership Agreement and the sub-contracting processes are enablers/mechanisms for the providers delivering the transformational change and they will be producing delivery plans setting timeline etc. Further discussions will take place with Providers to identify joint priorities and development opportunities to maximise resources and ensure consistent delivery models that deliver desired outcomes.

3.2. Governance

Go Live Status	GREEN

Lead Providers are responsible for a robust governance to enable the Provider Collaborative to work effectively, ensure independence of quality oversight, and transparency of decisions on investment. This must include:

- Delineation of pathway and budget management (commissioning) and provider functions within the Lead Provider, with pathway and budget management functions being independent to be able to hold providers effectively to account.
- A named Non-Executive Director and Executive Director who are accountable for the commissioning functions and separate to the Executive Leadership of the Operational provider functions.
- Appropriate governance processes, such as Board sub-committees.
- Robust procedures for management of conflict of interest.
- Agreed processes to ensure open dialogue with NHS regional teams on the quality and performance of services, and early notice of problems or issues.
- Agreed processes for agreeing new services and investment.
- Agreed processes for dispute resolution within the Provider Collaborative.
- Experts by Experience as part of the governance frameworks for Provider Collaboratives and part of decision making for commissioning decisions.

The Board has approved the new governance arrangements in its July 21 meeting. The terms of references have now been agreed by Provider Collaborative Partners. The Independent Board Assurance report produced by ANHH provides details of the agreed Governance Framework.

3.3. Partnership Agreement & Risk and Gain Share

Go Live Status	GREEN (Mental Health)

The NHSE devolution process requires formal a Partnership Agreement and Financial Risk and Gain Share Agreement to be agreed between the Collaborative Partners.

A Partnership Agreement setting the terms of collaboration, roles and responsibilities, decision making, dispute management and entry into and exit from Collaborative have been agreed (appendix 3). Significant financial due diligence and modelling within the established arm of the Reach Out Collaborative resulted in mental health providers being able to establish core principles to manage financial position and agree a risk and gain share model (refer to schedule 4 of the Partnership Agreement). This included the approach to carry forward underspend, investment in new services and arrangements for risk share protocol between the providers, based on contract value percentage.

Go Live Status	AMBER (LDA)

Significant progress has been made to mobilise the LDA Alliance and develop a clinical model and the business case. Discussions amongst Partners took place and the principle of risk share based on contract value percentage has been agreed. As the financial due diligence is ongoing, it will not be possible to finalise the financial model and agree the risk and gain share profile and the partnership agreement. NHSE is aware of the delays and asked that an agreement is reached by end of November 2021. The completion of the agreements will be subject to final agreement of budgets and assessment of financial risks.

Initial discussions regarding management of financial risks during the transition period (1st October 21 to 30th November 2021) have taken place between BSMFHT (as the lead provider), CWPT (as the lead partner) and NHSE. The CWPT Board will consider being the sole risk owner (at its Board meeting on 22nd September) during the transition period. Confirmation of the outcome of the discussion will be provided at the BSMFT Board meeting on 29th September 2021.

3.4. Finance

Go Live Status	GREEN (Mental Health)

Go Live Status	AMBER/GREEN (Learning Disability and Autism)

Mental Health Due Diligence

Reach Out received its revised allocation from the national NHSE team on October 9th 2020 amounting to £132.4m including mental health and learning disability/autism. The Collaborative had by this stage established a Finance and Commissioning Group which provided oversight, and additionally weekly task and finish group meetings with NHSE regional colleagues were also established.

The basis of the allocation from NHSEI was activity in the 2018/2019 financial year – the reconciliation confirmed patient details but also that since that date Reach Out has been able to achieve a considerable number of net discharges, the funding for which we have been able to confirm is retained by the collaborative.

The initial phase of the work identified three key workstreams– baseline reconciliation, financial due diligence on LD/ASD budgets and EPCs. Through this due diligence two significant adjustments were identified and these were supported by the regional/national NHSEI teams to the value of £1.4m.

Further detailed due diligence continued through this financial year – submissions were

made to NHSEI requesting support for previously funded pilot funds which have not been supported by the regional team. The table below therefore represents the final budget allocation for the period 1st October 2021 – 31st March 2022 and the following two financial years which the Board is asked to approve.

	H2 21/22	2022-23	2023-24
MI/PD revised allocation	57,944,006	116,467,451	117,049,788
PAM Values			
BSMHFT	22,996,312	46,222,587	46,453,699
MPT	7,391,458	14,856,831	14,931,116
SAH	9,864,789	19,828,225	19,927,367
OOA Activity Purchased	7,091,422	11,776,697	9,441,134
Investments	5,068,959	10,404,561	11,240,534
Infrastucture costs	938,363	1,885,590	1,894,499
EPC	2,825,750	5,679,758	5,708,156
Reserves	1,766,952	3,707,374	4,083,899
Total	57,944,006	114,361,623	113,680,404
(SURPLUS) / DEFICIT	0	(2,105,828)	(3,369,384)

The appendix 4 provides detailed overview of mental health financial model which form the final expenditure budget and will thus be the basis on which financial monitoring is completed.

Mental Health Financial Risks and Mitigation

The task and finish group identified a number of financial risks that needed mitigating which was the basis for the original reserves policy. It has become apparent in recent days that there are a number of emerging risks that also need to be highlighted.

In mid-September, the national policy direction for NHS finance was confirmed – this extends the block contract arrangements for NHS providers for the second half of the year. While this provides financial assurance to BSMHFT and MPFT over the risks of any income shortfall for under-performance, St Andrews has expressed a concern that they might now be liable for additional out of area spend that would otherwise have been offset by NHS under-performance. Work has commenced to undertake financial analysis and sensitivity monitoring to assess the impact but there is confidence that the existing reserves should be sufficient to cover this.

A second risk relates to whether CWPT would be seeking risk share agreement with BSMHFT from any over-spends. As a result of discussions between NHSE and CWPT, a number of assurances have been offered that it is now believed to offer sufficient assurance that the CWPT will be able to manage the risk themselves ahead of their formal risk share with other NHS LDA providers. This will be confirmed on receipt of CWPT board papers later this month.

A significant challenge has been to determine whether the funding envelope is sufficient for the future, and whether the net discharges achieved during the pandemic would be reversed in the future. Through a number of different sensitivity models using historical trend data we have been able to assess the financial requirements differentially for men's medium and low secure as well as women's medium secure. For example, the trend data for medium secure female activity was showing a reduction historically of 12% which was obviously not sustainable so the average of the other streams was used. For all cohorts, 2% activity growth has then been added to the baseline activity modelling to reflect the potential increase in demand.

The confirmation of these activity assumptions, and the reduction in out of area activity, has been the main reason why we have been able to develop a number of reserves.

The aim of the final model is to have mitigated as far as possible those risks, mainly through the introduction of a number of specific reserves that provide financial cover:

- Growth in Inpatient Risk Mitigation: 1% of the total budget,
- Exceptional Packages of Care - 0.5% of the total budget,
- Development- at a minimum of 1% subject to managing the overall financial envelope.
- Standardisation Reserve – allowing the standardization of contractual terms for all partners
- Specific Allocation Reserve – to receive any specific allocations outside of this agreed envelope (NHSEI have confirmed that Provider Collaboratives will be reimbursed for the additional inflation costs agreed with independent sector providers).

Learning Disability and Autism Due Diligence
Financial due diligence and modelling have now been completed. This has resulted in additional re-assurance being offered by NHSE around existing EHPCs (exceptionally high cost packages) and CWPT Board have accepted the financial plan on this basis. There remains an anxiety around future EHPCS which is subject to on-going discussions.

3.5. Contracting

Go Live Status	GREEN

As part of the financial due diligence process, the activity and finance data have been scrutinised to determine PAM levels. As described in the Commissioning and Contracting Intentions and the Finance Plan paper, the contracting methodology has been agreed between Mental Health Providers. Further modelling is required for LDA financial modelling and therefore it has been agreed to roll over the existing contract terms into H2 of 2021/22.

The National Provider Collaborative arrangements required 'Lead Provider to Lead Provider' contract for those patients placed outside their originating location. There are currently 65 mental health and 21 LDA patients (as of August 2021) placed outside West Midlands across 12 Host Commissioners/Lead Provider footprints. A detailed review of the existing out of area patient cohorts (West Midlands patients placed in other Lead Provider geographies) has been completed to determine the Collaborative's placement requirements over the term of the lead provider contract.

Draft sub-contracts will be issued to Collaborative Providers by the 30th September 2021. These will follow the format and content of the Lead Provider contract and any service development plans and additional requirements for quality monitoring will be included within these. Post 30th September, there will be a process of engagement with providers to finalise agreement of these with sign off of the documents no later than 31st December 2021. Plans are also in place to issue commissioning intentions to the Host Lead Providers by 30th September for patients placed outside West Midlands.

3.6. Quality Assurance Due Diligence

Go Live Status	GREEN

NHSE/I Quality Maturity Framework clearly sets out the Provider Collaboratives responsibilities in terms of quality assurance and improvement and delineation of commissioning from the Lead Provider activities.

Reach Out is collaboratively working with the NHSE/I Regional quality team to oversee the quality of providers across the Provider Collaborative, commencing go-live at minimum of

level 2 (Normalising Level) of the Quality Maturity Framework with our intentions set to achieve Level 1 (Established and Optimised Level) within 6 months.

A unified Quality Assurance and Improvement Framework (QAIF- appendix 5) has been developed to provide a framework for the coordination of quality assurance across Adult Secure Mental Health and Learning Disabilities and Autism services. The QAIF is undergoing 'stress-testing' in September to validate the robustness of the Collaborative quality systems and processes so to ensure robust Ward to Board to Reach Out Commissioning Sub-Committee governance.

Key achievements

- Strengthened the Provider Collaborative quality governance processes and systems and progressed quality functions to meet the requirements of the Quality Maturity Framework.
- Developed a robust Quality Assurance and Improvement Framework that derives from best practice shared by Provider Collaboratives nationally and applied to the Collaborative's local context.

Due Diligence

A quality due diligence exercise was undertaken to assess Providers' current challenges and areas of concern. We leveraged intelligence and data shared with us by NHSE/I and Reach Out case management function to inform the following quality position:

Providers' Surveillance:

Mental Health:

All providers in the Collaborative are currently under 'routine surveillance' by NHSE/I.

Birmingham and Solihull Mental Health NHS Foundation Trust	CQC Rating: Requires Improvement
Concerns were raised by NHSE/I re. admission of 3 informal patients into BSMHFT secure care outside of the national commissioning guidance. Initially this warranted a request for BSMHFT to report this as a Serious Incident with the view of identifying learning to avoid similar future admissions but BSMHFT did not see the admissions as meeting SI threshold. This concern remains unresolved to date and will continue to be monitored through Contract Review Meetings.	
Midlands Partnership NHS Foundation Trust	CQC Rating: Good
No quality concerns noted for Midlands Partnership NHS Foundation Trust Secure Mental Health services.	
St.Andrew's Healthcare Birmingham	CQC Rating: Good
St.Andrew's Birmingham site remains under routine surveillance by NHE/I with a single concern relating to Covid Outbreak on site. However, it must be noted that St.Andrew's Healthcare services located in the East Midlands (CQC Rating: Inadequate), not part of Reach Out, are currently under increased scrutiny by the CQC, NHSE/I and Commissioners and are at an increased surveillance level after a Section 31 notice was issued related to inadequate staffing levels. We will continue to monitor the impact of the wider provider regulatory enforcement on St.Andrew's Healthcare Birmingham with regular oversight through Reach Out Case Management function and intelligence sharing with NHSE/I Regional Quality Team.	

Learning Disability and Autism

All providers in the LDA Alliance are currently under 'routine surveillance' by NHSE/I.

Coventry and Warwickshire Partnership NHS Trust	CQC Rating: Good
Concerns regarding staffing levels at Brooklands Site (CWPT) that culminated in an unannounced quality visit by Case Managers. We await the outcome of the final report to inform surveillance level. Concerns raised at CWPT Contract Review Meeting on 09/09/2021 with further assurance sought from the provider.	
Black Country Healthcare NHS Foundation Trust	CQC Rating: Good
Concerns at Black Country Healthcare Gerry Simon Clinic re. levels of racial abuse towards staff. Oversight continues through virtual reviews by NHSE/I and Contract Review Meetings.	
Midlands Partnership NHS Foundation Trust	CQC Rating: Good
No quality concerns noted for Midlands Partnership NHS Foundation Trust Secure LDA services.	

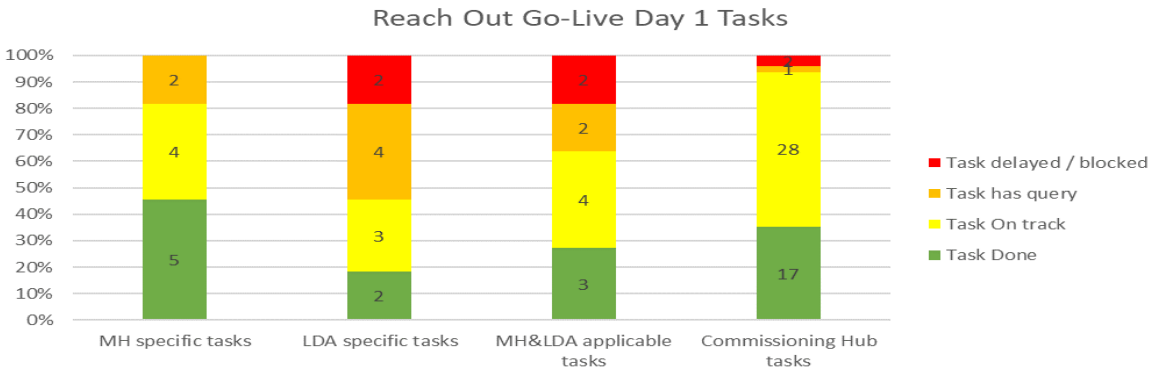
Operational Readiness

Quality and Governance Lead is now in post supporting Clincal Program Director and actively engaging with NHS E as part of handover and due diligence. Also supporting Adult MH Secure Care and LDA Secure Care to ensure governance and quality processes and structures are in place for October 1.

A checklist was developed to track progress and coordinate quality tasks in preparation for go live with monitoring oversight provided by a weekly task and finish group. The checklist includes tasks related to handover from NHSE/I Regional quality team, management of serious incidents, surveillance monitoring and escalation, quality governance structures, quality reporting, quality systems and compliance against the quality elements of the Quality Maturity Framework.

The statistics below represent the latest position as of 07/09/2021:

- There are 107 quality tasks in total, 81 of which (75%) are due by 1st Oct 21– Day 1.
- Re. Day 1 tasks:
  27 tasks (33%) have been completed, 39 tasks (48%) are underway or scheduled to be completed with no anticipated delays. And 15 tasks (19%) have queries (n=9), or are delayed/blocked by another task (n=6).



Top 3 Risks

Description	Mitigating Actions
There is a risk of delays in going-live if Reach Out does not demonstrate a minimum of level 2 maturity against the Quality Maturity Framework as assessed by NHSE/I	- QAIF developed and being stress-tested and operationalised in preparation for go-live. - Open lines of communication and direct engagement with NHSE/I to consult on preparations. - Monitoring of progress against the QMF - Reach Out 'Quality Checklist' in place and monitored weekly - Dedicated resources to support Go-Live quality preparations.
There is a risk of reduced quality assurance due to inconsistencies in providers' contractual quality reporting to support the development of Quality Dashboards, Integrated Quality Reports and thematic reviews of fundamentals of care at QAIG and SQG.	- Escalated to Reach Out Associate Director who arranged for additional contract support. QGL to meet with Lead Provider Contract Manager and Reach Out Contract Lead to progress as a priority. - Reach Out is working with Providers across the collaborative to establish revised quality reporting requirements providing clarity and consistency through improved subcontracts.
There is a risk of limited capacity to support quality governance activities by the Lead Partner for LDA Alliance due to high reliance on interim colleagues to support Reach Out go-live process.	- Assurance from CWPT re. planned permanent resources to support Lead Partner responsibilities post go-live.

3.7. Case Management

Go Live Status	GREEN

Under the devolution arrangements, case management function and resources will transfer to Lead Provider under TUPE arrangements. Case managers operate under the National Case Management Standard Operating Protocol, and expectations in regards caseloads; 100 patients per case manager for mental health services and 30 patients per case manager for LDA services.

Case Managers play a vital role in quality assurance and pathway facilitation by providing oversight of patient pathways. They do this by identifying potential/actual gaps in provision and barriers to progress; monitoring and reviewing the quality of provision; observing providers in practice and monitoring and reviewing quality information and local intelligence. They are a crucial component of the monitoring and escalation of quality concerns providing 'hard and soft' intelligence and potential early signs of quality issues to Reach Out.

The mental health case management function (a senior case manager and five case managers) was already transferred into BSMHFT under the New Care Model arrangements and has been operating successfully. With the transfer of LDA function, three further case managers will be transferred to BSMHFT. The formal TUPE process began in August and on track to conclude by 1st October 2021.

There are 2 vacancies at present – one will be filled by October 1st in Adult Mental Health

and the LDA vacancy remains covered by the 2 case managers in post supported by the interim case manager. It should be filled again when a secondment ends later in the year.

3.8. Operational Readiness- Infrastructure/Resources

Go Live Status	AMBER/GREEN

Following the publication of the 'NHSE Devolution Programme, Lead Provider Role and Responsibilities document', the standard operating protocols for the

- Commissioning and contracting,
- Quality assurance,
- Financial planning and management, and
- Performance oversight and management

functions have been developed and submitted to NHSE for approval in February 2021. The staffing requirements to deliver the functions were identified and budget requirements were submitted to Provider Collaborative Steering Group to secure funding.

The previous sections of this report have highlighted operational readiness for finance, contracting and quality functions, assuring the Board, that there are resources in place for BSMFHT to assume its Lead Provider duties from October 2021. Assurance can also be given that there is an existing investment in the informatics team to collate, analyse and reporting performance activity.

However, the above team is currently made up of temporary and permanent staff and the full establishment is not yet in place. There are posts that need to be recruited into (i.e. expert by experience, communications lead, support staff for finance, quality and contracting) although these are not essential for the first few months.

The delays in recruitment are as a result of pursuing discussions with the Midlands Partnership Foundation Trust (Lead Provider for Adult Eating Disorders) and Birmingham Women's and Children's Hospital Trust (Lead Provider CAMHS) to establish a Regional Commissioning Support Hub. The benefit of this approach was to minimise the cost pressure on baseline budgets of the Lead Providers as there are no transfer of funds from NHSE to support the new infrastructure requirements. Following a period of discussions with the Lead Providers, it has been concluded that there is limited or no scope for collaboration and that each Lead Provider should establish their own infrastructure. The next step for Reach Out is now to sign off the budget requirement at the Provider Collaborative Steering Group to commence the recruitment process and ensure the additional capacity is in place by the end of this year. The financial model developed and agreed included infrastructure requirements and discussions are taking place with CWPT to confirm their requirement before joint recruitment initiative begins.

Discussions also took place with NHS England Regional team and it has been confirmed by the Regional Director that resources and support will be in place until end of March to support transitional arrangements quality assurance and contract management support until the new year.

4. Recommendation

4.1 The Board is asked to:

- Note the progress made since March 2021 to become Lead Provider of Adult Secure Care Services (Mental Health, Learning Disability and Autism)
- Approve the Final Reach Out Business Cases (adult secure and learning disability

and autism secure care)

- Note the financial due diligence completed on mental health budgets and approve the final allocation
- Approve the Final Reach Out Partnership Agreement
- Note that LDA Partnership Agreement will be completed later in this calendar year
- Note that LDA Risk and Gain Share will be agreed upon completion of the full financial modelling later in this calendar year
- Note the quality due diligence completed and approve the Quality Assurance and Improvement Framework
- Approve that Trust enters into formal Lead Provider contract discussion with NHSE Approve 'Go-Live' on 1st October

17th September 2021
Ebru Oliver- Reach Out Associate Director, Commissioning
Richard Sollars- Reach Out Finance Lead
Jeremy Kenney-Herbert- Reach Out Clinical Programme Director

Meeting	**Trust Board**
Agenda item	**12**
Paper title	**Reach Out Provider Collaborative** **The Commissioning and Contracting Intentions, and the Financial Plan**
Date	29th September 2021
Author	Ebru Oliver and Richard Sollars
Executive sponsor	Dave Tomlinson

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

Executive Summary & Recommendations:

The Trust will assume its Lead Provider role and take the responsibility of the adult secure care commissioning budget of c£138m (plus associated inflationary uplift and increases in baselines) and the quality assurance of services from 1st October 2021. The Provider Collaborative has developed its strategy and the clinical model which set the commissioning and contracting intentions, and also a financial model which has been the essential component for the Collaborative's risk and gain share agreement.

The Board is recommended to:

- approve the commissioning intentions that stem from the Collaborative's Business Cases,
- approve allocation by provider to initiate the formal contract offer process for in and out of area providers
- approve the overall financial plan including the reserves
- delegate responsibility for assurance to FPP with a particular focus on ensuring that the Provider Collaborative are operating within the agreed financial plan,
- delegate responsibility for assurance to FPP for any decisions outside the financial envelope taken by the Executive Directors within their delegated limits,
- delegate responsibility to IQC and FPP for assurance on any business cases that flow from the Provider Collaborative to use either the investment reserve, or savings generated or new income received, and any disinvestment in services,
- delegate responsibility for assurance to IQC with a particular focus on ensuring quality, safeguarding and safety of patients and services across West Midlands,
- delegate responsibility to the Commissioning Sub-Committee for the decision making, the implementation and monitoring of the business case, financial plan and quality assurance.

Reason for consideration:

The Trust becomes the lead provider/commissioner of secure care services for West Midlands patients from 1st October 2021. The service providers will need to be issued with their sub-contracts by the 30th September 2021 and NHSE expects sub-contract negotiations to conclude within long stop date, three months post go-live. The sub-contracts will follow the format and content of the Lead Provider contract and any service development plans and additional requirements for quality standards and monitoring will be included within these.

Contracting arrangements for out of area providers will be managed via the Lead Provider contract for that Collaborative and the development of the activity and payment terms for these placements, to be shared with those Lead Collaborative Providers by 30th September 2021.

Previous consideration of report by:

- Commissioning Sub-Committee on 16th September 2021
- Provider Collaborative Steering Group on 23rd September 2021
- FPP Committee on 22nd September 2021

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)*

The final settlement with NHSE has allowed for the inclusion of sufficient budgets to cover the mental health secure care expenditure, to increase the available envelope for exceptional packages of care to meet expected demand and need and to provide sufficient reserves to mitigate any financial risks.

For the LDA budget CWPT Board have confirmed the acceptance of the funding envelope from NHSE, and the budget has now been incorporated within the Reach Out final budget plan. Financial implications related to exceptionally high cost packages of future cohorts remain a concern and further discussions to be held amongst senior stakeholders to agree mitigating actions.

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

There are no new risks associated with delivery of the strategic risks.

Equality Impact Assessments:

Not applicable for this paper as we no decision is being sought to change service configuration at this point. The commissioning intentions set out in the paper put the service user at the heart of the improvement and development initiatives with a view to address any variation and inequality within services, for patients, carers and staff. There will be consideration of Equality Impact Assessment when any service change is introduced as part of the commissioning intentions.

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

Over a period of time, there have been numerous engagement and coproduction opportunities for staff, patients, families and system partners to be part of the development of the strategy and business case.

West Midlands Adult Secure Care Provider Collaborative
Commissioning and Contracting Intentions and Finance Plan

1. Situation

1.1. The Trust, through Reach Out Provider Collaborative, is taking on devolved responsibilities for commissioning of adult secure mental health, learning disabilities and autism services across the West Midlands from NHS England Specialised Commissioning on 1st October 2021, subject to the final Trust Board approval on 29th September 2021.

1.2. The purpose of this paper is to present for approval the commissioning intentions and financial plan which flow out from the financial due diligence and negotiations with NHS England and wide ranging financial and clinical discussions with Partners on areas where the Collaborative wishes to work differently, improve quality or transform service delivery.

1.3. Finance colleagues from CWPT and BSMHFT have been working to develop the financial plan for the LDA pathway – this analysis is being finalised given the receipt of the letter from NHSEI confirming additional LDA financial allocations. The intention is for a paper to be presented to the CWPT Board which will be shared with the Commissioning Sub-Committee when received and a verbal update provided.

2. Background

2.1. The Trust Board and its Committees (IQC and FPP) received regularly updates on progress and achievements of the Collaborative, and the Lead Provider set-up including the outstanding issues and risks.

2.2. The Collaborative have developed its strategy, a clinical model and business case that set out the vision, strategic objectives, priorities and transformation/improvement plans.

2.3. Significant work has also taken place to develop the Collaborative's financial plan to support the delivery of the commissioning intentions and the risks and benefit share approach. The financial plan has been initially approved by NHS England on 13th September 2021.

2.4. This business case and the financial plan provide the backdrop for the commissioning intentions and the basis to begin the sub-contracting process.

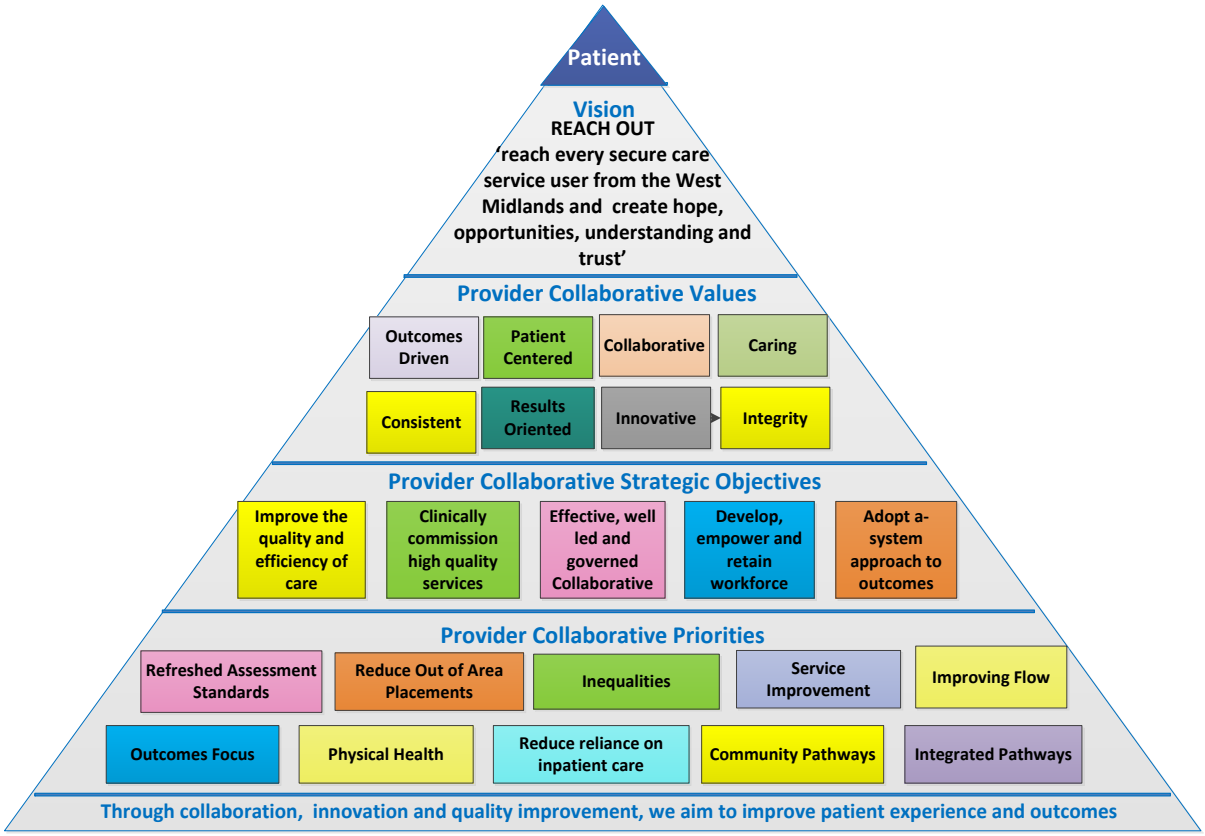
3. Commissioning and Contracting Intentions

The Intentions for 2021/22- 2023/24 will build on the partnership approach adopted through the development of Reach Out Provider Collaborative. The shift to our intentions will be underpinned by a set of principles by which the Collaborative would like to work together. We will:

- Work for the benefit of West Midland patients;
- Involve local people on our design, planning and decision-making;
- Find innovative ways to cede current powers and controls to explore new ways of working together;
- Be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates;
- Find ways to risk-share during transformational change;
- Find ways to share joint incentives and rewards;
- Make improvements by striving to be the best together;
- Be rigorous in ensuring value for money and financial sustainability.

The commissioning and contacting intentions detailed herewith are in accordance with Lead Provider contract and national planning requirements, and reflects the work required to support delivery of the Provider Collaborative's shared ambition and commitment to deliver transformational change as set out in the business case. The diagram below is the strategic

framework outlining Collaborative's vision, strategic objectives and priorities and the outcomes framework within which the success will be measured against.



REACH OUT PROVIDER COLLABORATIVE OUTCOMES FRAMEWORK
(Aligned with National Impact Framework)

Co-production and Engagement	Patient Experience	Patient Safety and Quality of Care	Inequalities	Workforce
Patients feel they are respected and supported to be involved as equal partners in their care planning, commissioning, and monitoring. Families and carers are supported and engaged with as they are recognised as invaluable sources of expertise to contribute to the recovery of their family members.	Patients are resilient, autonomous, and as self-sufficient as possible. Patients feel they are supported to live independently and accessing education and employment.	Patients receive right care, right place, at the right time for their health needs. Patients feel that staff are compassionate and invested in their safety and recovery. Only patients who need inpatient care are admitted for the shortest duration, leveraging a proactive approach of care to prevent escalation and/or readmission to secure care Patients are supported to maintain and develop skills to improve their resilience and increase positive life outcomes. STOMP stopping over medication of people with a learning disability, autism, or both with psychotropic medicines	Patients feel that they are understood, accepted, and supported in a safe and inclusive environment whatever their needs and characteristics. Patients will have improved physical health outcomes	Patients feel that they are supported and cared for by a compassionate, value-based workforce. Workforce is recruited, retained, and trained to provide culturally competent, high quality specialist treatment and support

3.1. Commissioning Intentions

The following themes have (previously) been agreed by the Provider Collaborative Steering Group. The details of the intentions for adult secure mental health services can be found in appendix 1, and also in the Reach Out Business Case.

- **System Working/ICS integration-** There is a continued need to ensure that the Provider Collaborative is included as key stakeholders in the ongoing strategic system development and pathway transformation programmes. We will adopt a 'whole system'

approach to designing and commissioning seamless services that includes Secure Care service user needs.

- **Strategic Planning-** We will undertake demand and capacity work, and inpatient needs analysis to ensure that a 'needs based' approach to service transformation is achieved. This intelligence will inform the pathway needs at the strategic commissioning level and at operational design and delivery level meaning that services are based on the current and future population needs.
- **Demand Management-** We will focus on providing support at the earliest point in the pathway to, where possible, prevent escalation of need into secure care necessitating closer working with stakeholders who interface with Secure Care services e.g. Secondary Care services and Prisons. Demand management schemes will ensure that opportunities to build capacity and capability across the 'system' are optimised for the benefit of patients who are at risk of stepping into or who are stepping out of Secure Care.
- **Outcomes Focused Commissioning**- We will commission robust person-centred care that achieves the outcomes that patients say matter the most to them and that promote health, wellbeing, choice, and control.
- **Admission Avoidance-** We will work in partnership to identify 'whole pathway' solutions that ensure that alternative options to admission are available and utilised where appropriate ensuring that lengthy admissions are avoided, and patients are treated in the least restrictive environments as possible.
- **Community Provision-** We will review and align services and pathways to ensure unwarranted variation is eliminated, gaps in provision are identified and transformation plans are developed and implemented. This will ensure high-quality recovery focused pathways are available and work seamlessly with different sectors and pathway interfaces.
- **Right Time, Right Care, Right Place**- We will interface and integrate pathways across the 'system' that are flexible, responsive and need appropriate. That patients have access to the right level of choice and support in the least restrictive way appropriate to their needs as close to their home, families, and carers as possible. We will work in partnership to ensure that there is capacity in the system for patients to move through their care pathway in a timely way.
- **Minimise Transitions and Improve Patient Experience-** We will avoid disruptive and unnecessary moves between services that create delays in patient progress, and consider alternative approaches, such as blended levels of security.
- **Complex Needs-** We will bring balance between the need for specialised services and pathways, and managing complexity within mainstream services e.g. for individuals with acquired brain injury, deafness, complex personality disorders, complex communication needs and autistic spectrum conditions.
- **Improve Physical Health-** We will focus on improving health outcomes for our patients including promotion of healthier lifestyles and with appropriate opportunities for increasing physical activity across the pathway.
- **Address Inequalities-** We will improve our understanding of inequalities experienced by our patients through our co-produced and expert by experience led inequalities service evaluation and develop local and regional plan to deliver informed and compassionate services that improve patient experience and outcomes.
- **Improve Quality-** We will embed proactive quality assurance with shared learning from areas of excellence across providers and nationally to ensure robust quality surveillance, escalation, and risk appropriate responses in relation to any concerns or trends.
- **Develop Workforce-** We will work with our partners and other agencies (e.g. Health Education England) to develop a workforce strategy to ensure a well-trained and motivated workforce improving recruitment and retention.

- **Financial Sustainability-** We will understand the cost of delivering services and change the way we work to align incentives, reduce duplication, and take unnecessary cost out of the system. As a Collaborative we will work jointly to deliver service changes and we will develop schemes that manage activity growth to secure the sustainability of services.

- **Develop Intelligent Collaborative Commissioning–** We will use intelligence and insight effectively and develop capacity and capability to improve commissioning decisions.

3.2. Mental Health Contracting Intentions

3.2.1. Inpatient Services

As part of Collaborative's financial modelling and the development of the contracting approach, the Collaborative Partners have agreed the following principles

- All partner capacity should be utilised first to deliver the contract. Out of area Independent Sector capacity should only be used when partner capacity is exhausted.
- Any investment in new services or to meet cost pressures will be included in the contract offers only after being recommended by the Reach Out Steering Group, and approved by BSMFHT Commissioning Sub-Committee.
- All out of area activity will initially be on a cost per case basis but alternative arrangements will be considered if economically advantageous.
- CQUIN is included where applicable but final national approach to CQUIN metrics for 21/22 not yet certain.
- With the exception of price, contractual terms should be consistent between the Partners
- Major terms agreed to be consistent are: type of contract (cost and volume), tolerances, marginal rates and inclusions (observations), future price inflation (22/23 and beyond as 21/22 has been set by National Team)

Following extensive discussion it was agreed to adopt a transitional approach to contract standardisation. The agreed timetable as follows:

Period 1: October 2021-March 2022	Start the collaborative with existing terms for MPFT and BSMHFT (cost and volume) for the 1st 6months, and introduce change to STAH contract (part 'cost and volume' and part 'cost per case'.)
Period 2: April 2022-September 2022	Shadow standardised contracts alongside existing term
Period 3: October 2022 -	Full standardisation

It has been agreed that sub-contracts will be for the duration of 2 ½ years with contract variations in the event of changes relating to contract type or financial elements.

During these transitional arrangements, MPFT and BSMHFT would retain the cost and volume arrangements in place before the emergency Covid19 financial framework came into operation. To address STAH concerns over the certainty of income levels, it has been agreed that their contract includes a split between a Cost and Volume and a Cost per Case elements. The offer is now based on 80% of the agreed capacity being contracted on a Cost and Volume basis and the remaining contract being Cost per Case. Given the hybrid nature of this arrangement, tolerances to contract will need to work differently from a fully Cost and Volume Model. It has further been agreed that there are no tolerances above or below the Cost and Volume Threshold. Any under or over activity are paid for or recovered at 100% of the agreed occupied bed day price.

Price and activity Matrices (PAMs) will be developed for each provider and inflation will be added consistent with national direction on contract inflation. This means 19/20 prices will initially be uplifted by 1.4% plus 0.5%. A further non-recurrent uplift of 1.4% will be added to Q2 contract value to reflect the uplift applied to H1 block payments. The contract value will be reviewed for H2

when 21/22 contract uplifts for all NHS contracts are confirmed.

The Lead Provider will have a contract with each NHS and Independent sector provider within the region for all activity delivered, regardless of whether the patient is registered within the West Midlands or from out of area. The Lead Provider will also contract with Host Lead Providers for West Midlands patients placed outside the geographical footprint.

3.2.2. Community Services

Reach Out has been able to invest substantial levels of funding in community mental health services, as out of area inpatient spend has reduced. To date this investment has been allocated every year, but in contractual terms is regarded as non-recurrent.

As seen in the financial section below, the financial position of Reach Out and the recognition of the importance of this part of this pathway have seen all of these funds confirmed as permanent and added as such to provider recurrent baselines. It has been discussed and agreed at the Collaborative Steering Group that those services that are commissioned need to demonstrate continued positive impact on the overall needs of the patient pollution and where this is not the case options for decommissioning and service change should be considered as part of service reviews and future commissioning intentions.

3.2.3. National Pilot Incentives

BSMHFT on behalf of Reach Out has enjoyed some significant success in recent years in being allocated national pilot funding. Two schemes, Women's Service Blended Service, and the Specialist Community Forensic Team have both been allocated non recurrent funding over recent years. The national assumption was that this funding would allow proof of concept and that Provider Collaboratives would then confirm the recurrent funding. Business cases and work is still ongoing to confirm the long term viability of these projects and while funds have been allocated in the financial plan, these have not yet been agreed with providers pending the completion of a new service specification to be ready and in place for 2022/2023.

3.3. Mental Health Finance Plan

3.3.1. Allocation and Expenditure

The finance teams of BSMHFT and NHSEI (West Midlands) have been working over the last few months to ensure that the financial allocation for Reach Out is correct and reflects the necessary income levels to meet current inpatient, community and infrastructure needs. At various stages over the last year the teams have identified discrepancies or errors that have needed investigating and amending. With a final letter from NHSEI received on September 2021 clarifying the final allocations adjustments, we are now in a position to present a final balanced budget for the remainder of this financial year and into 2022/2023.

The PAM values identified in the table reflect agreed inpatient spend based on assumed occupancy levels for mental health services only. As can be seen there is a significant reduction in planned spend with out of area providers, and this continues the direction of travel that has allowed significant investment in community services.

	H2 21/22	2022-23	2023-24
MI/PD revised allocation	57,944,006	116,467,451	117,049,788
PAM Values			
BSMHFT	22,996,312	46,222,587	46,453,699
MPT	7,391,458	14,856,831	14,931,116
SAH	9,864,789	19,828,225	19,927,367
OOA Activity Purchased	7,091,422	11,776,697	9,441,134
Investments	5,068,959	10,404,561	11,240,534
Infrastucture costs	938,363	1,885,590	1,894,499
EPC	2,825,750	5,679,758	5,708,156
Reserves	1,766,952	3,707,374	4,083,899
Total	57,944,006	114,361,623	113,680,404
(SURPLUS) / DEFICIT	0	(2,105,828)	(3,369,384)

3.3.2. Future Funding Risks

The financial planning associated with the business case, has made a number of assumptions around occupancy levels and future inpatient demand. The financial impact of these decisions is the single biggest uncertainty in the financial model, but the reserves (see next section) have provided sufficient financial cover to reduce the impact.

In addition to this activity growth risk, there is obviously uncertainty around future funding from NHSEI. As the NHS looks to recover from the impact of Covid 19, there remains significant uncertainty over future income to cover providers increased costs. At the moment these risks are mitigated through block income for NHS providers but this is unlikely to be the case as we enter 2022/2023 while the costs will remain.

3.3.3. Reserves

Reach Out Steering Group have agreed a multi-level reserve approach for mental health budget with an annual review process to agree allocations. Annual committed reserves will be agreed following the clearance any prior year overspend. The proposed priority order of the reserves are as follows:

- Growth in Inpatient Risk Mitigation: 1% of the total budget,
- Exceptional Packages of Care - 0.5% of the total budget,
- Development- at a minimum of 1% subject to managing the overall financial envelope.
- Standardisation Reserve from 1.10.22 it is the intention to standardise all partners on to the same contractual terms. An indicative reserve of 1% from 1.10.22 has been set to support this ambition.
- Specific Allocation Reserve – NHSEI have confirmed that Provider Collaboratives will be reimbursed for the additional inflation costs agreed with independent sector providers. In addition, it is likely that there will be a number of small adjustments to the financial baseline as the final queries are resolved. All of these specific allocations will be included in this reserve. At this time, no amount has been included in the final allocation plan highlighted above.

3.3.4. New Investments

As highlighted in section 3.2.3, Reach Out is currently reviewing the model and funding requirements of services previously funded as pilots. The Women's Blended Service, and the Specialist Community Forensic Team allocations have been included in the financial model but these will be held centrally pending confirmation of plans – non recurrent allocations will be made to cover costs incurred by providers but no recurrent allocations will be made.

In addition, and following representation by BSMHFT operational colleagues, financial allocations have been included in the financial plan which would allow the provider baseline to be increased to take account of additional costs incurred by the women's service recognising higher levels of acuity. It is proposed that this funding is also held centrally pending confirmation of service plans for this and an understanding of how this allocation would allow the service to operate a separate and distinct service on the women's pathway, just below the Women's Enhanced Medium Secure service.

3.4. LDA Contracting Intentions

CWPT as the Lead Partner will work with the inpatient providers of the Alliance to plan for local bed capacity required to support BSMFHT as the Lead Provider to contract for 'in and out of area beds. To reflect the Lead Provider terms, it has been agreed by Reach Out that sub-contracts will be for the duration of 2 ½ years with contract variations in the event of changes relating to contract type or financial elements.

As the longer-term financial modelling continue it has been discussed and agreed by Reach Out and CWPT that the current contract terms would be rolled over into H2 of 2021/22. This enables the Alliance to have time to finalise the capacity modelling and determine pathway fund implications to review and revise contracting terms and financials.

The intention is also to utilise the existing quality outcomes and indicators in the initial contract term with the opportunity to review and refresh these through coproducing with Alliance Partners and patients and families to be included in contracts by variation.

The appendix 2 describe commissioning intentions stemming from LDA Business Case.

3.5. LDA Finance and Commissioning Plan

3.5.1. Allocation and Expenditure

CWPT Board has received the allocation of the £22m allocation of LDA budget and confirmed receipt. The table bellows outline the income and the expenditure.

NHSE/I MIDLANDS PROVIDER COLLABORATIVE PROGRAMME

	ACTIVITY PLAN (OCCUPIED BED DAYS)			FINANCE PLAN		
	Financial Year 21/22 Oct to March OBD	Financial Year 22/23 OBD	Financial Year 23/24 OBD	Financial Year 21/22 Oct to March £000	Financial Year 22/23 £000	Financial Year 23/24 £000
INCOME						
Provider Collaborative Allocation				10,730	21,459	21,459
TUPE income for Caseworkers				148	295	295
Non recurrent Allocations						
Other Recurrent Allocations						
TOTAL ENVELOPE				**10,877**	**21,754**	**21,754**
Expenditure						
In Area Providers						
CWPT	5,404	9,490	9,746	4,157	8,337	9,584
BCPFT	1,911	3,650	3,660	1,327	2,661	2,661
MPFT	1,671	1,766	1,098	1,012	2,030	2,030
Merseycare	182	365	366	127	255	256
Herfordshire Part	182	365	366	101	202	202
sub total in area providers	**9,350**	**15,636**	**15,236**	**6,724**	**13,485**	**14,733**
Out of Area Providers						
St Andrews	1,822	2,405	672	836	1,597	384
Priory	182	306	-	89	150	-
Cygnet	546	1,095	885	328	657	531
Partnerships in Care	182	365	366	99	198	199
Exceptional Packages of Care				1,689	3,209	3,049
sub total out of area providers	**2,732**	**4,171**	**1,923**	**3,041**	**5,812**	**4,163**
Total Provider	**12,082**	**19,807**	**17,159**	**9,764**	**19,296**	**18,896**
Case Managers				148	295	295
HUB Infrastructure				75	150	150
Commissioning Infrastructure				150	300	300
CRTs				50	100	100
Contingency @ 2.5%				268	536	536
Fair Pricing cost pressure				295	590	590
Investment reserve				126	486	886
TOTAL EXPENDITURE				**10,877**	**21,754**	**21,754**
SURPLUS/(DEFICIT)				0	0	0

Having accounted for the necessary infrastructure costs to discharge the commissioning responsibilities that will be delegated to the Provider Collaborative, the due diligence exercise identifies a fully committed budget position but the planned discharges during October 2021 to March 2022 should enable a modest (2.5%) contingency reserve to be created.

3.5.2. Risk/Issues and Mitigations

Risk	Mitigations
Baseline Due Diligence - Potential additional cost pressures	Whilst relatively confident that we have captured all known commitments, we will continue to review and update our base model, including for **Enhanced Packages of Care** (EPoC) **Current Exceptional High-Cost Individuals** - five high-cost packages approved

	since 18/19 baseline.
	NHS Midlands have confirmed funding for two patients. Further clarity required on a third (CAMHS transition). The remaining two are EHCP risks rather than current commitments. Costs for a sixth potential complex patient admitted into a medium secure bed on 6th September to be confirmed to determine if a new EHCP.
Future Exceptional High-Cost Individuals - *A £1.0m placement is a significant risk on a £20.0m commissioning budget.*	Devising risk share arrangements to ensure the fairest way of managing this risk. Ongoing conversations with PC partners, CCG Commissioners and NHSEI to provide clarity on how patients funding flow to ensure no delays in patient discharges
LD&A patients in MH beds - *Potential financial imbalance in the system*	To confirm and document to the agreement within Reach Out to manage the funding flows and especially the risk of increased new diagnoses whilst in-patients within a MH bed.
Pathway Funds - *Funding for net in-patient reductions is now based on actual savings released*	Working closely with local CCG and Local Authority commissioners to build understand of the new Pathway Fund arrangements and to agree mitigating actions to help manage the increased financial exposure.

3.6. Specialist Services (Deaf/ABI/Womens Enhanced Medium Secure)

NHS England following a consultation with Provider Collaboratives determine that these specialist services should be commissioned nationally and retained budgets from each region based on three year historical performance. This will need to be closely monitored for financial impacts. The risk of any over performance will result in further payments to NHSE which would need to be funded from inpatient reserves. However, the underperformance would result in savings being released back to the Collaborative.

4. Recommendation

.4.1 The Board is asked to:

- approve the commissioning intentions that stem from the Collaborative's Business Case,
- approve allocation by provider to initiate the formal contract offer process for in and out of area providers
- approve the overall financial plan including the reserves
- delegate responsibility for assurance to FPP with a particular focus on ensuring that the Provider Collaborative are operating within the agreed financial plan,
- delegate responsibility for assurance to FPP for any decisions outside the financial envelope taken by the Executive Directors within their delegated limits,
- delegate responsibility to IQC and FPP for assurance on any business cases that flow from the Provider Collaborative to use either the investment reserve, or savings generated or new income received, and any disinvestment in services,
- delegate responsibility for assurance to IQC with a particular focus on ensuring quality, safeguarding and safety of patients and services across West Midlands,
- delegate responsibility to the Commissioning Sub-Committee for the decision making, the implementation and monitoring of the business case, financial plan and quality assurance.

Ebru Oliver- Associate Director, Commissioning
Richard Sollars- Deputy Director of Finance, BSHMFT, Reach Out Finance Lead
23rd September 2021

13. Independent Assurance Report (ANHH)

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**TRUST BOARD**
Agenda item	**13**
Paper title	**REACH OUT – INDEPENDENT ASSURANCE REPORT**
Date	29th September 2021
Author	ANHH Consulting Ltd
Executive sponsor	Executive Director of Finance

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

Executive summary:

The Board of Directors is aware that work has been continuing for several months to put in place those agreements and arrangements necessary to enable BSMHFT to assume responsibilities as Lead Provider for the Reach Out Provider Collaborative from 1st October 2021.

ANHH Consulting Ltd has been supporting the Company Secretariat, the Reach Out leadership team, and the various partners to shape the thinking around these issues.

Reason for consideration:

The Report is one of two that will be received by the Board at its September meeting. The first is from the Reach Out team, which describes readiness to proceed with a focus on quality, finance, commissioning, contracting, and Partnership Agreements. This complementary Report has a focus on governance and is authored by ANHH as an Independent Assurance Report for the Board.

The Report is supplemented by a pack of papers that is provided in the Reading Room.

Recommendations:

The Board is asked to:

- **CONSIDER and ACCEPT** the at-a-glance readiness assessment
- **APPROVE** the governance architecture and the principles underpinning it
- **APPROVE** the proposed changes to the Constitution

- **NOTE FOR ASSURANCE** the work that is ongoing to update the Standing Orders, Standing Financial Instructions, and Scheme of Delegation
- **CONSIDER and AGREE** the most appropriate procedural framework for the Board of Directors
- **APPROVE** the Terms of Reference for IQC and FPP, **including** the expanded role of IQC to incorporate Mental Health Legislation
- **APPROVE** the Terms of Reference for the Reach Out Commissioning Sub-Committee
- **NOTE FOR ASSURANCE** agreement on Terms of Reference for the governance architecture below ROCSC
- **NOTE FOR ASSURANCE** the continuing work to develop the Lead Provider Risk Register
- **NOTE FOR ASSURANCE** the continuing work to develop and embed the Partnership Risk Registers
- **CONSIDER and NOTE FOR ASSURANCE** the independent assessment of the governance readiness to proceed
- **APPROVE** go live on 1st October 2021

BSMHFT BOARD OF DIRECTORS, 29TH SEPTEMBER 2021

REACH OUT – INDEPENDENT ASSURANCE REPORT

1. AT-A-GLANCE STATUS ON GOVERNANCE READINESS TO PROCEED

Item	BRAG Rating		Commentary
	Pre-BoD	Post-BoD	
Governance Architecture	Agreed	Agreed	The governance architecture has been agreed and signed off by all Partner Boards.
Corporate Documents			
Constitution	Defined	Agreed	The CoG approved suggested changes at their meeting on 9th September. Subject to the BoD's endorsement, they will become formal changes to be ratified at the Annual Public Meeting.
Standing Orders Standing Financial Instructions Scheme of Delegation	On Track	On Track	These are being revised to reflect Reach Out, SSL, business development, *et al.*, and will be received in draft at the Audit Committee in October. ANHH is liaising with the Deputy DoF to incorporate necessary changes. This is not a barrier to the planned "Go-Live" for Reach Out.
Board Assurance Framework	In place	In place	The BAF is embedded as a live document that reflects the new strategy. FPP is the assurance committee for a strategic risk related to failure to take advantage of new contractual mechanisms.
Terms of Reference			
Board of Directors	TBC	TBC	The BoD needs to approve changes to these three ToR to reflect the Trust's expanded role as commissioner. IQC and FPP received and discussed their ToR at September meetings.
IQC	In Use	In Place	
FPP	In Use	In Place	
Reach Out Commissioning Sub-Committee	In Use	In Place	The BoD needs to approve the ToR to establish the Commissioning Sub Committee. ROCSC has met twice and is operating to the draft ToR.
Adult Secure Care SG	In Place	In Place	ROCSC has approved these two ToR, with both Steering Groups reporting into the Sub-Committee in a decision-forming capacity.
LDA Executive SG	Agreed	Agreed	
Adult SC Groups	In Place	In Place	The ToR for the 2 Groups and 5 Sub-Groups for adult secure care have been approved by the Steering Group. CWPT used those drafts to shape the ToR for 3 Groups and 4 Sub-Groups for LDA, with comments from ANHH. These form part of the partnership documentation.
Adult SC Sub-Groups	Agreed	Agreed	
LDA Groups	Agreed	Agreed	
LDA Sub-Groups	Agreed	Agreed	
Risk Management			
Lead Provider Risk Register	On Track	On Track	There are four existing risks on Eclipse, to which ANHH has added a further five. ROCSC will hold a risk workshop in October. This is not a barrier to the planned "Go-Live" for Reach Out.
Adult Secure Care RR	Agreed	Agreed	Each secure care service needs a live partnership risk register. ANHH has supported the development of the adult secure care Register and will now work with LDA partners.
LDA RR	On Track	On Track	

2. INTRODUCTION and PURPOSE

The Board of Directors ("**BoD**") is aware that work has been continuing for several months to put in place those agreements and arrangements necessary to enable BSMHFT to assume responsibilities as Lead Provider for the Reach Out Provider Collaborative from 1st October 2021.

With this change, BSMHFT will have:

- Continuing responsibility for as a provider delivery of adult secure care with a current funding of £44.1m
- New responsibility for commissioning services with a current funding of £137.9m, comprising:
    - £116.1m adult secure care (including the £44.1m BSMHFT service)
    - £21.8m LDA (learning disability and autism) secure care.

ANHH Consulting ("**ANHH**") has been supporting the Company Secretariat, the Reach Out leadership team, and the various partners to shape the thinking around these issues.

The Report is one of two that will be received by the Board at its September meeting. The first is from the Reach Out team, which describes readiness to proceed with a focus on quality, finance, commissioning, contracting, and Partnership Agreements. This complementary Report has a focus on governance and is authored by ANHH as an Independent Assurance Report for the Board.

The **At-A-Glance Status** table on the first page provides a summary report on governance readiness to proceed on 1st October 2021. The two columns marked 'Pre-BoD' and 'Post-BoD' identifies any change of status that will be occasioned assuming the BoD's acceptance of the Report's recommendations.

The typical RAG rating has been extended to add a blue rating (BRAG). When reflecting on change, ANHH believes it is important to differentiate between those items that are 'just' complete (**green**) and those items that are embedded ('in place') as evidenced, substantive change (**blue**) – transactional and transformational.

This Report provides a summary narrative position on four key headings:

- Governance Architecture
- Corporate Documents
- Terms of Reference
- Risk Management.

The Report is supplemented by supporting documentation, which has been placed in the **Reading Room**.

In summary, ANHH advises that there is **sufficient assurance on governance** to inform a positive decision **to go live on 1st October.** There is some work still needed in specific areas, but this does not impact materially on readiness.

The Board is asked to consider the recommendations at the end of the Report.

3. GOVERNANCE ARCHITECTURE

3.1 Context

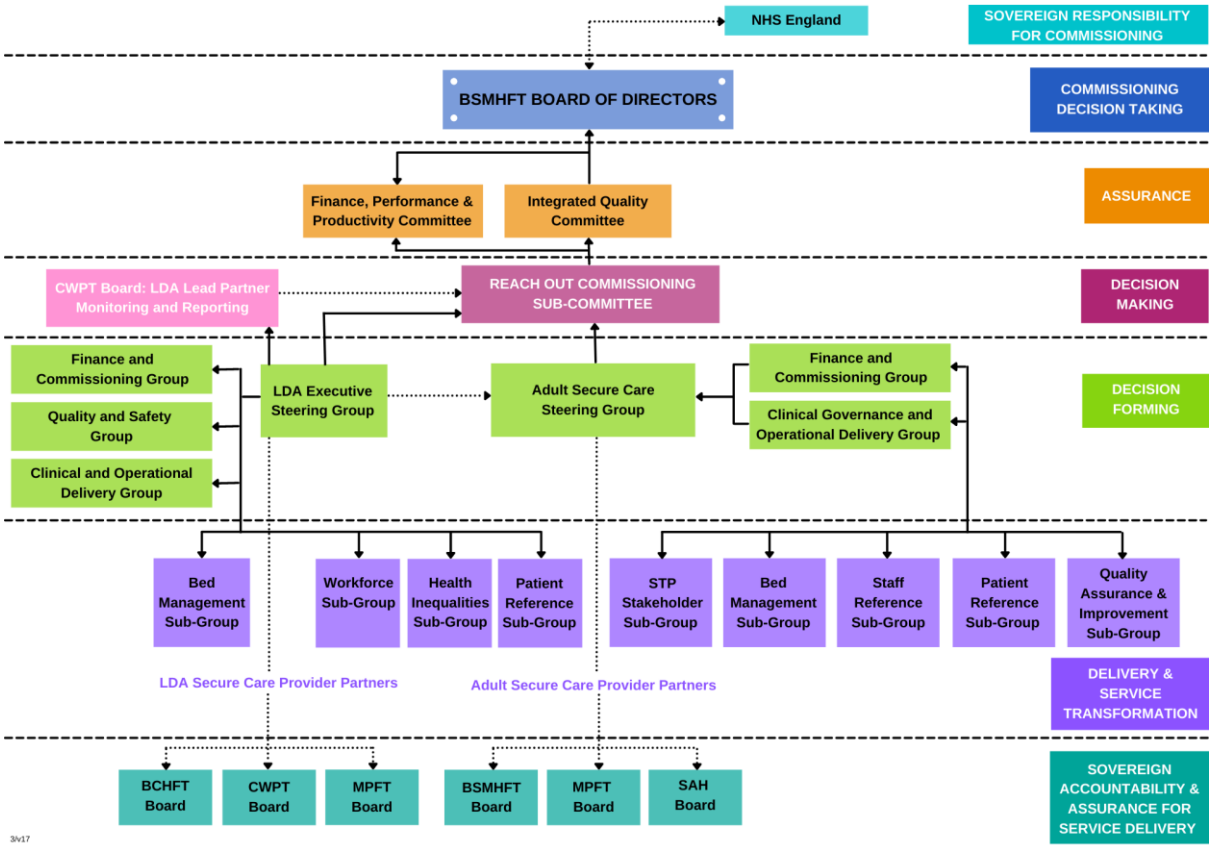
BSMHFT has been operating as a partner with (principally) Midlands Partnership NHS Foundation Trust and St Andrew's Healthcare, in the provision of adult mental health secure care, for more than four years. There is a well-established governance infrastructure that sits under what was formerly called the Provider Collaborative Board.

Arrangements are less established for the learning disability and autism ("**LDA**") secure care services, which reflects the relatively recent inclusion of those services as part of the Reach Out Provider Collaborative.

3.2 The Architecture

As part of the preparatory work, ANHH has supported the development of a new architecture, which defines arrangements with BSMHFT as Reach Out's Lead Provider. The BoD has seen this before, but it is re-provided as Figure One.

Figure One: Reach Out Governance Architecture



This architecture has been agreed by every partner organisation.

3.3 Governance Principles

The Provider Collaborative (PC) means that group of independent yet aligned healthcare providers that have created a legal partnership in pursuit of common goals and initiatives.

The Adult Secure Care PC has been operating since 2017, and the LDA Secure Care service formally will join that PC on 1st October 2021.

The overall purpose of the collaborative is to work together, and to spend money in a way that provides the best outcome for patients. While final decision-taking responsibility will reside with BSMFHT BoD, the two Steering Groups have a critical role in helping to (in)form commissioning decisions.

“Reach Out” is an umbrella entity, effectively a name but certainly not an organisation. It does not have any direct legal or financial powers. Hosted by BSMHFT but funded by all provider partners, Reach Out has a small team that works across all services to ensure quality and safety management, consistent standards, budgetary control, and effective partnership.

The governance architecture is informed by a small number of important principles:

- Separation of responsibilities for the shaping of decisions:
    - Decision-forming: clarifying what part of the architecture will set the context and drive strategic thinking, with some decision-making powers
    - Decision-making: clarifying what part of the architecture will do the heavy lifting needed to make judgements and recommendations
    - Decision-taking: confirming the accountable and responsible forum.
- Confirmation of responsibility for assurance
- Clarity in nomenclature, i.e., only one Board, Sub-Committees reporting to Committees, Sub-Groups reporting to Groups, etc.

3.4 Lead Provider and Lead Partner

The BoD should be aware of the difference between Lead Provider and Lead Partner.

Lead Provider relates to BSMHFT.

NHSE will enter a contract with BSMHFT, and the Lead Provider will subcontract specific roles and responsibilities (and allocate risk associated with their performance) to providers, including BSMHFT itself.

BSMHFT will be responsible to NHSE for the delivery of the entire Provider Collaborative service (both adult mental health secure care and LDA secure care), and for the coordination of the sub-contractor providers. The sub-contracting model is supported by the provisions of the NHS Standard Contract.

Lead Partner relates to Coventry and Warwickshire Partnership NHS Trust (CWPT).

CWPT will be BSMHFT's Agent for learning disabilities and autism secure care services. BSMHFT (lead provider) will delegate to CWPT (lead partner), through a formal contractual vehicle.

This lead role will encompass:

- Developing in co-production the clinical model for LDA secure services
- Determining and managing the Region's bed and community capacity
- Overseeing financial management of LDA secure care, including risk and gain share arrangements
- Leading on pathway funding panels
- Giving expert advice and leadership on the commissioning and quality oversight of all Learning Disability and Autism partners
- Providing quality assurance on LDA to the Commissioning Sub Committee via the Clinical Programme Director.

CWPT will not hold decision-taking powers as these will reside with BSMHFT, as they do for adult mental health secure care services. BSMHFT's arrangement with CWPT's Board of Directors recognises CWPT's specific skills and experience in the leadership and management of LDA secure care services.

4. CORPORATE DOCUMENTS

There are a small number of key corporate documents and instruments that need to be amended to reflect BSMHFT's changed responsibilities as Lead Provider.

4.1 Constitution

More detail is provided at **Annex One** in the Reading Room.

In line with its powers, the Council of Governors ("**CoG**"), at its meeting on 9th September, was asked to approve amendments to the Constitution. That approval was given and the CoG now advises the BoD to add its approval.

In summary, the amendments allow for:

- Expansion of the Trust's principal purpose to assume commissioning responsibilities so it becomes both provider and commissioner (paragraph 2 of the Constitution)
- Adoption of a new power with delegated responsibility for NHS England (paragraph 3)
- Identification of the Executive Director of Finance and a Non-Executive Director (not named, but Anne Baines) as the Executive and Non-Executive Leads for commissioning (paragraph 19)
- Recording of the need for Members of the Commissioning Sub-Committee to disclose that interest in the Register of Interests (paragraph 28) and the provision of a new clause k, at Annex 8, to include it as a "relevant and material interest"

The Company Secretariat is embarking, in the next month, on an exercise to tidy and tighten up the Constitution in several areas. The changes needed for Reach Out will be incorporated as part of that exercise.

Formally, it is only at the Annual Public Meeting that any changes to the Constitution can be ratified but the CoG and BoD have powers to agree those changes until that ratification is delivered.

4.2 Standing Orders, Standing Financial Instructions, and Scheme of Delegation

These documents are being revised to reflect several changes, including Reach Out. Some of the changes for the Constitution will drive amendments to these corporate instruments.

The amended documents will be submitted as final drafts to the Audit Committee in October. ANHH is liaising with the Deputy Director of Finance to incorporate the necessary changes for Reach Out.

This work in progress is not a barrier to the planned go live.

4.3 Board Assurance Framework

The BAF is approved and is embedded as a live and dynamic part of the Trust's governance, with a Q2 progress report scheduled as part of the BoD's cycle of business for October.

Risk FPP1 relates directly to this matter:

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.

In short, the provider collaborative model is here to stay and is likely to afford opportunities for other services in the Trust's portfolio. The Trust is working hard to exploit and benefit from those models in the interests of its service users, and Reach Out has provided significant learning for the future.

5. TERMS OF REFERENCE

For the governance architecture to work effectively and to its full potential, it is important that there is clarity in authority and delegated powers of the various forums, and their remit, membership, and attendance.

It is also critical that the terminology used across all governance forums and corporate documents is consistent. Once these are agreed, ANHH will audit all the relevant documentation.

The key details are captured in Terms of Reference. ANHH has worked to develop new and amend existing Terms of Reference.

5.1 The Board of Directors

The BoD is asked to consider how it wishes to discharge its duties as Lead Provider from a procedural perspective.

ANHH advises that the clearest approach would for the Board to meet separately, with discrete agendas and minutes, as provider and then commissioner (Lead Provider). This would mitigate any potential conflicts of interest.

When the BoD has decided on its approach, ANHH will address the Terms of Reference. This work in progress is not a barrier to the planned go live.

5.2 Assurance Committees

More detail is provided at **Annex Two** in the Reading Room.

IQC and FPP have both received their proposed amended Terms of Reference, that capture their respective responsibilities to ensure and assure on behalf of the Board the quality and safety / finance and contracting aspects of the provider collaborative.

The proposed changes are highlighted in green at Annex Two.

The IQC ToR also includes some changes highlighted in yellow that enable the dissolution of the Mental Health Legislation Committee.

5.3 Reach Out Commissioning Sub-Committee

More detail is provided at **Annex Three** in the Reading Room.

ROCSC has developed and seeks Board approval to its Terms of Reference. The Sub-Committee has an extensive remit and an atypical membership and, as the Board has previously discussed, might otherwise be a full Board Committee.

It is suggested that the ToR be reviewed in three months.

5.4 Adult Secure Care and LDA Executive Steering Groups

More detail is provided at **Annex Four** in the Reading Room.

The two Steering Groups report into ROCSC from the two secure care services. ROCSC has approved these ToR within its (assumed) delegated powers.

5.5 Groups and Sub-Groups

The Partnership Agreements contain full sets of ToR for the various Groups and Sub-Groups that report through to the Steering Groups. ANHH has (re)drafted to ensure consistency across the two secure care services.

6. RISK MANAGEMENT

ROSCS is determined that the business of the Provider Collaborative will be driven and informed by a rigorous approach to risk management. There are three key Risk Registers that will support this model.

6.1 Lead Provider Risk Register

There are certain risks that are exclusive to BSMHFT as the Lead Provider. There were an existing four risks on Eclipse (one added in November 2016, the other three in February 2021), and ANHH has proposed a further five risks.

ROCSC will be the governance forum responsible for oversight and management of the Risk Register, on behalf of the Board. The Sub-Committee has received the document as work in progress, and has determined to spend an extended period of its October meeting to review and further develop it.

There are two risks that have been indicatively identified for the Board's consideration. The first relates to a failure to manage conflicts of interest between provider and commissioner functions. The second relates to a failure to achieve a high level of shared understanding and awareness of commissioning roles and responsibilities. These may be escalated to the Board following the risk workshop.

This work in progress is not a barrier to the planned go live.

6.2 Partnership Risk Registers

ANHH has worked directly with the Reach Out team and the partners in the adult mental health secure care service to develop a Partnership Risk Register. That will be owned and overseen by the Steering Group, and any issues will be escalated upwards to ROCSC.

The LDA business case includes an embryonic register and CWPT has asked for support in developing this to a similar level.

This work in progress is not a barrier to the planned go live.

7. THE DECISION TO GO LIVE

It is ANHH's view that there is **sufficient assurance on governance** to inform a positive decision **to go live on 1st October.** There is some work still needed in specific areas, but this does not impact materially on readiness.

This is a big, strategic decision, and there is limited guidance on how decisions of this type should be made and taken, and none that are specific to provider collaboratives. ANHH highlights two appropriate models.

7.1 Risk-Based Decision-Making

Although a product of the early 2000s, one of the best documents of relevance to the Board's decision is Monitor's *Risk Evaluation for Investment Decisions by NHS Foundation Trusts.*

Its content is not perfectly aligned, and the decision to be taken cannot be fully described as an investment, but the guidance poses some very pertinent questions. At its core is a focus on decision-making and ultimate decision-taking influenced by and in response to risk.

This lies at the very core of good governance.

The Table below offers ANHH's independent assessment of the key questions in Monitor's guidance.

Table One: Risk-Based Decision-Making

Monitor question	ANHH assessment
Is the decision being reviewed at the right organisational level?	**Yes.** The Board of Directors is the controlling mind and utlimate decision-taking authority of the Trust. The decision has also been reviewed by the IQC, FPP, and the Commissioning Sub-Committee.
Does the Foundation Trust have the legal power to take the required decision?	**Yes**. The decision sits squarely within the boundaries of the Board's statutory powers. It is not a "significant transaction" so does not require formal approval by the Council of Governors.
Does the decision align with the Trust's strategy?	**Yes**. The provider collaborative model, and the opportunities and benefits it affords, fits well with the four key themes of quality and safety, sustainability, people, and clinical services.
Has expected risk return be identified?	**Yes**. A strong and mutually-agreed risk and gain share agreement sits at the core of the Partnership Agreements.
Are risks clear and quantified where possible?	**Partially**. Financial risks have been identified as part of the due diligence process. The Lead Provider Risk Register remains work in progress, but there is a clear plan to develop it.
Is there confidence in the partners' cultural fit?	**Yes**. The mental health secure care service has been working as a successful partnership since 2017. The LDA secure care service is new to Reach Out, but significant work has been delivered to establish strong relationships with CWPT as the Lead Partner.
Is accountability for the venture's success clear?	**Yes**. The Partnership Agreements define shared ambition and accountability, which is reinforced by Contracts.
Is it clear how performance and ongoing risk will be managed?	**Yes**. The governance architecture and the associated terms of reference provide clarity, with ROCSC the engine room of BSMHFT's Lead Provider arrangements.

7.2 NHS England Transaction Review

As part of the Provider Collaborative selection process, NHSE&I defined a formal transaction review process that would apply to all Trusts in which the lead provider contract had an incremental financial impact of over 40%.

This did not apply to BSMHFT, but the self-certification process was based on a series of questions that are still worthy of consideration.

Based on the most pertinent elements of the checklist, ANHH suggests that BSMHFT has:

- ✓ Considered the option of not being Lead Provider before deciding that that status will benefit both patients and the trust in delivering its strategy
- ✓ Conducted an appropriate level of financial, clinical, and quality due diligence
- ✓ Conducted appropriate enquiry about the probity and quality governance of partners, considering the nature of the services provided and the potential reputational risk as Lead Provider

- ✓ Received appropriate external advice from independent professional advisers with relevant experience and qualifications
- ✓ Established the organisational and management capacity and skills to deliver the planned benefits
- ✓ Involved senior clinicians at the appropriate level in the decision-making process and received confirmation from them that there are no material clinical concerns in proceeding.

8. RECOMMENDATIONS

The Board is asked to:

a. **CONSIDER and ACCEPT** the at-a-glance readiness assessment

b. **APPROVE** the governance architecture and the principles underpinning it (Section 3)

c. **APPROVE** the proposed changes to the Constitution (Section 4.1 and Reading Room Annex One)

d. **NOTE FOR ASSURANCE** the work that is ongoing to update the Standing Orders, Standing Financial Instructions, and Scheme of Delegation (Section 4.2)

e. **CONSIDER and AGREE** the most appropriate procedural framework for the Board of Directors (Section 5.1)

f. **APPROVE** the Terms of Reference for IQC and FPP, **including** the expanded role of IQC to incorporate Mental Health Legislation (Section 5.2 and Reading Room Annex Two)

g. **APPROVE** the Terms of Reference for the Reach Out Commissioning Sub-Committee (Section 5.3 and Reading Room Annex Three)

h. **NOTE FOR ASSURANCE** agreement on Terms of Reference for the governance architecture below ROCSC (Sections 5.4 and 5.5 and Reading Room Annex Four)

i. **NOTE FOR ASSURANCE** the continuing work to develop the Lead Provider Risk Register (Section 6.1)

j. **NOTE FOR ASSURANCE** the continuing work to develop and embed the Partnership Risk Registers (Section 6.2)

k. **CONSIDER and NOTE FOR ASSURANCE** the independent assessment of the governance readiness to proceed (Section 7)

l. **APPROVE** go live on 1st October 2021

14. Guardian of Safe Working

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	14
Paper title	**GUARDIAN OF SAFE WORKING HOURS, QUARTERLY REPORT**
Date	29/9/21
Author	Dr Sajid Muzaffar
Executive sponsor	Dr Hillary Grant

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

Executive summary & Recommendations:

The number of exception reports raised during this quarter were higher than the previous quarter. No immediate safety concerns were raised. Majority of the exceptions were about working hours. One doctor raised exceptions about absence of senior support which was resolved by allocation of a supervisor. One doctor raised a series of exceptions about the workload in the same post and the individual exceptions were resolved by TOIL and the pattern has been highlighted to the Associate Medical Director, Medical Education. There were several shift vacancies but all were filled by locums.

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)

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

Financial Implications *(detail any financial implications)*

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Equality impact assessments:
No concerns
Engagement *(detail any engagement with staff/service users)*

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

April – June 2021

High level data (Data obtained from HR department)

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

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
CT1-3	9	10	19	0
ST 3-6	1	3	3	1
GPVTS	0	0	0	0
Total	10	13	22	1

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
CT1-3	9	10	19	0
ST 3-6	0	0	0	0
Forensic	1	3	3	1
GPVTS	0	0	0	0
Total	10	13	22	1

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	19	0
ST3-6	0	0	3	1
GPVTS	0	0	0	0
Total	0	0	22	1

Status (13 exception reports - figures include 10 exceptions carried forward);

1 Reviews are pending
22 Completed
0 Request for more information
0 Unresolved
0 Waiting for Doctor Agreement
0 Miscellaneous

Type of Exception:
Total number of exceptions: 13
Immediate safety Issues: 0
Working pattern related issues:3
Work hours related issues: 9
Educational opportunities related exceptions: 1

b) Locum bookings

Locum bookings April 2021 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	14	14	132.50	132.50
Rota 2	10	10	97.50	97.50
Rota 3	9	9	71.00	71.00
Rota 4	4	4	27.00	27.00
Rota 5	10	10	98.50	98.50
Rota 6	10	10	91.00	91.00
ST4-6 North	26	26	364.00	364.00
ST4-6 Rea/Tam	4	4	72.00	72.00
ST4-6 Sol/East	22	22	408.00	408.00
ST4-6 South	26	26	368.00	368.00
Total	135	135	1729.50	1729.50
Locum bookings May 2021 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	5	5	53.00	53.00
Rota 2	12	12	138.50	138.50
Rota 3	4	4	41.00	41.00
Rota 4	4	4	33.50	33.50
Rota 5	8	8	88.50	88.50
Rota 6	2	2	17.00	17.00
ST4-6 North	34	34	473.00	473.00
ST4-6 Rea/Tam	4	4	80.00	80.00
ST4-6 Sol/East	23	23	432.00	432.00
ST4-6 South	19	19	260.50	260.50
Total	115	115	1617.00	1617.00

Locum bookings June 2021 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	25	25	247.50	247.50
Rota 2	16	16	156.00	156.00
Rota 3	15	15	152.00	152.00
Rota 4	5	5	52.50	52.50
Rota 5	15	15	136.00	136.00
Rota 6	1	1	4.50	4.50
ST4-6 North	32	32	456.00	456.00
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 Sol/East	18	18	320.00	320.00
ST4-6 South	21	21	299.00	299.00
Total	151	151	1879.50	1879.50

Locum bookings April 2021 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	57	57	517.50	517.50
ST4-6	78	78	1212.00	1212.00
Total	135	135	1729.50	1729.50

Locum bookings May 2021 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	35	35	371.50	371.50
ST4-6	80	80	1245.50	1245.50
Total	115	115	1617.00	1617.00
Locum bookings June 2021 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	77	77	748.50	748.50
ST4-6	74	74	1131.00	1131.00
Total	151	151	1879.50	1879.50

Locum bookings April 2021 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	80	80	1007.00	1007.00
Sickness	6	6	90.00	90.00
COVID 19	11	11	166.00	166.00
Off Rota	33	33	426.00	426.00
Emergency Leave	3	3	36.00	36.00
Total	135	135	1729.50	1729.50
Locum bookings May 2021 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	65	65	948.00	948.00
Sickness	6	6	50.00	50.00
COVID 19	4	4	68.50	68.50
Off Rota	40	40	550.50	550.50
Total	115	115	1617.00	1617.00

Locum bookings June 2021 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	82	82	1016.50	1016.50
Sickness	5	5	53.50	53.50
COVID 19	9	9	124.50	124.50
Off Rota	55	55	685.00	685.00
Total	151	151	1879.50	1879.50

Vacancies

		Vacancies by month					
Rota	Apr	May	Jun	Total gaps (average)	Number of shifts uncovered		
Rota 1	14	5	25	14.6	0		
Rota 2	10	12	16	12.6	0		
Rota 3	9	4	15	9.3	0		
Rota 4	4	4	5	4.3	0		
Rota 5	10	8	15	11	0		
Rota 6	10	2	1	13	0		
ST4-6 North	26	34	32	30.6	0		
ST4-6 Rea/Tam	4	4	3	3.6	0		
ST4-6 Sol/East	22	23	18	21	0		
ST4-6 South	26	19	21	22	0		
Total	135	115	151	100.3	0		

c) **Fines**

No fines were accrued during this quarter

d) Qualitative information

The number of exceptions reports raised has increased during this time and a majority of exceptions were closed.

There is no immediate safety concern.

Majority of exceptions were about working overtime and resolved by facilitating time off in lieu.

One of the doctors raised exceptions about lack of senior support. The issue was resolved as he was allocated a new supervisor.

A series of exceptions about overtime were raised from the same post and suggested a pattern of overwork. The individual exceptions were resolved by providing TOIL and payment for extra time. No more exceptions were raised from May onwards for this post. I have highlighted the pattern to the Associate Medical Director, Medical Education.

e) Issues arising and solutions

There are no major concerns. No immediate safety concerns were raised. Most of the exceptions are about working overtime and resolved by TOIL.

One post led to a series of exceptions about lack of supervisor support and was resolved by allocating a supervisor.

The supervisor for the outstanding exception has been emailed a reminder.

The number of vacant shifts continued to be high. On positive note all the vacant shifts were filled.

f) Summary

The number of exceptions in this quarter was higher than had been in the previous quarter and majority was resolved with time off in lieu. No post needed a formal work schedule change. There was one outstanding exception at the end of the quarter and this is a significant improvement from previous quarters.

15. Questions from Governors and Public (see procedure below)

16. Any Other Business (at the discretion of the Chair)

17. SNAPSHOT REVIEW OF BOARD PERFORMANCE

Were items appropriate?
Were timings appropriate?
Are there any items for inclusion on the action log?
Are there any items to be disseminated across the Trust?
Were the papers, clear, concise and aided decision making?

18. RESOLUTION

The Board is asked to approve 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
- 27 October 2021