BOARD OF DIRECTORS PART I

Schedule	Wednesday 7 June 2023, 9:00 AM — 12:30 PM BST
Venue	Uffculme
Organiser	Hannah Sullivan

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The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

Date & Time of Next Meeting 560
2 August 2023, 09:00-12:30

Agenda

AGENDA
BOARD OF DIRECTORS MEETING
Time: 09:00AM, WEDNESDAY 7 JUNE 2023
Venue: Plymouth Room,
The Uffculme Centre,
52 Queensbridge Rd, Birmingham, B13 8QY

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

Values
The Board will ensure that all its decisions are taken in line with the Values of the Trust: Compassion, Inclusive and Committed
Staff Story to be supported by Wilton Chiswo

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Apologies for absence & Declarations of interest	*Chair*	09:30	*Verbal*	
2.	Minutes of the previous meeting		09:32	*Attached*	Approval
3.	Matters Arising/Action Log		09:35	*Attached*	Assurance
4.	Chair's Report		09:40	*Attached*	Assurance
5.	Chief Executive's and Director of Operations Report	*R. Fallon-Williams*	09:50	*Attached*	Assurance
6.	Trust strategy - 2022/23 Review and 2023/24 Goals	*P. Nyarumbu*	10:00	*Attached*	Approval
7.	**QUALITY**				
7.1	(a) QPES Chair's Assurance Report April. (b) QPES Chair's Assurance Report May.	*L. Cullen*	10:10	*Attached*	Assurance
7.2	Patient Safety Report	*S. Forsyth / Lisa Pim*	10:20	*Attached*	Assurance
8.	**PEOPLE**				
8.1	(a) People Committee Chair's Assurance Report April. (b) People Committee Chair's Assurance Report May	*M. Shafaq*	10:30	*Attached*	Assurance
9.	**SUSTAINABILITY**				
9.1	(a) Finance, Performance & Productivity Committee Chair's Assurance Report April. (b) Finance, Performance & Productivity Committee Chair's Assurance Report May.	*B. Claire*	*10:40*	*Attached*	Assurance
9.2	c) Finance Report	*D. Tomlinson & R. Sollars*	*10:50*	*Attached*	Assurance
9.3	Audit Committee Chair`s Assurance Report April	*B. Claire*	*11:00*	*Attached*	Assurance
9.4.	Charitable Funds Chair`s Assurance Report April	*M. Shafaq*	*11:10*	*Attached*	Assurance

compassionate

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
9.5	Integrated Performance Report - Front sheet Enclosure 1: Integrated Performance Report	*D. Tomlinson*	*11:20*	*Attached*	Assurance
10.	**GOVERNANCE & RISK**				
10.1	Updates on any Action Plans arising from (Good Governance Reviews, External Visits, CQC, Coroner etc)	*G. Mordain & D. Tita*	*11:35*	*Verbal*	Assurance
10.2	Updates on any Externally Commissioned Reports and Investigations	*G. Mordain & D. Tita*	*11:50*	*Verbal*	Assurance
10.3	Freedom To Speak Up Annual Report	*E. Randle*	*12:00*	*Attached*	Assurance
10.4	Quarterly Guardian of Safe Working Report	*Dr Shay-Anne Pantall*	*12:05*	*Attached*	Assurance
10.5	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:10*	*Verbal*	-
10.6	Any Other Business *(at the discretion of the Chair)* **10.6a.** Health inequalities (including PCREF, Blaichir & Internal work). **10.6b.** To schedule an extraordinary Board Meeting on 21st June 2023 from 14:00 – 14:35 to ratify the Annual Report & Accounts for 2022/23. **10.6c.** Ratification of Trust Constitution and associated documents. **10.6c1:** BSMHFT Constitution, incorporating Standing Orders for the Commissioning Committee **10.6c2**. BSMHFT Scheme of Delegation **10.6c3**. BSMHFT Standing Financial Instructions (SFIs) **10.6d.** HSE - NHS Chief Executive Letter and Report on MSDs and V&A Interventions - March 2023	*Chair* *J.Kaur / F. Aria* *Chair* *D. Tita* *S. Forsyth*	*12:20* *12:25* *12:26* *12:27* *12:29*	*Verbal* *Attached* *Verbal* *Attached* *Attached*	 *Assurance* *Information* *Noting* *Information & Noting*
11.	**FEEDBACK ON BOARD DISCUSSIONS**	*Chair*	*12:30*	*Verbal*	-
12	**RESOLUTION** The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
	Date & Time of Next Meeting 2 August 2023, 09:00-12:30		*12:30*	*Chair*	

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

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

Procedure for questions from the public at board meetings

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

Questions

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

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

Relevance of questions

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

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

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

Notice requirements

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

Limitations on numbers of questions or time allowed

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

There are no limits to the questions for Governors.

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

Response to questions

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

Staff Story to be supported by Wilton Chiswo

1. Opening Administration:
Apologies for absence & Declarations of interest

2. Minutes of the previous meeting

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	BOARD OF DIRECTORS
Date	5 April 2023
Location	VIA MICROSOFT TEAMS

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

Attendance	Name and Title		
Present	Phil Gayle	-	Interim Trust Chair
	Roisin Fallon-Williams	-	Chief Executive
	David Tomlinson	-	Director of Finance
	Vanessa Devlin	-	Director of Operations
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	Linda Cullen	-	Non-Executive Director
	Anne Baines	-	Non-Executive Director
	Winston Weir	-	Non-Executive Director
	Bal Claire	-	Non-Executive Director
In Attendance	Lorraine Joyce	-	Executive PA to CNO
	David Tita	-	Associate Director of Corporate Governance
Observers	Leona Tasab	-	Clinical Staff Governor
	Mustak Mirza	-	Service User Governor
	Maxine Blake- Jones	-	Executive PA
Apologies	Fabida Aria		
	Steve Forsyth		

Agenda item	Patient story	Action (Owner)

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** The Chair welcomed all who were observing the meeting. Mr. D Tomlinson confirmed conflict of interest as Managing Director of Summerhill Supplies Limited.	
2.	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meetings held on the 1 February 2023 were approved as a true and accurate record of the meeting.	

Agenda Item	Discussion	Action (Owner)
3.	**CHAIR'S REPORT** The Board received an overview of the Chair's key areas of focus since the last Board meeting. Mr. P. Gayle confirmed he continues to have monthly meetings with Professor David Sallah from Birmingham Community Healthcare NHS Foundation Trust. I have had an introductory meeting with Tom McNeil West Midlands police and Crime Commissioner, who is keen to re-develop partnership working with our Trust. We intend to have a further meeting with a view of possibly having a representative from the police linked to our Trust. Mr. P. Gayle confirmed had a meeting with Professor Patrick Vernon, interim Chair of BSoL ICB to discuss the collaborative and the development of the ICB. In addition, he briefly had a discussion with Andy Cave from Birmingham Healthwatch, and we will be arranging regular monthly meetings. Mr. P. Gayle confirmed he has met with the interim chair of UHB, B Dame Yve Buckland, on how we can develop our partnership working. It is my endeavor to continue to develop these partnerships. Monthly meetings with Mr. Shane Bray, Managing Director of Summerhill Supplies Limited continue. These meeting a helpful to understand some of the challenges and opportunities our subsidiary companies have. Also, to share from the Trust perspective areas of concern or that require clarity. Mr. P. Gayle confirmed he continues to meet on a monthly basis with our Freedom to Speak Up Lead to hear about key themes of concerns from staff which are captured through FTSU. During February Mr. P. Gayle chaired an interview panel for a Consultant Psychiatrist position for our children and adolescent services (CAMHS SLOAR) in Solihull to which we successfully appointed. Mr. P. Gayle was pleased to be able to visit the Zinnia Centre and spend some time meeting staff and service users. He noted he was very impressed of the work our staff do both with our inpatient units and the community outreach teams. Mr. P. Gayle confirmed he had attended the Integrated Care Partnership Board along with other system partners. Giving him an opportunity to network with partners in the system whom he had not previously connected with. He also attended the West Midlands BSoL Chairs meeting which takes place monthly. Mr. P. Gayle was pleased to confirm the Trust are currently working on updating our Membership and Governor Engagement Strategy and hope in due course to circulate this for comments to the Council of Governors approval. Mr. P. Gayle was pleased to confirm our Council of Governor Board development sessions have been developed and agreed for the coming year. These sessions will allow the core development of the Council of Governors. Following a robust elections process Mr. P. Gayle was pleased to announce the Lead and Deputy Lead Governor have been appointed. Mr. John Travers has been appointed as Lead Governor and Mr. Mustak Mirza has been appointed as Deputy Lead Governor.	

Agenda Item	Discussion	Action (Owner)
	The report was received and noted.	
4.	**CHIEF EXECUTIVE'S AND DIRECTOR OF OPERATIONS REPORT** Mrs. R. Fallon-Williams and Ms. V. Devlin presented the Chief Executive and Director of Operations report and highlighted the salient points as follows: Industrial Action by Junior Doctors took place for 72 hours on 13th – 15th March. Within BSMHFT, 119 Junior Doctors had the option to take strike action. 65 doctors took strike action (55%), 44 undertook normal working duties (37%) and 10 (8%) were on pre-approved leave. Contingency plans were made to cover all out of hours duties with a 'back up' Rota established for all 48 shifts within the period of industrial action. The 'back up' doctor was required to cover 22 of the 48 shifts throughout the period. Remuneration was 3x hourly pay for each hour of the out-of-hours duty covered. The People team is progressing well with the review of a large suite of policies. This has been supported by an extensive engagement plan with various stakeholders throughout the Trust and has encapsulated the principles of Project Flourish. Policies are due for ratification in May and will be followed with the launch of our brand-new HR toolkit training for managers. Sickness rates had decreased significantly since December 2022. Our rate in February was 5.4% which is the lowest we have seen since June 2021 and nearly a 2% drop from December. ICCR in particular are now below KPI at 3.6%. In addition, we have also seen a steady decline in our 12 month plus Long Covid cases where we have either supported staff back to work or to access ill health retirement. Fundamental e-learning Training Compliance for TSS staff is now at 87.5% (KPI 75%) this is a significant increase from this time last year (42.3%) The 360@ tool has been created and roll out will commence in April. It is anticipated that this tool will be used to support leadership programmes and Human resource process e.g., Enough is Enough as appropriate. ICCR community mental health teams are continuing to work through transformation. Mental Health Primary care teams are present in each locality with varying numbers of staff recruited. We are continuing to work closely with primary care colleagues to develop the process and pathways to ensure individuals receive mental health support in a timely manner at their GP surgery. Solar continues to experience staffing vacancies and continues with their recruitment drive and workforce planning to reduce these. Weekly meetings continue to take place to review risks, waiting lists, recruitment, and staffing. The new Intensive Community rehabilitation service has now gone live. The team is building their caseload based on need with the intention of reducing high intensity bed usage, the need for placing service users out of area and to help ease the service user's rehabilitation journey. The service had a successful community launch event in March to celebrate the newly developed team and offer to our service users. Mrs. R. Fallon-Williams congratulated Mr. C Beet as being the person appointed jointly by the Trust and Birmingham Community Trust as the Lead Director for Digital and	

Agenda Item	Discussion	Action (Owner)
	Informatics; and the benefits this will bring across the organisations going forward. Services continue to experience significant RMN recruitment challenges across the men's and women's services, and we are continuing to engage with active recruitment. There was positive feedback from recent CQC visits regarding the MH Act to Hillis Lodge, Swift, Severn, and Laurel wards. Staffing has been increased in the Psychiatry Decisions Unit (PDU) to increase service user access to, and movement through, the PDU. Figures currently available show an increase from 60 to 78 referrals over the last two months. A review of the PDU model will take place as part of the to the wider acute and urgent care pathway refresh as highlighted and agreed as a priority in the Mental Health Provider Collaborative. All wards in Dementia & Frailty continue to work with over their establishment staffing numbers due to high acuity and required observation levels on the wards. A number of Staff Nurse (Band 5) sickness-related absences have also created additional nurse staffing pressures. Teams have, however, been very flexible and supported other areas in Specialties. Care Home Liaison and CERTS are also being asked to support Community Mental Health services too. Following a successful recruitment drive we are very pleased that the vacant occupational therapy posts have been offered to applicants and the new starters are due to join us in the coming months. The annual Allied Health Professionals conference went well with good representation from Dementia and Frailty. Colleagues from across the BSOL system continue to explore how the new mental health investment should be utilised. Funding has continued for existing transformation programmes, such as our community programme, as well as new funds which we need to ensure supports the ongoing work around reducing our out of area placements, as well as other local priorities such as the Urgent and Emergency Care Pathway working into A&Es and the Urgent Care Centre at the Oleaster. The Board are aware that following a short shadow period the BSoL Mental Health Provider Collaborative and our associated role as lead provider went live on April 1st. Whilst this is the start point of new working arrangement and opportunity to realise benefits for service users and their families, a considerable amount of work has been undertaken across the partnership to get us to this point, thank you to all who been involved in enabling this. The CQC completed their full inspection of the Trust in December 2022 whereby they completed a number of visits, reviewed numerous reports, and met with a wide range of staff including formally interviewing all member of the Trust Board as part of the well led assessment. We expect the final report to be published in early April. Ms. A. Baines notedthe additional and newly qualified staff at Ardenleigh, and queried the level of assurance in relation to safeguarding and safer staffing levels being re-enforced for new starters? Ms. V. Devlin assured the Board that there was a robust induction programme, and robust training with clinical supervision in place. Support for new staff is in place andstaff	

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Agenda Item	Discussion	Action (Owner)
	do not work alone on shift and have allocated “work buddies” alongside them. Regular Management supervision is ongoing. Mrs. R. Fallon-Williams confirmed educator roles are in place, tosupport in-situ by working alongside new staff. It was noted that the recruitment strategy plan had been reviewed by all Committees in May 2023 and would be presented to Audit and Trust Board in June 2023 for approval. Mr. P. Gayle acknowledged the demand and ongoing challenges faced within ICCR and queried the impact of recruitment on services? Mrs. V. Devlin advised work is ongoing with colleagues at Birmingham Women and Childrens NHS Trust on the development of the integrated pathways. Waiting times continue to be a concern. Service areas continue to work closely with partnership organisations to reduce pressures where possible. . Mrs. R. Fallon-Williams noted the organisation was not able to continue in this way and that will be an opportunity for ICB to review the model of care and develop the plan going forward. Ms. V. Devlin advised a more detailed report, covering demand and capacity pressures, would be present to the Board in June 2023.	
6.	**BOARD OVERVIEW TRUST VALUES** Dr. L. Cullen shared an overview on experiences within relation to staff colleagues and patient services. Compassion: Commitment to staff wellbeing had been evidenced on numerous occasions; one particular example was encouragement of staff to rest and recover properly by not working or attending meetings when working from home. When things go wrong with patients and families being proactive immediately e.g., a recent incident on Sage ward and an immediate apology to the patient and carer was given. Inclusion: The recent interview process of the appointment of the Trust Chair. After reviewing previous senior appointments, a wider inclusivity in the stakeholder groups outside of the organisation and from within the organisation was included. Mr. P. Gayle thanked Dr. L. Cullen for the encouraging update and noted how good it was to see the Trust Values were making a good impact for staff as well as patient family and Carers.	
7.	**QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE CHAIR’S ASSURANCE REPORT** The Board received the assurance report from the Quality, Patient Safety and Safety Committee following the meetings during February and March 2023 highlighting the following salient point as: **February** Staff Story – Service User Mr. Max Carlish, Chair of the LEAR Group gave a detailed presentation with detailed overview of the experience of Service Users medication that is	

DRAFT

Agenda Item	Discussion	Action (Owner)
	prescribed and how these decisions are made clinically with little input of the service users and lack of explanation as to why medications are prescribed. Whilst this was personal experience of mental health services the committee were assured that the Trust is seeking to work alongside service users and their needs. CQC Update – the committee were assured all door monitoring alarm systems had now been installed in all en-suites in Acute Care. Safer staffing continued to recruit to current vacancies and the training plan for E- Rostering, Safecare and the Loop commenced in January 2023. Section 29A notice issued by the CQC in December 2022 was responded to on the 23rd January 2023. The committee was assured the Trust continued to implement its place in response to the CQC. Mental Health Legislation Committee – The committee was updated and assured that arrangements were I place for oversight of MHA issues as well as processes in place regarding multi-agency working in the form of Joint System Oversight Group (JSOG) Terms of Reference were reviewed, and some changes were suggested to include all of the sub-committees. The Board were requested to approve the Terms Of Reference. **March** CQC Update – the Trust had now received the draft report from the Core and Well-led inspections that took place in October and December. The organisation responded on the 8th March 2023 to the points of factual accuracy from the feedback received from service areas and other Corporate Specialists and await the final report. The committee was pleased to be advised of the MHOST data collection and that work had begun, and an update on progress was expected in July 2023. The committee noted the importance of updating QPES on the Safer Staffing progress reports due to the impact this had on quality. The Committee had a very detailed discussion about the data provided in the Serious Incidents and Learning report. The Committee were partially assured int hat clinical areas that had been identified as having low compliance would gain focused support. Further Assurance was required from the Trust Clinical Governance Committee on the progress of Action Plans. There was recognition that new safety summits were to be established where there are safety or quality concerns to work with individual wards or divisions. It was also recognised that the ward accreditation programme was to be considered. The Committee received the QI Framework and agreed the item needed further review and a paper would be brought back to the Committee in June on the framework proposed and the internal investment in resources to achieve QI outcomes. The monthly Quality report assured the committee that following a deep dive into all incidents currently open on the system back to 2011 when Eclipse was 1st integrated into the Trust that a methodology for safe closure of historic incidents has been created. This methodology would be enacted by the Patient Safety team in collaboration with the CG Facilitators and Divisional Leads. The Committee were assured that the organisation continues to have high levels of reporting of incidents and that the Trust remains below the national average for incidents resulting in harm to patients. The Committee noted the detailed Complaints and Parliamentary and Health Service Ombudsman (PHSO) updates report. Partial assurance received on the complaints handling process and noted the progress being made to reduce wating times. The Committee were please to note the change in the conclusions of complain investigation in the spirit of the new Patient Safety Response Framework (PSIRF). A new complaints tracker was now in place with ongoing review to improve local reporting to divisions. A	

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thematic review, including health inequalities, was to be presented to the June Committee.
The Committee approved changes to the Terms of Reference.
Mrs. A. Baines queried the level of activity in relation to the Mental Health Act (MHA)and the number of cases and the percentage of discharges as the data reported was low in relation to the work completed?
Mrs. A. Baines noted the ongoing challenges getting Investigating Leads and highlighted the similarity with the same issue for the Freedom to Speak Up Guardians (FTSU); and queried how the organisation could improve this.
Dr. G Beresford provided a comprehensive overview of the process for discharge in relation to MHA and provided assurance that this remains a key focus for the teams..
Mr. P Gayle queried the reference to Community Treatment Orders (CTO) evaluation last reviewed 15 months ago and when the update to the comprehensive review would be available for the Board to see?
It was noted QPES would be the first Committee to review and reflect in May 2023 and then hopefully to the Board in June 2023.
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Patient Safety Report
Ms. L. Pim presented a detailed report and summary highlighting the following salient points:

Whilst the 60-day mandated investigation standard had been removed externally, the organisation would still be working to this as an internal standard to prevent delayed learning for services and the orgnisation and increased risks of this type from reoccurring. It was noted there had been a reduction from 12 to 8 investigations that exceeded 60 days, from first review in January 2023.
The data for serious incidents within the detailed report evidences an upward shift in incidents reported as SI's from January onwards. An important area to note has been the reinstating of the SI oversight Group in January this year. Continuous review of incident themes and trends progressing forward will enable the Trust to determine if there were any additional contributing factors to the upward trend.
A deep dive was undertaken in February of the total number of SI actions open as an organisation. Work has been agreed between the patient safety team, clinical governance facilitators, and divisions to review and agree timelines for closure of historic SI actions. This will be supported through the new SI action module on Eclipse.
Work is now underway with relevant divisional stakeholders, to action recommendations from the recent concluded and published NICHE reviews, following two historical domestic homicide incidents occurring in 2014, and an independent multi-agency review on behalf of the statutory services involved (mental health, police, probation, and prison services) into the care, treatment, and management of a service user, who committed a number of stabbings in Birmingham city centre in September 2020. NHSE have also recently commissioned Psychological Approaches to undertake a new review following a homicide which occurred in 2018, with a focus on; Access to AMHP services, Services listening to relatives and Regulation 28 report requirements.
Implementation of the Patient Safety Incident Review Framework (PSIRF) is broadly discussed and identifies that the Trust was in a positive position in relation to its preparations in relation to transition phasing. The Board was advised there would be several decisions required in the future, relation to PSIRF: i.e., organisational training, testing of organisations safety climate and consideration and agreement of oversight arrangements as Lead Provider of the Provider Collaborative.

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Agenda Item	Discussion	Action (Owner)
	• A deep dive on outstanding actions taken from complaints was undertaken during January 2023 with detailed percentages and evidence in the detailed report circulated to the Board this month. Ms. A. Baines congratulated Ms. L. Pim on the excellent and detailed report presented. Mrs. R. Fallon-Williams personally thanked Ms. Pim for the achievements taken place in a short period of time. There was a detailed discussion in relation to key themes and feedback to understand where there could be further improvements made. It was noted the NICHE report was due in June 23, and that the organisation was one of 13 involved in the work offering involvement from families. It was confirmed Mr. Forsyth and Mrs. Fallon-Williams have a scheduled meeting with the family involved.. It was noted for assurance, PSIRF was nationally tested and tried and the Trust was learning from other organisations. Overall feedback was extremely positive. Key issues in relation totraining for all levels either through online learning or bring in external experts will be explored.It was agreed there needs to be clear understanding how to reconcile the spend with limited resources. It was noted this piece of emerged from the CQC well led visit in 2022. The Board agreed how and when the frequency of updates to future meetings. Mr. W. Weir queried the complaints and timings of completion and investigations noting the average working time for completion of an investigation taking 90 days? Ms. L Pim advised the national standard was removed during COVID, but that organisation will maintain that standard internally. The Board were assured the Complaints policy was under review and the PHSO deadline was 6 months, but the Trust target level will be 6 – 8 weeks. Mr. P. Gayle thanked Ms.L Pim for the clear and concise paper and noted the Board are looking forward to the Patients Safety and Experience Report due to be received to the June 23 Board.	
8.	**PEOPLE COMMITTEE CHAIR'S ASSURANCE REPORT** The Board received the assurance report from the People Committee following the meetings during February 2023 and March 2023 and highlighted salient points. **February:** The Committee were partially assured on the work underway to address issues but asked that a clearer journey to improvement rather than target achievement be demonstrated The continuing issue of vacancies remains a significant concern as well as the cost of temporary workforce cover. Although there were positive developments and actions plus the number of appointments of overseas colleagues, committee members reiterated their concerns, particularly on the wellbeing of existing staff. It was disappointing to note the poor performance in 6-week rostering. Although the data was being checked it was clear that a plan for improvement was needed. Members reiterated that an effective forward plan for work commitments contributed to a feeling of security and value for colleagues. The Committee were pleased to hear that an improvement action plan was being developed following a drop in colleague appraisal rates. Members stressed that training for appraisers was key.	

Agenda Item	Discussion	Action (Owner)
	Due to a change in measure the numbers for Dignity at Work cases had increased. The new measure reflects the number of people against which a case may be investigated i.e., possibly more than 1 or a team. This would reflect the degree to which 'group think' or systematic issues can be identified. Committee was assured that work was underway to address the key wellbeing issues. This was important given our performance in sickness rates is not good and that increasing numbers of colleagues are experiencing stress and anxiety. This further reiterated discussions earlier in the meeting regarding the roles of the organization to ensure that processes, procedures, and training exist to support all colleagues to do their job and feel fulfilled and valued everyday The Committee were assured regarding the processes in place but emphasized that the impact of initiatives and understanding their contribution towards an improvement was essential to gaining assurance regarding delivery. It was hoped that the Workforce Plan when finalised would provide some of this for monitoring **March:** The Committee could only take partial assurance from the KPI report due to the actual performance reported. The Trust is working in very challenging circumstances with the recruitment to nursing in particular, being a national issue. The Committee were assured however that the representatives were doing all they can to address these issues and it will be particularly interesting to see what may come out of the work as part of the NHSE Overhauling Recruitment Project The Committee received a detailed report on the gender pay gap and noted The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require public bodies with 250 or more employees on the snapshot date of 31st March of any given year to report their gender pay gap. After discussion, it was felt the report only provided partial assurance. It was disappointing to note the response to the staff survey and that overall staff experience. It was noted however that there appeared to be confidence in staff reporting poor experiences (whether that be formally or via the survey) which is likely to mean that results will be worse before we start to see a positive shift. The Exec were asked to set out how they would demonstrate in year improvements or changes given that the survey is carried out annually. Partial assurance taken. It was disappointing to note the response to the staff survey and that overall staff experience had declined. It was noted however that there appeared to be confidence in staff reporting poor experiences (whether that be formally or via the survey) which is likely to mean that results will be worse before we start to see a positive shift. The Exec were asked to set out how they would demonstrate in year improvements or changes given that the survey is carried out annually. It was felt that only partial assurance could be taken. Mr. W. Weir appreciated the information about staff wellbeing. He noted it wascommendable to see the work ICCR is doing to reduce the sickness rate, and highlighted the importance of ensuring staff are being encouraged for this. Mr. P. Gayle noted the use of agencies significantly for consultants within ICCR and queried whether teams were looking at job descriptions and offers to staff to make the substantive roles more attractive. Mrs. V. Devlin confirmed there are gaps in community mental health teams and SOLAR are using agency staff that are being embedded into the teams to reduce the current staffing pressures.	

Agenda Item	Discussion	Action (Owner)
	She confirmed the Clinical Director for ICCR is leading on a review, including a review of job descriptions, caseloads, team hold and a deep dive into where community transformation supports primary care. There was an agreement to have Clinical Leads in the directorate. Mr. P. Gayle confirmed following meetings with colleagues from Staffside and Unions, they need to be updated on key themes and overall progress. Mrs. R. Fallon Williams noted the first item in the Assurance report from February 23, '*The partially assured on the work underway to address issues but asked that a clearer journey to improvement rather than target achievement be demonstrated'* and raised the question of what would be seen in terms of consequences? Mrs. A Bains confirmed that due to the delivery of some targets being challenging and the constant comment on processes changing further discussions are being held to include 'the steps forward' to achieve for improvement and expect to see change. This process has more positive outcome.	
9.1	**FINANCE, PERFORMANCE AND PRODUCTIVITY COMMITTEE CHAIR'S ASSURANCE REPORT** Mr. B. Claire presented the Committee assurance reports for both February and March and highlighted the salient points as: **February:** The Committee received partial assurance from the Reach Out report and verbal discussion that took place. Due to the changes to the leadership and governance of Reach Out previously discussed, a concern was raised regarding the timing of responsibilities transferring to the (shadow) Commissioning Board. Long Term approach was right and sensible, however, for the near term it was deemed a potential risk. It was noted there was potentially one more Shadow Commissioning Board before April 2023, the risk was deemed low. Work continues with finance colleagues across BSoL ICS to develop a financial plan. 22/23 – partial assurance in that it was likely the Trust would achieve a break-even position for year-end or potentially deliver a surplus. There still remained several dependencies that currently remain unclear to provide certainty. 23/24 – limited assurance as it was noted, the level of 'system wide' thinking and collaboration had increased which was a positive. Unless there is a fundamental shift in the way we deliver savings, the risk is that our year-on-year financial gap is only likely to increase. The organisation also does not appear to have a long-term savings plan that would provide adequate levels of assurance. The committee challenged based on how the organisation planned to address this and what the opportunities and/or behavioral changes necessary to develop credibility and assurance. A productive conversation took place that discussed alignment to the delivery of the transformational elements of Trust's strategy, the introduction of Service Line Reporting, developing a Trust-wide culture around continuous improvement and more structured/programmatic approach to delivery. The Committee received partial assurance on the Integrated Performance Report. There had been good progress toward the year end and continues. The fundamental issues underpinning the Trust ability to address out of area beds, bank/agency expenditure and the lack of recurrent saving opportunities remain. The committee challenged the need for greater clarity on the 'get well' plans, in particular clarity on when the current action plans will start to make a positive impact. The Trust's capital plan for 23/24 would be presented at the next FPP. It was also noted	

Agenda Item	Discussion	Action (Owner)
	that the capital planning cycle is clearly included in the Trust's annual business calendar. The Committee received the revised Terms of Reference for approval, and they were approved subject to minor changes. The BAF was discussed, and David Tomlinson and David Tita were requested to review the financial challenges discussed during the meeting against the current risk narrative. In particular, the 23/24 financial savings challenge and the apparent lack of a long-term savings plan (i.e., through strategic transformation) appeared to be less explicit within the Trust's risk profile. **March:** The Committee noted it would be likely that the Trust will achieve a break-even position for year-end, or potentially deliver a surplus through year-end I&E recovery. The committee challenged the Trust to provide greater financial assurance in terms of year-end outcomes a lot earlier on 23/24, and not necessarily leave things till M12. A meeting took place on 10th March 2023 between the Execs and Non-Execs to discuss the alignment between the Trust's strategic priorities and how each will contribute towards delivering financial headroom. Whilst there was recognition that this is necessary, the Trust hadn't previously looked at the strategic priorities in this context, and therefore currently there is no pipeline of opportunity being developed through the strategic workstreams. It was agreed that the team will start to pursue this approach/mindset and consider a first draft of a view for the Strategy review at the June Trust Board. Note – the strategy review will come to FPP in May, ahead of the June Trust Board for comment. The Trust remains challenged across its core financial pressures points of out of area beds, temporary staffing, and recurrent savings opportunities. The committee welcomed the greater clarity and therefore assurance on the 'get well' plans that indicated a forward view of the impact trajectories. The Committee received the detailed breakdown and noted the capital allocation submitted to NHSEI as part of our plan was higher than the indicative capital envelope set out. This is because the Trust has had to account for our 'fair share' of SCIF (System Capital Investment Fund). It was recognised that whilst capital funding will be challenging both within and across the system, the committee felt reasonably assured that the shape of the plan was a realistic as can be. Mrs. R. Fallon-Williams commented on Transformation, noting that whilst the organisation is ahead digitally, estates rationalization point of view, and in terms of the BSOL systems bathrooms, what other items for example, Pathway of Care, and other items could be done more collectively going forward. The Chair thanked B. Claire for the report.	
9.2	**INTEGRATED PERFORMANCE REPORT** Mr. D. Tomlinson presented the Integrated Performance Report, noting this has been received for completeness following the presentations to Board Committees, i.e., Finance, QPES and People. At the January 2023 FPPC meeting members requested a more detailed update on the key themes, factors affecting performance, actions, and improvement trajectories for the following metrics: • Inappropriate Out of Area Bed Days. • IAPT – service users seen within 6 and 18 weeks.	

Agenda Item	Discussion	Action (Owner)
	• Referrals over 3 months with no contact. • Service users with a CPA review in the last 12 months. • CPA 7 day follow up. • People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates. The above areas have been considered by the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. Relevant Leads have provided an update on each area for FPPC. Mrs. R. Fallon-Williams noted The importance of consistency as to what had been discussed at committees. The report was received and noted.	
9.3	**Finance Report** The month 11 consolidated Group position is a deficit of £0.6m year to date. This is £0.6m adverse to the break even plan as submitted to NHSE on 20.6.22. The Group position is mainly driven by the Trust month 11 deficit of £1.2m year to date. Key pressures contributing to the year-to-date deficit position are slippage on savings delivery, out of area pressures and staffing pressures, with a significant level of temporary staffing expenditure. These are partly offset by vacancies across the Trust and slippage relating to Service Development Fund (SDF) investment, SDF income has been deferred in relation to this. A paper regarding the approach to income deferral was approved at the Operational Management Team meeting on 14.3.23. The Group position includes a £37k deficit for our wholly owned subsidiary, Summerhill Services Limited (SSL) and a £229k surplus position for the Reach Out Provider Collaborative in line with the agreed contribution to Trust overheads year to date. Total year to date bank expenditure at month 11 is £28.1m. This has predominantly been incurred within the following service areas: Acute & Urgent Care £11.2m, Secure and Offender Health £7.2m, Specialties £4.5m and ICCR £2.9m. Total bank spend of £2.5m in February is in line with prior month and is just below the average monthly bank expenditure year to date of £2.6m. This is £0.4m above the 2021/22 monthly average and £0.7m above the 2020/21 average. The Board noted the options appraisal for the contract renewal from Summerhill Supplies Limited (SSL) and considered the proposals. Following a detailed discussion the Board agreed the SSL proposal for option one. ***DECISION: The Board agreed the SSL proposal for option one.***	
9.4.1	**GENDER PAY GAP REPORT** Ms. J. Kaur presented the Gender Pay Gap for 2022 noting the following salient points and recommendations: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require public bodies with 250 or more employees on the snapshot date of 31st March of any given year to report their gender pay gap. We have grown our substantive workforce by 88 colleagues with a very small percentage increase of women's representation from 70.9% (3386 in 2021) to 71% (3451 in 2022). • Our gender pay gap for 2022 is 8.76%, with a median of 1.56%; reduction on mean of 9.07% and an increase on the median of 0.00% reported in 2021.	

Agenda Item	Discussion	Action (Owner)
	• The bonus gender pay gap has reached equity. • The mean age pay gap has increased for women aged 51+ in 2022. • The mean ethnicity pay gap has increased from 4.18% in 2021 to 5.53% in 2022. • The mean disability pay gap has decreased from 9.5% in 2021 to 4.98% in 2022. • The sexual orientation pay gap has moved from 0.33% in 2021 to -1.82% in 2022. **Recommendations**: Utilise gender pay gap to increase understanding in the importance of accurate data and self-declaration. Socialise the gender pay gap information across Divisions to enable informed decisions, awareness, and ownership. Encourage Divisions to explore their own internal data. Embed data informed positive action initiatives through FLOURISH. Intentions are to reduce the pay gap across the protected characteristics through informed decision making. Explore positive action approaches through intersections. Points for consideration were made around the recommendations And it was agree further information was required on timelines before the proposals could be approved. The Board will receive a further update at a future Board for final approval. T Chair thanked Ms.J Kaur for the presentation.	
9.4.2	**WRES REPORT** The Board was presented with the WRES (Workforce Race Equality Standard) report for the 2021/22 reporting year with attached appendices providing a summary of the national and regional WRES consideration in comparison to the local BSMHFT data. Salient points from the summary report as follows: • Key headlines from the 2021/22 summary as follows: • •he Race Disparity Ratio for the non-clinical workforce, middle to upper level is lower than the national and regional ratio, ranked in the top 18% of all UK Trusts. • The Board representation is ranked in the top 5% of all Trusts in the UK • -ive The lower to upper ratio for the clinical workforce is considerably higher than the regional and national ratio. Ranked in 5th percentile. • -The likelihood of being appointed from shortlisting for Black, Asian, and Minority Ethnic colleagues is the worst in the region and ranked in the 68th percentile. • -The experience of harassment, bullying and abuse from patients, relative or the public across the Trust is considerably worse than the regional and national experience for all staff Ms. J Kaur noted this remains a work to progress, particularly around the experience of colleagues. The Chair thanked Ms. J. Kaur for the detailed report.	
9.5	**Staff Survey** Mr. P. Nyarumbu presented the Board with the results of the Staff Survey report that had been received and published. The results showed that our employees' overall experience of being part of	

Agenda Item	Discussion	Action (Owner)
	BSMHFT has marginally declined year on year, significantly so with regard to the themes of being recognised and rewarded and overall morale. The committee will remember this follows on from a decline in 2021. The results were already being shared on a team-by-team basis. Teams were being assisted to analyse and reflect upon their individual scores and to take actions to make changes. Our People and OD Department was also reflecting on the results, engaging with colleagues and deciding what it means in terms of adapting our ongoing people-focused work programmes. As the results are shared more widely we we'll listen to views across the organisation to develop specific plans in response. This will mean we can clearly say what we said and did at both a corporate level and at a team level. The results had been shared along with further details at both the Transforming Culture and Staff Experience Committee and the People Committee already where plans on responding had been set out in more detail. The Board was asked to note, the recommended actions in the paper being taken forward and that further assurance continues to be sought in sub-committees.	
10.1	**BOARD OF DIRECTORS AND COMMITTEE SCHEDULE** The Board received the schedule for Board and Committee meetings for approval. Mr. D. Tita enquired whether the monthly Commissioning Board needed to be face to face? All members of the Board agreed these meetings are to be held face to face. ***DECISION: The schedule for Board and Committee meetings were approved.***	
10.2	**BOARD OF DIRECTORS FORWARD PLANNER** The Board received the forward planner for approval. All members of the Board approved the forward planner. ***DECISION: The forward planner for the Board was approved.***	
10.3	**BOARD OF DIRECTORS TERMS OF REFERENCE** The Board received the terms of reference for approval. All members of the Board approved the terms of reference. ***DECISION: The terms of reference for the Board was approved.***	
10.4	**DRAFT ANNUAL GOVERNANCE STATEMENT** The Board noted the draft annual Governance Statement and will be brought back to the Board in the near future.	
10.8	**QUESTIONS FROM GOVERNORS AND PUBLIC** Ms L Tasab referred to the Staff Survey noting there are a number of big commitments being made, however staff feedback highlighted when employed at a local level it was felt to be contradictory.	

Agenda Item	Discussion	Action (Owner)
	Ms. L Tasab highlighted a recent example of an incident where a member of staff had experienced racism from a service user. This resulted in the vulnerability of the staff member and this had a wider impact on the team providing care in the service area. The need for zero tolerance through local campaigns is key to understanding and improving experiences going forward. It was noted this was a prime example of what needed to be done, in that while the experience was difficult, the more of those challenging conversations are had, the more example will be of it actually working. This would be a great example of where leadership prevails in working with the team to achieve the right result. Mr. Mustak expressed gratitude for Ms. L. Tasab coming into post and bringing fresh ideas for the Trust to be involved in, along with the presence of Mrs. M. Blake-Jones & Mrs. L. Joyce as Executive Personal Assistants to equally be involved. There was a question from a member of the press in relation to the two niche reviews as to whether they were available for the public to view? It was confirmed that the at the current time only one is due to be published in June 2023. Confirmation of when the other review will be published for the public to view will be confirmed in due course.	
10.9	**ANY OTHER BUSINESS** **There were no other items of business for discussion.**	
11.	**RESOLUTION** The Board asked that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.	
12.	**DATE & TIME OF NEXT MEETING** 09:00am Wednesday 7 June 2023	

3. Matters Arising/Action Log

BOARD OF DIRECTORS – DECEMBER ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
February 2023 Item 3	**MATTERS ARISING/ACTION LOG** Governance Action Plan: Six Monthly Review which will be updated at the April 2023 meeting.	D. Tomlinson	April 2023		Scheduled for June 2023

RAG KEY

Overdue
Resolved
Not Due

4. Chair’s Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	Item 4
Paper title	**CHAIR'S REPORT**
Date	7 June 2023
Author	Phil Gayle, Chair
Executive sponsor	Phil Gayle, Chair

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

Executive summary & Recommendations:

The report is presented to Council 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 COUNCIL OF GOVERNORS

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 Council giving an overview of my key areas of focus since the last Council meeting with my intention to provide a regular update at each meeting.

2. CLINICAL SERVICES

2.1 We now have in place the buddy schedule for NEDs and Council of Governors to undertake site/service visits over the coming months. Most NEDs and governors now have the appropriate level DBS certificate on file.

3. PEOPLE

3.1 Monthly meetings with Professor David Sallah from Birmingham Community Healthcare NHS Foundation Trust continue to take place.

3.2 I met with Andy Cave and Richard Burden from Healthwatch and will be maintaining these meetings on a quarterly basis.

3.2 As reported in my previous chairs report I meet monthly with Shane Bray, Managing Director of Summerhill Supplies Limited. Our meetings are beneficial as it gives me the opportunity to hear about future developments and challenges SSL experience.

3.3 I had the pleasure of being filmed along with the FTSU team to promote within our Trust, Freedom to Speak Up Inclusion and its importance. I also continue to meet monthly with our Freedom to Speak Up Lead Guardian.

3.4 I attended our successful Staff Values Award Ceremony held at Birmingham City Centre Council House. This was the first in person Values Award since the lockdown (2019), and it was a pleasure to see our colleagues recognised and awarded for the great work that they do.

3.5 I have commenced the NED appraisals, and these will be concluded this month.

3.6 I chaired interviews for the Company Secretary role which we successfully appointed and a consultant position for Reaside Clinic.

3.7 I was pleased to attend the Medical Advisory Committee away day where I was accompanied by the Chief Executive.

3.8 I was pleased to meet with Sean Duggan, Chief Executive, Mental Health Network, NHS Confederation.

4. QUALITY

4.1 I and John Travers, Lead Governor, visited and spoke with colleagues at our Small Heath Health Clinic. This was my first time visiting the clinic to have the opportunity to speak and listen to colleagues' concerns.

4.2 I also visited in the evening, EDEN PICU, along with Anna Sykes, Head of Communications, to present a lifetime achievement award to a member of staff. Whilst at EDEN PICU I had the opportunity to have an escorted visit of the unit and speak with staff.

5. SUSTAINABILITY

5.1 I attended the monthly BSOL ICB Chairs meeting and I also attended BSOL Integrated Care Partnership meeting held at the Alexandra Sports Stadium.

5.2 We are currently working on updating our Membership and Governor Engagement Strategy, this will be circulated for comments and the first draft presented to the Council of Governors in June 2023.

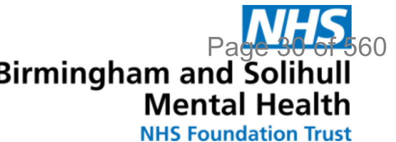
5.3 I am pleased to confirm our Council of Governor Board development sessions have been developed and agreed for the coming year. These sessions will allow the core development of the Council of Governors.

5.4 I am pleased to be able to confirm that the elections process for the Council of Governors will be launched in June 2023.

5.5 I was pleased to Chair the Council of Governors meeting this month where we met in person for the first time since the pandemic. At the meeting we formally acknowledged three members of the Council who have stood down, Stephanie Bloxham, Diane King and Councillor Mick Brown. I would like to once again thank them all for their dedication to the Council of Governors over their terms and acknowledge their hard work and passion for mental health. We wish them all the very best of luck in their future endeavors.

PHIL GAYLE
CHAIR

5. Chief Executive’s and Director of Operations Report



Meeting	BOARD OF DIRECTORS
Agenda item	Item 5
Paper title	CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT
Date	7 June 2023
Author	Vanessa Devlin and Roisin Fallon-Williams
Executive sponsor	Roisin Fallon- Williams

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

Executive summary

Our report to the Board provides information on our areas of work focused on the future, our challenges and other information of relevance to the Board, in relation to our Trust strategy, local and national reports and emerging issues.

Reason for consideration

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

Paper previous consideration

Not Applicable

Strategic objectives

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

Financial implications

Not applicable for this report

Risks

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

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

CHIEF EXECUTIVE and DIRECTOR of OPERATION'S REPORT

PEOPLE

Industrial Action

A second period of Industrial Action by Junior Doctors took place for 96 hours on 11th – 14th April 2023. Within BSMHFT, 133 Junior Doctors had the option to take strike action. As an average over the 4 days, 50 doctors took strike action (37.5%), 50 undertook normal working duties (37.5%) and 33 (25%) were absent for another reason (sick leave, annual leave, rostered day off, compassionate leave etc).

Contingency plans were made to cover all out of hours duties with a 'back up' rota established for all 64 shifts within the period of industrial action. The 'back up' doctor was required to cover 27 of the 64 shifts throughout the period and remuneration arrangements were agreed in advance with BMA colleagues.

In preparation for the industrial action, non-emergency junior doctor clinics were cancelled and re-arranged and the medical workforce on duty ensured that cover was sufficient for the inpatient, MHA and Urgent Response work required.

Thank you to all involved in enabling us to continue to provide safe levels of service during this period.

Policy Development

The People team are progressing well with the review of a large suite of policies. This has been supported by an extensive engagement plan with various stakeholders throughout the Trust and has encapsulated the principles of Project Flourish. Due to further valuable feedback received from our staff networks and to fall in line with commit agendas, the remaining policies are planned to be formally ratified by July 2023.

Sickness

Sickness rates has decreased significantly since December 2022. Our rate in April was 4.8% which is the lowest we have seen since August 2020 and nearly a 2.5% drop from December. In addition, we have also seen a steady decline in our 12 month plus Long Covid cases where we have either supported staff back to work or to access ill health retirement.

Values in Practice -360@ feedback tool

The 360@ tool has been created to help colleagues reflect on their own behaviours in line with our Trust values, and also to seek views from peers, line managers and other colleagues both internally and externally. It's roll out commenced with senior leaders in May. It is anticipated that this tool will be used to support leadership programmes, personal development and informal processes such as Enough is Enough as appropriate.

CLINICAL SERVICES

Summary

The post pandemic period has presented service areas with challenges in particular in

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

Integrated Community Care and Recovery (ICCR)

ICCR community mental health services are continuing to develop in line with our transformation model pathways. New roles have been recruited to across community teams including Support Time and Recovery Workers, Health and Well-being Practitioners, Psychologists and Occupational Therapists. Mental Health Primary care teams are present in each locality with varying numbers of staff recruited. Service users have been supported by the new primary care arm of our service and teams have received excellent feedback.

Our ADHD service is part of a wider BSOL piece of work to re look at our system model to ensure that we have joined up and age inclusive seamless pathways of care and take a collective approach to the pressures across our ADHD services. The collaborative work will enable us to support our long waiting lists and a consistent offer of care across our system.

Our new Head of Service is in place across the Addictions, Homeless and Solar service who is also the lead in Solihull for the Mental Health delivery plan, he is a key link into the Place committee and the community Integrator project. This is ensuring seamless coherent representation from mental health in all Solihull system work.

A key area of focus within ICCR services is on workforce and staff experience, prioritising staff to ensure we have an engaged, skilled, well supported, inclusive and listened to staff culture within ICCR. Many teams and individuals in ICCR were nominated for or won Values Awards. In addition, several teams have been nominated as team of the month. We are very proud of these achievements.

Secure Care & Offender Health (SCOH)

Ward managers and Clinical Nurse Managers/Matron's are meeting daily on each site to prioritise work and assess current challenges with staffing vacancies. Support continues between sites ensuring the flexibility of staff to cover other wards. Ward Managers and Matron's have worked within numbers where necessary, and our OT/Psychology colleagues are being utilised to support activities on the wards. Some vacancies remain with recruitment drives on going to fill vacancies.

There remains a challenge to access probation officers to manage the community risk in the Offender Personality Disorder service contracts. Discussions with Her Majesty's Prison Probation Service continue in terms of trying to resolve this in creative ways.

A Covid outbreak on one of the Reaside wards has been managed well.

Tamarind received feedback from a recent Mental Health Act compliance visits that was extremely positive for Laurel, Acacia and Cedar Wards with several firsts for a medium secure ward. The care teams on these wards can be proud of this feedback from the Care Quality Commission on maintaining these high-quality standards in the face of nursing staffing challenges.

Ardenleigh have recruited into some nursing vacancies and environmental works in the

women's service (seclusion) are ongoing. Ardenleigh women's service hosted a very successful conference at the National Arboretum, which was well attended and well received.

The Forensic Intensive Recovery Support Team (FIRST) Team continue to work closely with our assertive outreach teams to ensure the safe step down of service users, which has recently posed challenges due to caseload capacity. Transformation work is under way with all professions and work streams are being set up. Successful recruitment to the service will see further staff joining the team in the next two months.

His Majesty Prison (HMP) Birmingham had a positive HMP report. Pressures remain in the system with regard to nursing vacancies across all partners in HMP healthcare. We continue to work together to ensure service user safety whilst recruitment takes place. The Head of Healthcare post is now substantively recruited too, and Deputy Head of Healthcare interviews will take place shortly.

The Secure care and offender health division won four gold awards and four bronze awards in the BSMHFT value awards. This has had a positive impact on the staff across the division, the recognition and pride in their work has improved morale.

Acute and Urgent Care

The directorate continues to participate in a variety of recruitment drives as part of efforts to recruit to vacant posts to help reduce staff vacancies. Some areas continue to report 1 Registered Mental Health Nurse (RMN) per shift but work alongside other professional groups as a staff team.

The senior management team remain committed to explore ways of sustaining the recruitment efforts to address challenges including the low level of applications received for vacancies advertised for some wards. All wards within the Central locality now have an Occupational Therapist and Activity Worker. Across the acute service wards, acuity levels continue to remain high resulting in enhanced patient observations. Sensory assessment and autism training for staff has taken place throughout the months of April/May 2023 at the Oleaster as part of the Sensory Friendly Ward project and Autism training requirement for staff.

Despite the increase to 3 rooms in the Place of Safety within the Urgent Care Centre there has not been a corresponding increase in patient flow through this facility. April saw 80 patients detained under Section 136 and brought to the Urgent Care Centre Place of Safety which is the lowest since September 2022. Collaborative work is ongoing with the police to try and address this matter.

The number of calls to Street Triage have continued to increase in recent months. The Street Triage currently incorporates the Call before Convey service and this, coupled with the collaboration with Community Mental Health Teams have contributed to the diversion of ambulances from the emergency departments. There is ongoing data collection via the acute hospitals to determine the impact on reducing attendances at A&E. Weekly locality based Delayed Transfer of Care (DTOC) deep dive meetings are currently held with relevant stakeholders to find solutions to delays which are preventing successful service user discharge.

Lavender ward was the proud recipient of the Gold Award for Team of the Year in Clinical Services at our Values Awards 2023 in recognition of the efforts made by the ward to demonstrate how excellent multidisciplinary working is improving the quality of care and experience for our service users.

Dementia & Frailty

All wards in Dementia & Frailty continue to work over their established numbers due to high acuity and ongoing patient observations. Work is also ongoing to deliver the complete Care Quality Commission (CQC) recovery plan and clinical improvement plans.

The service is developing a Pathway 2 Discharge Manager role to support the discharge pathway and create increased bed capacity. A Registered General Nurse/Occupational Therapy post is also being developed dedicated to falls prevention to support the wards to reduce using level 3/4 observations.

Demand and capacity pressures continue in the Older Adult Community Mental Health Teams with an increase in referrals and an increase in the levels of complexity and acuity. A successful Specialties awayday was held for team managers on 15th May 2023 and a new Ward Manager has been appointed on Cilantro Ward.

The perinatal community teams are finalising the operational framework update which involves the development of a 'therapies only' pathway. This involves a small number of service users accessing the service directly with therapists.

The Bipolar Service has been shortlisted for the Health Service Journal (HSJ) award finals for Improving Mental Health by Digital means new staff are in post and therapies pathway and additional psychological provision is now available for people with bipolar disorder across Birmingham.

The rolling programme of recruitment continues for Birmingham Healthy Minds (BHM) Talking Therapies. BHM Talking Therapies is working in partnership with Living Well Consortium to recruit to a number of Senior Employment Advisors and Employment Advisor posts with funding allocated until 2025.

The Veterans Op Courage service has integrated well with the partner collaborative across the Midlands Region to ensure that service delivery has transitioned smoothly to implement the new clinical model and pathways. The service is aiming to achieve the standards set under the (VCHA) Veteran aware reaccreditation mark to evidence that our trust policies ensure Veterans are not disadvantaged and all services across our organisation are aware of our obligations under the Armed Forces Covenant Act 2021. The ICB Board member visit to the service in May, was received well and provided a helpful opportunity for Veterans Op courage service users to share their experience and for the team to answer queries that were posed around the clinical model and commissioning.

An Health Education England / National Health Service England Arts Psychotherapies film is being launched Nationally and via Connect. The film has been developed to broaden the psychological therapies offer to include less verbal therapies, that ensures equity of access to psychological interventions for people who struggle to talk about their emotional experience. The film is being used to support other services to develop arts psychotherapies resource, and reduce issues of health inequality and support people to consider training.

SUSTAINABILITY

2023-24 Funding

Significant levels of new funding for mental health services has been allocated to the new BSOL Mental Health Provider Collaborative for this financial year. A large element of this

will come to BSMHFT to support the continued expansion of the community transformation programme, improvements in the urgent and emergency care pathway, Talking Therapies, perinatal and other services. Funding will also support BACFT (FTB) and voluntary sector partners with their expansion in service pathways as well.

We also continue to work with system partners to ensure that the full cost of the pay award is funded.

West Midlands Mental Health, Learning Disability and Autism Provider Collaborative

The Collaborative continue to make progress in agreed areas of work:

Key Priority Area 1- Development of an All-Age West Midlands MH and LDA Strategy

The Collaborative has agreed the framework for the development of the strategy. The population health needs analysis has been delayed due to the operational planning round and availability of capacity. A review of the system priorities for each ICB and Trust is underway to identify key challenges and to inform priorities. Engagement with Business Intelligence leads is planned in June to understand local data and pooling what is relevant to inform future demand against priority areas. The key output on completion of the analysis phase will be a short list of Strategic priorities that could be tackled at scale. These will go through a process of engagement with partners to agree our West Midlands wide priorities.

Priority 2- Regional Bed Strategy

This work is aligned with the wider mental health and learning disability and autism strategy development, and the data gathering exercise commenced to ascertain local capacity and demand information. The initial information collated suggests a number of potential areas of discussion amongst Trusts, including female PICU beds, LDA beds, Rehab beds and block commissioned Independent Sector Provider (ISP) beds.

Priority 3- Community CAMHS Pathways Improvement

Discussions with the Regional CAMHS Tier 4 Provider Collaborative resulted in a joint initiative to further develop and roll out the IROC (Intensive Residential Outreach Care) clinical model and intervention, offering bespoke support to professional and care giver system.

Priority 4- Increase of Supervision Capacity for Psychological Therapies

Following the completion of the demand analysis, discussions with national bodies and private providers have begun to bring in additional supervision capacity. Contract negotiations are expected to be finalised in early June with a view to allocating resources across the Collaborative later in June. Discussions with foundation level training providers will commence later in June and staff will be identified to attend courses from Sept/Oct 2023. The development of standards and a competency framework for the supervisors are underway and the programme has been identified as 'good practice' to share our practice and learning.

Priority 5- Clinical Support Worker Role Development

'Developing Health Care Talent' and 'New to Care' training programmes have been successfully launched, and are currently being delivered by our partner, Talent for Care, and participant feedback has been positive.
The development of the common competency framework (CF) for bands 2 to 4

HSW/CSWs in both hospital and community settings are in the final stages of development and upon completion will be reviewed by each Trust for adoption and implementation. Three Trusts, (MPFT, BSMHFT and BWC) have developed project proposals to improve workforce recruitment and retention issues within their organisations and the Collaborative Board has approved the allocation of funds to support these projects.

Other Developments

Learning Disability and Autism Complex Needs Regional Advisory Panel Development

A small task and finish group has been established to review Local ICB Panel Processes to help develop the regional panel process and the next steps. The work has been delayed due to the availability of key stakeholders to develop and approve processes; however, the importance of the work has been recognised and supported by each System and Trust to make progress over the summer period.

Regional ADHD Approach

An initial discussion took place between the Directors of Strategy, and it has been agreed to undertake an initial data gathering exercise to ascertain the level of demand and capacity for the diagnostic services, as this is a key challenge for systems.

BIRMINGHAM AND SOLIHULL ICS

ICP Ten Year Strategy

This 10-year Integrated Health and Care Strategy has been developed by the Integrated Care Partnership for the Birmingham and Solihull ICS, setting out our vision for the future and the improvements that we want to see over the next ten years for everyone who lives, works and receives care within Birmingham and Solihull.

Further details can be found on the following link:
https://www.birminghamsolihullics.org.uk/about-us/our-integrated-care-partnership/our-integrated-care-strategy-2023-2033

BSoL Mental Health Provider Collaborative goes live 1st April 2023

Following a detailed assurance process led by the ICB, BSMHFT were given approval to move from mobilisation to delivery of the BSoL Mental Health Provider Collaborative from the 1 April 2023.

The mobilisation process commenced in January 2023 and included:

- Sign off of the BSoL Mental Health Provider Collaborative Partnership Agreement
- BSMHFT due diligence and readiness to operate assessment
- Shadow governance arrangements from January 2023 with formal governance arrangements including the Commissioning Committee taking effect from April 2023
- The tupe of 18 staff from BSoL ICB into BSMHFT from 1st April 2023 to support the delivery of the collaborative. This includes staff working in the Mental Health Commissioning Team and the Specialist Placement Team.
- Appointment of key roles to support the delivery of the new commissioning function of the Trust, including the appointment of a new Deputy Director of Commissioning & Transformation.
- Engagement Events with the third sector to inform of the changes taking effect from 1st April 2023

Since going live on the 1 April 2023, the Provider Collaborative have commenced delivery of the key plans set out within the BSoL Mental Health Provider Collaborative Delivery Plan including taking forward key activities to support the development of the Provider Collaborative's Strategy. Progress against the Mental Health Road Map is also being presented at the ICB System Oversight Group.

QUALITY

CQC Focused Inspection

Following consultation with service areas, subject matter leads and the Executives, we submitted the agreed action plans in response to the Must and Should Do findings to the CQC on May 12th.

We have had acknowledgment of receipt of the action plans from the CQC with a request for monthly updates to our lead inspector. The first of which will be provided ahead of our monthly monitoring meeting on June 20th.

Governance arrangements for oversight of the action plans have been agreed and are outlined in the action plans.

The Compliance team will continue with their programme of assurance testing, incorporating any areas from this report that were not already included in our assurance framework.

The Trust has been allocated two new inspectors, including a new lead inspector. The Executive Director for Quality and Safety and the Head of H&S and Regulatory Compliance had a brief introductory meeting with the new lead inspector on May 15th. Given the evidence that we have submitted to date (28 monthly submissions to date), we have been advised that the CQC will stand down the Section 31 notice in June. We were requested to submit one final summary report for May in support of this.

We are also awaiting a response from the CQC in relation to the Section 29 that we provided a response submission to in January 2023. The new inspector has advised us that she will look into this matter and come back to the Trust with a response.

OTHER TRUST MATTERS

Dr Fabida Aria – Royal Collage of Psychiatrists (RCP)

Our Medical Director Fabida Aria has been awarded a Fellowship with the RCP for 'outstanding contributions to Psychiatry'. Congratulations on behalf of the Board and Team BSMHFT Fabida.

Ofsted Report on Birmingham Local Authority Childrens Services

Since the last inspection in 2018, much progress has been made by Birmingham City Council and Birmingham Children's Trust in improving the experiences and outcomes of their children. Children are now safeguarded through effective 'front door' arrangements, thorough child protection assessments and a strong response to safeguarding children at risk of exploitation. Children are supported at an early stage to remain in their families where possible. When intervention is required to protect children, it is proportionate to risk and need. When children need to come into care,

their needs are met well in appropriate placements. Some children spend too long in stable placements awaiting the appropriate change in legal status to secure their permanence. Care-experienced young people benefit from a strong corporate commitment and ambition to enable them to fulfil their potential in life. Personal advisers develop supportive and encouraging relationships with young people, though for some, the earlier involvement of a personal adviser would help in their preparation for adulthood. Children in care and care-experienced young people are genuinely listened to and actively engaged in recruitment, staff training and service development. Despite significant trust investment and partnership engagement response to domestic abuse is not proportionate to demand in the city.

The latest inspection grade is now Good.

NATIONAL ISSUES

Mental Health- National Audit Office (NAO)
This National Audit Office report considers the progress being made in improving mental health services in England. The report looks at increases in workforce, funding and information and the impact on services for patients.

The full progress in improving mental health services in England - NAO report can be found at the following link:
https://www.nao.org.uk/wp-content/uploads/2023/02/Progress-in-improving-mental-health-services-CS.pdf?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=13770937_NEWSL_HMP%202023-02-10&dm_i=21A8,875Q1,3PLD4R,XMOQW,1

Children and Young People's Mental Health
This report from the Children's Commissioner considers trends in the data on Children's Mental Health services including referrals, access, activity, spend and experiences of Inpatient provision. The report sets out a series of recommendations based on the themes of the review.

The full report can be found at the following link:
Childrens-Mental-Health-Services-2021-2022-1.pdf (childrenscommissioner.gov.uk)

Learning Disabilities and Autism
NHS England commissioned the NHS Transformation Unit to carry out a thematic review of the key findings from safe and wellbeing reviews set up to check whether people with a learning disability and autistic people who were being cared for in a mental health inpatient setting were safe and well following the deaths of adults with learning disabilities at Cawston Park.

Further information can be found on the following link:
PR1889-Safe-and-wellbeing-review-thematic-review-and-lessons-learned.pdf (england.nhs.uk)

Inequalities
This briefing paper from the Association for Young People's Health is part of the Health Inequalities Policy Programme. It considers the drivers of ethnic health inequalities and their impact on health outcomes.

Further details can be found on the following link:
https://ayph.org.uk/wp-content/uploads/2023/02/Data-report-Ethnicity-and-young-peoples-healthinequalities.pdf?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=13821180_NEWSL_HWB_2023-03-20&dm_i=21A8,888HO,3PLD4R,XRR4J,1

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Trust strategy - 2022/23 Review and 2023/24 Goals

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	TRUST BOARD
Agenda item	Item 6
Paper title	Trust Strategy – 2022/23 Review and 2023/24 Strategic Goals
Date	7 June 2023
Author (s)	Abi Broderick, Head of Strategy, Planning and Business Development
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships
Executive sign-off	☒ Yes ☐ No (Tick as appropriate)

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

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

Executive summary & Recommendations:

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

- Clinical Services
- People
- Quality
- Sustainability

Each year we agree goals for each strategic priority. The goals for 2022/23 (year 2 of our strategy) were taken through Committees and Board at the beginning of the financial year and a mid-year update was provided in November/December.

As agreed by Trust Board in May 2022, a prioritisation exercise was carried out on the Trust goals and goals prioritised as level 1 are reported to Trust Board.

For 2022/23, across our four strategic priorities we had 99 goals. 28 of these are prioritised as level. The report contains narrative about our achievement against the milestone plans for each of these goals, including a rating of red, amber or green. At the end of the year 86% of the level 1 goals are rated 'Green' or 'Amber which means they are exactly where we expected them to be in relation to their milestone plans or have only minor issues impacting delivery that are being addressed to bring them on track. Four goals are rated 'Red' (11%) which means they are not where we wanted them to be in relation to their milestone plans. All the red goals are

carried forwards to 2023/24 where there will be renewed focus on their delivery.

For 2023/24, year 3 of our strategy, our annual goals have been developed through a combination of review of national, regional and local drivers and landscape, as well as comprehensive engagement through workshops and discussions with senior leaders, senior management teams, subject leads and expert by experience representatives. We have identified 97 goals of which 39 have been prioritised as level 1.

The purpose of this report is to provide:

- Part A - a summary of the delivery of our goals at the end of 2022/23 (year 2) **for assurance** about how we are delivering the strategy.
- Part B – the proposed goals for 2023/24 (year 3) **for approval**.

What is the ask? ***(Please state specifically what you like the meeting, committee or Board to do).***

The committee (FPP, QPES, People Committee etc) or Board is requested to:
1. GAIN ASSURANCE of the progress made in delivering our annual strategic goals for 2022/23 (year 2 of our strategy)
2. APPROVE the 2023/24 (year 3) annual strategic goals.

Confirm level of assurance demonstrated and evidenced in the report (tick as appropriate):

☐ Substantial Assurance
☒ Reasonable Assurance
☐ Limited Assurance
☐ No Assurance

Previous consideration of report by: (If applicable)

Detailed reports relating to each strategic priority have been taken to the relevant Board sub-committees on 24 May 2023 where 2023/24 goals were approved prior to coming to Trust Board as follows:

- Clinical services: FPP and QPES Committees
- People: People Committee
- Quality: QPES Committee
- Sustainability: FPP Committee

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

CLINICAL SERVICES: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.
PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service

users
QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve
SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population

Financial Implications *(detail any financial implications)*

Any goals with financial implications have costed plans/budgets.

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

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

Equality impact assessments:

Our Trust Strategy recognises that we have diverse communities and populations across our geographical area. Improving access, experience and outcomes, reducing health inequalities, removing unwarranted variation between services, and improving the experience and wellbeing of our staff are all therefore core to the Strategy. Any new developments taken forward will have an equality impact assessment carried out.

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

Goals have been developed with leads for each of the areas covered and they were also discussed at the Participation, Experience and Recovery (PEAR) group in April 2023, which comprises experts by experience alongside experience and participation leads from the Trust.

Acronyms *(List out any acronyms used in the report)*

Minimal acronyms are used in the report, and if used they are spelt out in full on the first occasion.

Defining levels of assurance:

Level of assurance	Definition
Substantial Assurance	The evidence provided demonstrates there is a sound system of

	governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.
Reasonable Assurance	The evidence provided demonstrates there is generally a sound system of governance, risk management and controls in place. However, there are some issues e.g. with quality, non-compliance and performance that have been identified which may put at risk the achievement of objectives in the Division or Department, hence there is scope for improvement.
Limited Assurance	The evidence provided demonstrates there are significant gaps, weaknesses or non-compliance that have been identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the Division/Department.
No Assurance	There is absolutely no evidence to demonstrate, hence immediate action is required to address the fundamental gaps, weaknesses or non-compliance that have been identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the Division or Department.
Assurance (System/process-based assurance & outcome-based assurance)	Provides certainty through the evidence you may triangulate in demonstrating confidence that systems and processes are working properly and what needs to happen is happening (i.e. system/process-based assurance). However, this may not imply that expected outcomes will be achieved as planned (outcome-based assurance). It is often useful to stop and ask: • Do we really know what we think we know? • Where does the assurance come from? • How reliable is this assurance? • What is this assurance telling us?
Reassurance	This is the feeling of being assured and may be based on good performance, the lack of contradictory evidence or perhaps because someone with a professional background or expertise or management, tells you that something is so, and so it must be true.
Assurance is defined as - "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization." (HM Treasury – 2012).	

Our Trust Five Year Strategy

2022/23 Review and 2023/24 Goals

Trust Board
7 June 2023

compassionate

inclusive

1. Purpose of this report

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners. It comprises **four strategic priorities – Clinical Services, People, Quality and Sustainability**, each of which has a number **of strategic aims** which describe our particular areas of focus.

Each year we agree **annual goals** for each strategic priority, aligned to the strategic aims. The goals for 2022/23 were taken through Committees and Board at the beginning of the financial year for approval and a mid-year update was provided in November/December 2022.

The purpose of this report is to provide:

Part A - a summary of the delivery of our goals at the end of 2022/23 (year 2) **for assurance** about how we are delivering the strategy.

Part B – the proposed goals for 2023/24 (year 3) **for approval**.

Detailed reports relating to each strategic priority have been taken by the leads for each priority to the relevant Board sub-committees on 24 May 2023 where 2023/24 goals were approved as follows:

- Clinical services: FPP and QPES Committees
- People: People Committee
- Quality: QPES Committee
- Sustainability: FPP Committee

2. Our Trust Strategy

Trust Five Year Strategy

	Clinical Services	People	Quality	Sustainability
Strategic priorities	Clinical Services	People	Quality	Sustainability
Strategic aims	Leader in mental health Recovery focussed Rooted in communities Prevention and early intervention Clinically effective Changing how we work	Shaping our future workforce Transforming our culture and staff experience Modernising our people practice	Improving service user experience Preventing harm A patient safety culture Quality assurance Using our time more effectively	Transforming with digital Balancing the books Caring for the environment Changing through partnerships Good governance

Delivery: Annual goals and business plans

Cross cutting themes:

Driving change and transformation
Leading the way and encouraging collaboration across systems to develop joined up, integrated mental health services for our population.

Working together in co-production
Co-producing our strategies and plans with our people, our partners and our services users, families and carers.

Reducing inequalities
Working in a way that tackles discrimination, addresses stigma, and encourages equality for all

Continuous improvement
Continually seeking to question, improve, learn and innovate through our practices, our research and our developments.

3. Prioritisation of goals

Birmingham and Solihull Mental Health NHS Foundation Trust

- We have an ambitious Trust strategy with a number of aims across our four strategic priorities.
- Our **annual strategic goals** for each aim are set through engagement with senior leaders, management teams, relevant committees/groups and experts by experience.
- A **prioritisation framework** is used to assess each goal and assign it a priority level between 1 and 4. This uses three drivers to assess the priority level of each goal:
    1. Does it address a risk in the Board Assurance Framework?
    2. Does it address a national priority? E.g. NHS Long Term Plan deliverable.
    3. Does it address feedback that we need to remedy? E.g. staff survey, CQC feedback.
- Prioritisation in this way helps to:
    - Inform what the most important goals are.
    - Define what is reported to Board and Committees for monitoring and assurance.
    - Make decisions about use of resources.
    - Identify whether any goals can be moved to subsequent years of the strategy.

Based on this prioritisation, Trust Board will receive information to give assurance about the level 1 goals.

Part A – 2022/23 end of year review

compassionate

4. Level 1 goals for 2022/23

Clinical Services

Leader in mental health

- Using inclusion/inequalities data and positive practice
- Effective interfaces between our services

Recovery focussed

- Family and carer pathway – review and refresh

Rooted in communities

- Community transformation programme
- Transformation of rehabilitation services
- Out of area placement reduction
- Partnerships with local communities to reduce inequalities

Prevention and early intervention

- Transformation plans for children/young people in Solihull
- Urgent care transformation programme
- Birmingham and Solihull Talking Therapies offer

Changing how we work

- Reaside re-provision and Highcroft redevelopment

People

Transforming our culture and staff experience

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

Modernising our people practice

- HR policies and processes are free from bias

Quality

Improving service user experience

- Service user involvement in care planning
- Carer involvement

Preventing harm

- Ligature alarm systems on acute wards
- Physical health monitoring

A patient safety culture

- Patient Safety Partner role
- Safety culture and incident reporting/learning from incidents

Sustainability

Transforming with digital

- Five-year clinically led ICT/digital map and strategy

Changing through partnerships

- BSOL Mental Health Provider Collaborative

Balancing the books

- Delivery plans for efficiency schemes
- Medium term revenue and capital plans

*** Inequalities goals highlighted in blue text ***

5. Trust goals: an overview of performance

Each year we set annual goals which underpin our strategic priorities and their aims. These align to the ambitions of what we want the future to look like as set out in our strategy. The annual goals have quarterly milestone plans which are regularly monitored and RAG rated throughout the year. This is currently our main mechanism for measuring how we are performing against our strategy.

We are in the process of developing an Impact Framework to set out the key measures of success for our strategy. This will mean for 2023/24 we will be able to triangulate performance against milestone plans with performance against key performance metrics and qualitative measures, to assess whether we are where we intend to be.

There are **99 Trust goals in total** for 2022/23, which is year 2 of our strategy. There are **28 goals prioritised as Level 1** and reported in detail to Trust Board in this report. A summary of the overall status at the end of the year is shown below.

Strategic aim	Red	Amber	Green	Total
Clinical Services	2	5	4	11
People	0	5	2	7
Quality	1	1	4	6
Sustainability	1	1	2	4
Total	**4** **14%**	**12** **43%**	**12** **43%**	**28**

RAG definitions:

Red = not started / major issues / seriously behind;

Amber = partially met / minor issues;

Green = fully met / fully on track

6. Trust goals: an overview of performance (continued)

It is encouraging that **86% of these goals are rated 'Green' or 'Amber** which means they are exactly where we expected them to be in relation to their milestone plans or have only minor issues impacting delivery that are being addressed to bring them on track.

This achievement is against a backdrop of significant pressures on services, which is a testament to the **commitment** of our teams to provide high quality, **compassionate** and **inclusive** care through driving improvement and transformation.

Green/ amber goals – some highlights:

Community transformation - young people, adult and older adult **On track ✓**	Mental Health Support Teams in place in Solihull schools **On track ✓**	Installation of door monitoring alarm systems **On track ✓**	Anti-racist/ anti-discrimination framework and initiatives e.g. pledges, training **On track ✓**	Launch of the Flourish programme **On track ✓**	BSOL Mental Health Provider Collaborative ready to go live 1 April 2023 **On track ✓**
Work with local communities on Patient Carer Race Equality Framework **On track ✓**	Working well collaboratively across the system to address our challenges **On track ✓**	Implementation of PSIRF is going to plan **On track ✓**	Implementation of Dialog+, including training and pilot roll-outs **On track ✓**	Freedom to Speak Up champions in place **On track ✓**	Widespread engagement in refreshing our ICT strategy **On track ✓**

7. Trust goals: an overview of performance (continued)

Red goals

Four goals are rated 'Red' (11%) which means they are not where we wanted them to be in relation to their milestone plans. These are:

- **Clinical services - Reaside re-provision and Highcroft redevelopment.** Department of Health and Social Care funding decisions have been continually delayed and different options are now being considered. This goal is carried forward to 2023/24.
- **Clinical services - Review and refresh the family and carer pathway**. This has fallen behind the anticipated timescales, which we recognise is disappointing. There has not been the anticipated/required momentum to move this forward with an additional factor being constrained capacity in clinical services to fully engage with the work. There is a renewed focus now on this goal, which will be carried forward to 2023/24.
- **Quality - Improve the involvement of carers in service user care and recovery**. Whilst some positive actions have been taken e.g. improving input into care planning and refreshing the role of the participation team to link better with carers, the delays flagged above to the review of the family and carer pathway mean risks to delivery of this goal as the pathway is a key mechanism to improve carers experience and engagement. This goal will be carried forward to 2023/24 through the clinical service goal.
- **Sustainability - Develop delivery plans and timescales for efficiency schemes**, due to the risk around identifying and delivering savings schemes impacting on financial balance and our current progress not being where we would like it to be. This goal is also being carried forward to 2023/24 but re-framed to have a focus on productivity and transformation.

We are also closely monitoring areas where although progress has been made and they are rated as amber, we are not achieving performance trajectories, e.g. IAPT, out of area placements. Recovery plans developed with system partners are in place.

8. Strategic priority: Clinical services

Goal: Build a library of local inclusion and equalities data and positive practice to influence Trust and ICS data quality, reducing inequalities and transformation plans.

Leader in mental health

Key achievements:

- ✓ All divisions have had Data with Dignity sessions to support health inequalities plans.
- ✓ Sessions being rolled out to smaller teams having been completed at divisional level, to enhance local ownership and consideration of holistic data to inform and challenge blind spots in delivery of equitable services.
- ✓ Good practice case studies and resources are being collated to support delivery of equitable services.
- ✓ Online platform in development as a repository of good practice.

Remaining risks and issues:

- Local ownership and governance to embed this work.

Is the goal being carried forward?

- Health inequalities work continues with the goal for 2023/24 to implement divisional health inequalities plans.

Goal: Make sure we have effective interfaces between our services, for example community services and acute/urgent care services, and secondary care and forensic services.

Leader in mental health

Key achievements:

- ✓ Senior leaders working group established as part of senior leadership development programme to look at better integration/interfaces between Trust services.
- ✓ Discussed at senior leadership forum.
- ✓ Discussed at clinical services workshop in January, where it was identified as a key theme for 2023/24 goals.

Remaining risks and issues:

- Delivery of the goal requires ensuring effective and early engagement.

Is the goal being carried forward?

- Yes, work to look at integration between service areas being carried forward in line with senior leaders working group with the goal around engagement and scoping .

Goal: Review and refresh family and carer pathway, ensuring consistent ownership and application across all service areas.

Recovery focussed

Key achievements:

- Work on family and carer pathway is behind schedule.

Remaining risks and issues:

- There has not been the anticipated/ required momentum to move this forward.
- Constrained capacity in clinical services to engage with this work is an additional factor.

Is the goal being carried forward?

- Yes. There is a renewed focus now on this goal, which will be carried forward to 2023/24.
- There is a piece of work to do in reviewing where the pathway adds value and aligning with Dialog+ care planning prior to next steps.

9. Strategic priority: Clinical services

Goal: Roll out community transformation across all geographical areas within the BSOL footprint, across young people, adult and older adult services.

Rooted in communities

Key achievements:

- ✓ Community Transformation Programme remains on track with recent achievements including:
  - ✓ Progress on caseload review and transition
  - ✓ Proposal submitted for voluntary, community, faith and social enterprise (VCFSE) provision for eating disorders
  - ✓ FREED worker (first episode rapid early intervention for eating disorders) recruited to and pathway mapped.
- ✓ Older adults are an integral part of the Community Transformation with older adult representation at all levels of the programme.
- ✓ Experts by Experience actively involved with
  - ✓ Co-producing information materials for the ICRT
  - ✓ Developing service user communications including podcasts
  - ✓ Developing of Dialog+ training package to capture the service user perspective.
  - ✓ Defining name for personality disorder pathway – 'Complex Emotion and Trauma' pathway

Remaining risks and issues:

- Recruitment challenges to ensure delivery against plans.
- Managing Primary Care Network clinicians' expectations about primary care teams and ARRS (Additional Roles Reimbursement Scheme) roles and what they can do.

Is the goal being carried forward?

- Yes. Community transformation overarching goal to also encompass specific focus areas such as rehabilitation, personality disorder, eating disorders and psychosis.

Goal: Develop and implement plans, building on work already undertaken, to eradicate acute inpatient out of area placements.

Rooted in communities

Key achievements:

- ✓ Work on acute out of area (OOA) placements has included:
  - ✓ Increased staffing in Psychiatric Decisions Unit (PDU) and patients to be referred there in the first instance rather than to an OOA bed.
  - ✓ Dedicated OOA discharge managers in place and senior clinical time allocated to review OOA patients.
  - ✓ Dedicated Assertive Outreach ward and discharge manager.
  - ✓ Place of Safety increased from 2 to 3 rooms.
  - ✓ System wide weekly multi-disciplinary team (MDT) discussions on longest lengths of stay.
  - ✓ Additional 10 acute beds contracted from external provider.

Remaining risks and issues:

- Ongoing impact of not meeting the OOA trajectory.
- Further local and national scrutiny.

Is the goal being carried forward?

- Yes, this work is ongoing including short term remedial plan and longer term transformations to support this goal.

10. Strategic priority: Clinical services

Goal: Transformation of rehabilitation services.
Part a: Creation of intensive complex recovery community service with access to local supported tenancies
Part b: HDU provision, secure appropriate accommodation flow and gender specific complex care services

Rooted in communities

Key achievements:

- ✓ Mobilisation of new local High Dependency Unit (HDU) in progress.
- ✓ Intensive Community Rehab Team (ICRT) soft launch commenced and working with 7 individuals with a further 5 in scope.
- ✓ Creation of gender specific complex care services at Knowle site completed.

Remaining risks and issues:

- None identified

Is the goal being carried forward?

- Yes. There are separate goals for 2023/24 for reviewing effectiveness and further development of the HDU and ICRT services post mobilisation.

Goal: Work in partnership with our local communities to transparently deliver and embed our commitment to reducing racial inequalities across service delivery, for example through programmes and initiatives such as the Synergi Pledge and Patient Carer Race Equality Framework (PCREF).

Rooted in communities

Key achievements:

- ✓ PCREF– 10 competencies identified from engagement work and community collaborative partnership agreement developed.
- ✓ Recommendations from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) have been mapped against PCREF competencies and the Equality Delivery System (EDS).
- ✓ Products are being developed in co-production with community collaboratives to support the PCREF competencies.

Remaining risks and issues:

- Local ownership and governance for health inequalities work.

Is the goal being carried forward?

- Yes, as this work is ongoing

11. Strategic priority: Clinical services

Goal: Development of a clear BSOL wide IAPT offer (including use of digital) of which Birmingham Healthy Minds plays an integral part.

Prevention and early intervention

Key achievements:

- ✓ As expected, system is still off track vs the access target.
- ✓ Recovery plan refreshed with actions targeted at waiting list reduction and workforce.
- ✓ Rolling recruitment programme in place.
- ✓ IAPT Programme Lead appointed to oversee transformation.
- ✓ New Clinical Development Lead and Step 2 Lead roles advertised to provide additional leadership, support and co-ordination to implement improvements.
- ✓ Reviewing actual activity vs expectations with teams weekly to understand issues and support improvements.
- ✓ System working has improved.

Remaining risks and issues:

- Remaining financial risk due to low IAPT activity from not meeting trajectories.
- Recruitment and retention challenges, exacerbated by attractiveness of some offers from other Trusts .

Is the goal being carried forward?

- Yes, as work is ongoing to move towards meeting national targets.

Goal: Progress urgent care transformation to relieve pressure on Emergency Departments and beds in acute hospitals.

Prevention and early intervention

Key achievements:

- ✓ Heartlands mental health hub fully functioning with posts covered by substantive staff as well as bank at present.
- ✓ Additional place of safety capacity operational.
- ✓ Psychiatric Decisions Unit (PDU) staffing and medical cover increased to facilitate increased throughput from Emergency Departments.
- ✓ Inability to recruit to positions for front door service at Queen Elizabeth Hospital due to lack of funding has been mitigated by proximity to the PDU.

Risks:

- Lack of funding from ICB to deliver all planned activity for urgent care, e.g. Queen Elizabeth Hospital front door service and Advanced Mental Health Practitioner (AMHP) recruitment.
- Staff recruited to Place of Safety and PDU becoming dissatisfied due to activity not yet increasing and being deployed to wards.

Is the goal being carried forward?

- Yes, as this is an ongoing and longer term programme of development.

12. Strategic priority: Clinical services

Goal: Deliver transformation plans for children and young people in Solihull, e.g.,18-25 service, Learning Disability and Autism (LDA) needs, mental health teams in schools, primary care liaison and eating disorder pathways.

Prevention and early intervention

Key achievements:

- ✓ Transition workers in place for children and young people and enhanced hospital avoidance commenced using existing resources/funding.
- ✓ FREED (first episode rapid early intervention for eating disorders) champion recruited and process and pathways are under development.
- ✓ 27 schools have Mental Health Support Teams.
- ✓ Enhanced hospital avoidance for learning disability and autism started using existing resources.

Remaining risks and issues:

- Recruitment for Mental Health Support Teams.
- Learning disability and autism funding not confirmed by the ICB.

Is the goal being carried forward?

- Yes, as this is an ongoing and longer term programme of work.

Goal: Progress with the developments for Reaside re-provision and Highcroft redevelopment.

Changing how we work

Key achievements:

- ✓ Reaside re-provision: strategic outline case (SOC) submitted externally to ICB Investment Committee in January 2023, who confirmed they are happy to provide a letter of endorsement.
- ✓ Highcroft redevelopment: work ongoing to keep capital costs down, use of modular build being considered and work undertaken on potential to phase the build.

Remaining risks and issues:

- Funding decision by the Department of Health and Social has been continually delayed and remains outstanding.

Is the goal being carried forward?

- Yes, goals for both schemes being carried forward while a decision on external funding remains outstanding.

13. Strategic priority: People

Goal: The Trust is an Anti-racist and Anti-discriminatory organisation.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Road map to becoming an anti-racist, anti-discriminatory organisation published, with subsequent finalisation of anti-racist framework.
- ✓ Anti-racism pledge campaign launched with over 2,000 colleagues signed up.
- ✓ LGBTQ+ pledge campaign launched with over 800 colleagues signed up.
- ✓ Senior leaders have undertaken anti-racism training.
- ✓ Launched Enough is Enough Campaign
- ✓ Data with Dignity Roadshows undertaken
- ✓ Workforce Race Equality Standard (WRES) reporting now containing staff voice.
- ✓ Health inequalities programme launched.
- ✓ PCREF (Patient and Carer Race Equality Framework) programme progressing in line with plans.
- ✓ Active Bystander training rolled out across the Trust.

Remaining risks and issues:

- Lack of focus on an inclusive and compassionate working environment impacting recruitment and retention of an engaged and effective workforce.

Is the goal being carried forward?

- Not in current format – the work is being incorporated in specific goals around staff survey improvement areas.

Goal*: LGBTQ+ and Black, Asian and Minority Ethnic Colleagues do not experience disproportionate Bullying and Harassment from colleagues, managers, and service users.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Enough is Enough campaign launched specifically to support LGBTQ+ and Black and Minority Ethnic colleagues.
- ✓ First and second person reflective tool developed to ascertain if a colleague is demonstrating inappropriate behaviours in their everyday activities.
- ✓ Reviewed the lived experience of those going through the enough is enough process and re-developed the reflective tool.
- ✓ Development of values and behaviours framework.
- ✓ Development of civility and team culture framework
- ✓ Values based leadership training for managers.

Remaining risks and issues:

- Lack of focus on an inclusive and compassionate working environment impacting recruitment and retention of an engaged and effective workforce.

Is the goal being carried forward?

- Yes but incorporated into a goal around demonstrating improvement in the key areas Identified within the 2022 NHS staff survey which require improvement which includes discrimination and bullying and harassment.

* *There are two separate 2022/23 goals covered together as they have common narrative.*

14. Strategic priority: People

Goal: Black, Asian and Minority Ethnic colleagues believe that we provide equal opportunities for career progression or promotion.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Flourish programme has been launched.
- ✓ Consultation with colleagues to confirm what they need to help them Flourish within the Trust.
- ✓ Offer developed and task and finish groups being mobilised to support implementation.
- ✓ Project plan and delivery milestones in place.
- ✓ Launch and roll out of new values based appraisal process.

Risks:

- Limited capacity within the organisational development function to support the number of task and finish groups required could affect delivery of this goal

Is the goal being carried forward?

- Yes – reframed as “Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme”.

Goal: Develop a clear strategy to support staff to speak up.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Freedom to speak up guardians in place
- ✓ Freedom to speak up champions model launched
- ✓ 8 champions recruited in cohort 1, with recruitment processes currently underway for cohort 2.
- ✓ Champions have been trained locally by the guardians and support measures are in place.
- ✓ Nearly 60% of champions identify as being from an equality group (BAME, LGBTQ+, disability and neurodivergence)
- ✓ Links with equality, diversity and inclusion forged

Remaining risks and issues:

- None identified.

Is the goal being carried forward?

- We are currently working on the NHSE Reflection and Planning tool to identify our strengths, identify gaps and formulate an improvement plan. This work will inform / add to our existing strategy – depending on what the outcomes are, a specific goal may be added mid year.

15. Strategic priority: People

Goal: Improve our staff survey

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Developed the vision and team-based organisational development plans based on last year's results.
- ✓ Continued to undertake the quarterly pulse surveys
- ✓ Participated in NHS Wide surveys.
- ✓ Regular staff comms to promote and encourage completion, both within team briefings and electronic means.
- ✓ Staff Engagement Lead focussed on promoting staff survey throughout the Trust and supporting teams to dedicate time to enable completion. Now working with teams to interpret results, develop action plans and share good practice across the organisation.
- ✓ Increased response rate in latest staff survey outcomes .

Risks:

- None identified.

Is the goal being carried forward?

- Yes – reframed as demonstrating improvement in the key areas Identified within the 2022 NHS staff survey which require improvement. Discrimination, recognition, health and wellbeing and Inclusion.

Goal: HR policy and process implementation are free from bias.

Modernising our people practice

Key achievements:

- ✓ Consultation process has been improved to ensure processes are free from Bias.
- ✓ A suite of People policies have been reviewed to ensure compliant with best practice and aligned to Trust values, and currently going through ratification process.
- ✓ Roll out of support package for managers which include how to guides and videos to confidently support colleagues through the sickness policy.
- ✓ Revised flexible working policy launched with Lunch and learn sessions rolled out.

Risks:

- None identified.

Is the goal being carried forward?

- Not specifically, moved into business as usual as policies come to be updated.

16. Strategic priority: Quality

Goal: Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards.

Preventing harm

Key achievements:

- ✓ The door monitoring alarm system has now been installed in all en-suites in Acute Care.
- ✓ In terms of the broader physical environment agenda, we are continuing with the process of working with service areas to develop and finalise the capital programme for 2023/24. This will also include the prioritisation for the installation of the bedroom door alarm systems.
- ✓ Bedroom door alarm systems have also been installed on George Ward, Larimar, Melissa and Mary Seacole 2.
- ✓ To support this, local ward daily level safety huddles are in place and grand huddles are working well in looking at the picture across the service areas.

Remaining risks and issues:

- None identified

Is the goal being carried forward?

- This goal is not carried forward as much of it is complete, however there is a new goal around delivery of the capital programme to support reduction in harm.

Goal: To improve the physical health monitoring of patients in our care.

Preventing harm

Key achievements:

- ✓ Physical health strategy updated in BSMHFT and the Birmingham and Solihull (BSOL) physical health community transformation group.
- ✓ Physical health educators programme complete in acute care and moving to secure care inpatient areas, including self assessment and support in improving gaps in knowledge and training.
- ✓ Physical health connectors (navigators) are being recruited, contract awarded to a provider and work ongoing to develop job descriptions, integrated with the mental health hubs.
- ✓ QI approach to learning to improve serious mental illness (SMI) physical health checks in primary care, being presented at the BSOL wide physical health community transformation group in June 2023.
- ✓ Recommendations for a new systemic enquiry form complete, awaiting Rio team to develop. There is still a gap in access to data in real time and a usable format: discussions are ongoing regarding a patient safety dashboard.
- ✓ Training sourced from specialist services to support physical health aspects of care for inpatient service users with addictions needs.

Remaining risks and issues:

- Access to consistent data for wards, a data analyst, and integrated discussions about the wider patient safety dashboard are needed.

Is the goal being carried forward?

- This specific goal is not carried forward. Some broader goals for 2023/24 should impact positively on physical health.

17. Strategic priority: Quality

Goal: Improve the involvement of service users in MDT meetings and ensure that all service users have a copy of their care plan.

Improving service user experience

Key achievements:

- ✓ Implementation of Dialog+ will improve service user involvement in multi-disciplinary team (MDT) discussions and more holistic assessment and discussion leading to improvements in goal focussed care planning with a greater focus on what is important to the individual.
- ✓ Dialog+ training has been delivered through a 'train the trainer' approach.
- ✓ Roll out of training to teams commenced with a view to have all training completed and the new care plans live by October 2023.
- ✓ Quality improvement (QI) projects are under way to support teams to identify how best to incorporate Dialog+ into care.
- ✓ CERTS team are using QI methodology to test Dialog+ with their specific cohort of patients.
- ✓ The initial QI project at Zinnia inpatients was ceased to due capacity and will restart utilising learning from the previous project.

Remaining risks and issues:

- Challenges to clinical team engagement due to workforce pressures.

Is the goal being carried forward?

- No, as utilising Dialog+ care planning is captured in the Clinical Services goals and is carried over there to avoid duplication.

Goal: Improve the involvement of carers in service user care and recovery.

Improving service user experience

Key achievements:

- ✓ Organisational change in the Participation and Experience Team has laid the ground for more contact and engagement with carers and therefore increase involvement.
- ✓ Family and carer involvement is being built into care planning processes and recent figures show an improvement.
- ✓ Families and carers are also being encouraged to work collaboratively in relation to improvement and transformation programmes.

Remaining risks and issues:

- Work on family and carer pathway is behind schedule. There has not been the anticipated/required momentum to move this forward. Constrained capacity in clinical services is an additional factor, and we are reviewing where the pathway adds value prior to next steps.

Is the goal being carried forward?

- No, as a Clinical Services goal to review and refresh the family and carer pathway is being carried over and will capture this work to avoid duplication.

18. Strategic priority: Quality

Goal*: Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table.

Improving service user experience

Goal*: Strengthen the approach to confidence in incident reporting and learning from incidents resulting in an improved safety culture, including implementing the Patient Safety Incident Response Framework (PSIRF)

A positive patient safety culture

Key achievements:

- ✓ Reviewed our incident reporting training quality of responses provided to staff so we can advocate a learning, compassionate response.
- ✓ Reviewed existing resources to deliver PSIRF and developed a business case to support implementation.
- ✓ PMO support agreed to support the PSIRF implementation plan.
- ✓ PSIRF Implementation Group established.
- ✓ QI team are engaged to look at how future QI learning can be introduced in the Trust and ICS where applicable.
- ✓ Key stakeholders mapped.
- ✓ Review commenced of what is being done to support open and transparent reporting.
- ✓ Established a subgroup looking at Just Culture and how safe people feel to report incidents.
- ✓ Implementation of serious incident oversight group.
- ✓ Benchmarked against national standards for staff and family engagement.
- ✓ Thematic review of addiction service deaths commenced.
- ✓ Workshop held with EBEs to consider options to fulfil the Patient Safety Partner role and proposal developed to ensure the role is adequately resourced, accessible and rewarded fairly in line with the Trust's approach to participation.

Remaining risks and issues:

- None identified.

Is the goal being carried forward?

- The goal to implement PSIRF is carried forward.
- There are also goals aligned to the PSIRF relating to learning from deaths processes and inclusion of Patient Safety Partners.

** These goals are both covered by the above narrative.*

19. Strategic priority: Sustainability

Goal: Bring together clinicians, ICT, service users and carers to develop a clear strategy and five-year roadmap for how digital and technology will enable clinical services, quality and people transformations and developments

Transforming with digital

Key achievements

- ✓ Aim is to align our ICT strategy and digital roadmap with the ICS strategy, the trust strategy and the wider digital agenda.
- ✓ Contributed to development of the ICS Digital Strategy which has now been published.
- ✓ Clinical reference group and experts by experience/ user reference groups established. Our approach to projects and programmes and the planned technology roadmap has been shared with them.
- ✓ Across the Trust we have undertaken a large engagement piece with subject matter experts across ICT, services and clinical teams. In total c1,500 staff have been asked questions about digital / clinical innovation and their feedback has been incorporated into our strategic direction.
- ✓ We have used Artificial Intelligence to look at the feedback we have received over the last 3 years to pull out trends, issues and areas we have done well on, to help guide our direction and this has included 37,000 piece of feedback and comments.
- ✓ Our outline ICT strategy and implementation plan is in the process of being finalised and taken through approval processes.
- ✓ The Medical Director has taken a leadership role in terms of clinical roles and engagement in the digital agenda.
- ✓ Over the last 6 months, we have recruited 2 deputy Chief Clinical information Officers (CCIO's) this has bolstered the approach to clinical leadership within the organisation. There is now an established Clinical systems team, which the Chief Nursing Information Officer is also part of along with the Clinical Safety Officer and two project managers.
- ✓ Joint appointment of Director of Digital Services for BSMHFT and Birmingham Community Healthcare NHSFT and commitment to closer working between the two Trusts.
- ✓ Currently working with Forward Thinking Birmingham to align to a single care record system on RiO.

Remaining risks and issues

- Competing pressures on capacity preventing teams and clinicians from being able to engage with this work.

Is the goal being carried forward?

- The ICT strategy is in the process of being finalised and approved. Goals for 2023/24 will focus on i) specific strategic developments and ii) embedding clinical engagement in the digital agenda.

20. Strategic priority: Sustainability

Goal: Develop delivery plans and timescales for efficiency schemes following development of the Project Initiation Documents and Clinical Quality Equality Impact Assessments (CQEIAs) for these

Balancing the books

Key achievements:

- ✓ All NHS organisations have been asked to undertake a self assessment against a HFMA document around Sustainability. In this one of the key elements related to efficiency schemes. At the time of self assessment we scored ourselves relatively low but have since:
  - ✓ Refreshed our Savings Policy and shared at September Sustainability Board.
  - ✓ Through discussion with Non Executive Directors aim to change the debate on savings to one of productivity and transformational changes.

Remaining risks and issues:

- There is significant risk to achievement of financial balance if we do not develop and deliver savings plan. This has led to RAG rating of “Red”.

Is the goal being carried forward?

- Goal for 23/24 to be reframed around transformation opportunities that have a financial benefit rather than traditional budget/ cost cutting.

Goal: Formalise revenue and capital plans for the medium term.

Balancing the books

Key achievements:

- ✓ Preparation work carried out to review and realign revenue budgets to ensure our start point budget is as accurate as possible.
- ✓ Planning round for revenue for 23/24 completed as part of national submission.
- ✓ Multi year capital programme approved by Trust Board.

Remaining risks and issues:

- Delivery of this goal will ensure that the Trust remains within financial balance.

Is the goal being carried forward?

- Focus on future years is vitally important given the financial position of the Trust and BSOL system. Our goal is to shift the focus to the planning necessary for future years, including sensitivity analysis and assumptions

21. Strategic priority: Sustainability

Goal: Driving the development of the BSOL MH provider collaborative aligned to the ICS and supporting our key tests of reducing inequalities, managing demand, improving access, experience and outcomes, improving safety, and achieving value for money, including lead provider governance and infrastructure and partnership governance.

Changing through partnerships

Key achievements

- ✓ We have been through the Integrated Care Board's Delegation Assurance Process and provided submissions and evidence of our future intentions and plans, and responded appropriate to feedback from the Integrated Care Board (ICB). This included:
- Phase One - our collective vision, people and culture, improving outcomes and tackling inequalities, and governance structure.
- Phase Two - quality, performance and delivery, commissioning, governance/risk management, finance and use of resources, and IG, digital and cyber.
- ✓ Following this a joint report was produced for the ICB's Board on 9 January 2023 with the recommendation that they approve delegation from 1 April 2023.
- ✓ A mobilisation plan was implemented covering all functional areas and activities needing to be carried out January-March 2023 to be ready for go live.
- ✓ Key frameworks describing how we will work in the future developed including Commissioning, Contracting, Quality and Assurance, Governance.
- ✓ Key partnership documents drafted ahead of go live: Partnership Agreement, Memorandum of Understanding, Information Sharing Protocol, Risk and Benefit Framework.
- ✓ Trust Board approved shadow governance arrangements to be put in the place from January 2023.
- ✓ The Mental Health commissioning team resource from BSOL ICB was aligned with BSMHFT from 21 November 2022 and the Section 117 clinical team from 23 January 2023.
- ✓ ICB resources for other supporting infrastructure including finance and contracting have been identified to secure capacity and capability within the Trust to fulfil the lead provider function.
- ✓ Discussions ongoing regarding the development of a proposed Commissioning and Transformation hub.
- ✓ Due to this being a Significant Transaction for the Trust requiring approval from Council of Governors, they have been kept updated and approved the transaction in March 2023.
- ✓ The Provider Collaborative went live from 1 April 2023.

Remaining risks and issues

- Lack of funding and people to cover all infrastructure functions.
- Stakeholder engagement particularly with voluntary, community, faith and social enterprise (VCFSE) organisations and local authorities.

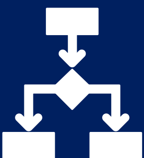
Is the goal being carried forward?

- Yes with a focus on embedding arrangements e.g. governance, contractual management, financial oversight, quality assurance, commissioning arrangements etc and specific strategic pieces of work.

Part B – 2023/24 Goals

22. Planning for 2023/24

Stage 1 - Review of key drivers and change in landscape



National

- Long Term Plan – trajectories and priorities for 2023/24 service delivery/ developments
- National People Plan
- National staffing shortages
- New national quality requirements e.g. PSIRF
- Political situation
- Cost of living

Regional/ System

- ICS Strategy – published late 2022/23
- BSOL Mental Health Provider Collaborative live from 1 April
  - Increased collaboration across the system
  - New mental health and commissioning plan
  - System scrutiny over poor performing areas – out of area and talking therapies
- Health inequalities priorities for 2023/24
- WM Provider Collaboratives developments (Reach Out, CAMHS, Eating Disorders, Perinatal)

Local/ Trust

- Latest staff survey results and known workforce issues (staffing, morale, wellbeing, inclusion)
- CQC action plan from recent inspection
- Financial position and need for efficiency savings
- Renewed focus on productivity and transformation
- Progress with 2022/23 goals and what we want to carry forwards
- Data and performance – hotspots and areas of focus

23. Planning for 2023/24 (continued)

Stage 2 – Engagement to determine our annual goals

- Senior leaders
- Senior management teams across divisions/ corporate areas
- Experts by experience (EbE)
- Executive team
- Relevant committees/ groups

Example of a clinical services co-production workshop with more than 60 service and corporate leads, including 14 EbE's

Stage 3 – Approval of goals

- Local areas
- Executive Team
- Board Committees
- Trust Board

Stage 4 – Delivery of goals

- Milestone plans – owners, outputs, timescales, risks
- Routine monitoring
- Assurance reporting
- Developing an Impact Framework
- Communication and engagement

24. Summary of goals

In total across our four strategic priorities, we have **97 goals for 2023/24**, which is year 3 of our strategy. These include a number of goals that have been carried forward from the previous year. In most cases this carry forward was predicted and reflects the longer term and complex nature of our transformation work and service developments rather than any lack of progress.

Similar to 2022/23, we have applied our prioritisation framework and the priority levels for the goals in shown in the table below.

As Trust Board are focussed on the **39 level 1 goals**, these are shown on the next page. A full list of all goals can be found in the reading room for information.

	Clinical Services	People	Quality	Sustainability	Total 2023/24	Total 2022/23
Level 1	11	8	12	8	**39**	***28***
Level 2	16	6	5	9	**36**	***44***
Level 3	11	1	0	10	**22**	***26***
Level 4	0	0	0	0	**0**	***2***
Total 2023/24	**38**	**15**	**17**	**27**	**97**	***99***
Total 2022/23	***44***	***24***	***11***	***23***	***99***	

compassionate

*** Inequalities goals highlighted in blue text ***

25. 2023/24 - Level 1 goals

Level 1 priorities : Report to Trust Board, QPES/FPP/People Committees, local governance structures

Clinical Services (11 goals)

Leader in mental health
- Implement divisional health inequalities plans
- Engagement and scoping for more integrated Trust services

Recovery focussed
- Family and carer pathway – review and refresh

Rooted in communities
- Community transformation programme year 3
- Out of area placement reduction
- Partnerships with local communities to reduce inequalities

Prevention and early intervention
- Transformation plans for children and young people in Solihull
- Urgent care transformation programme
- Birmingham Healthy Minds waiting times

Changing how we work
- Reaside re-provision
- Highcroft redevelopment

Quality (12 goals)

Improving service user experience
- Population profile of incident data
- Expert by Experience observers project
- Patient Safety Partners in the patient safety framework

Preventing harm
- Implement Patient Safety Incident Response Framework
- Ensure capital programme supports harm reduction
- Ensure safe staffing model across all inpatient wards

Patient safety culture
- Review of organisation's safety culture

Quality assurance
- New learning from deaths processes
- Develop and embed Think Family principles
- Improvement against CQC action plans

Using our time more effectively
- Introduce Quality Management system, including embedding strategic approaches to Quality Improvement
- Use QI approaches to develop pathways for improved access

People (8 goals)

Shaping our future workforce
- Delivering the commitments of our workforce plan
- Developing a Just Culture

Transforming our culture and staff experience
- Embed staff engagement programme
- Improve engagement scores to NHS staff survey
- Improvement in the four key areas identified within the NHS staff survey
- Providing a comprehensive Health & Wellbeing offer
- Equal opportunities offered via Flourish programme.

Modernising our people practice
- Developing digital solutions

Sustainability (8 goals)

Transforming with digital
- Shared Care Record across BSOL
- Clinical engagement in ICT strategy and developments

Balancing the books
- Implement framework for transformational change.

Caring for the environment
- Implement the Green Plan

Changing through partnerships
- Embed BSOL Mental Health Provider Collaborative
- Deliver West Midlands Provider Collaborative strategic priorities

Good governance
- Review of governance arrangements from Ward to Board
- Review of risk management arrangements

26. Strategy Governance Framework

The diagram below sets out our framework for monitoring delivery of our strategy and providing assurance through the organisation by describing the role of different groups and forums and the role they play.

	Clinical services	Quality	People	Sustainability
Delivery and accountability				
Local meetings	**Service Area FPP and Clinical Governance Committees, Team Meetings**		• Progress against local business plans, work programmes and milestones	
Trust-wide meetings	Operational Management Team	Clinical Governance Committee and Sub-Committees	Shaping Future Workforce Group and Culture, Staff Experience Group	Sustainability Board, Systems Strategy Board, SSL Service Agreement Forum
	Strategy and Transformation Management Board		• Transformation, improvement and change management • Management of interdependencies	
	Performance Delivery Group		• Performance against KPI's and metrics aligned to the four priorities	
Assurance				
Sub-committees	**Progress report**	**Quarterly**	• Progress against delivery of the strategic goals • Performance against key measures of success	
	QPES and FPP Committee	QPES Committee	People Committee	FPP Committee
Trust Board	**Integrated progress report**	**Bi-annually**	• Progress against delivery of our four priorities • Performance against key measures of success • A look forward at what's next • Reset direction if necessary	

27. Strategy developments for 2023/24

We have a range of developments planned for 2023/24 to ensure we have really embedded our strategy across the organisation, we have robust governance over accountability and delivery, and we truly know how the strategy is making a difference to our organisation.

Development	Actions	Timing
1. Strategy communications and engagement	• Build on the comms and engagement we did when we launched the strategy in 2021, by refreshing our communications plan to continue to raise awareness of our strategy, progress so far and areas of focus for 2023/24. Including a range of online and offline activities and mechanisms. • Support senior leaders in cascading engagement activities among their teams to reflect on what the strategy means to them and their role in helping to deliver it. • Identify expert by experience 'strategy champions'.	April - March
2. Review and refresh strategy governance	• Review and refresh which Trust wide groups have oversight of strategic aims and goals for each strategic priority. • Review role of Strategy and Transformation Management Board. • Embed monitoring and reporting into local FPP meetings. • Agree frequency of i) monitoring and ii) assurance reporting to Committees.	May/ June
3. Measure impact of the strategy	• Develop a framework for measuring the impact delivery of our strategic goals is having on clinical services, people, quality and sustainability. • Define who is involved in developing this (e.g. internal, system) • Define quantitative and qualitative measures of success. • Define where we want to be by the end of our strategy • Define our baseline. • Review impact at the end of year 3.	April-July March

How do we know we have made a difference?

What does good look like?

Our Trust Five Year Strategy

2023/24 Strategic Goals – for the Reading Room

Trust Board
7 June 2023

Clinical services

Strategic aim	Strategic goal	Priority level	Owner
Leader in mental health	Implementation of divisional health inequalities plans, following data with dignity sessions held in 2022/23, to ensure services are built on reducing inequalities data.	1	Associate Directors of Operations / EDI and OD
Leader in mental health	Engage on and scope potential for more integration between Trust services to avoid silo working and fragmentation of care.	1	Clinical Director for ICCR (recovery)
Leader in mental health	Be a key partner in developing place-based models for Birmingham (and its five localities) and Solihull and assessing how our services need to adapt to these new approaches.	2	Executive Director of Operations
Rooted in communities	Continue to implement plans, building on work already undertaken, to eradicate acute inpatient out of area placements	1	Associate Director Acute and Urgent Care
Rooted in communities	Continue to progress our detailed and wide-ranging plan to transform community services across all geographical areas within the BSOL footprint, across young people, adult and older adult services. Areas of focus include: - Personality disorder - Rehabilitation - Eating disorders - 18-25 - Psychosis - Older adults	1	Associate Director ICCR
Rooted in communities	Review effectiveness and further develop our Intensive Community Rehab Team.	3	Associate Director ICCR

Clinical services

Strategic aim	Strategic goal	Priority level	Owner
Rooted in communities	Complete the mobilisation of the new local High Dependency Unit and review effectiveness post mobilisation	2	Associate Director ICCR
Rooted in communities	Work in partnership with our local communities to deliver and embed our commitment to reducing racial inequalities and ensuring cultural competencies across service delivery, through programmes and initiatives such as the BLACHIR Review, Patient Carer Race Equality Framework and Synergi Pledge.	1	Associate Director EDI and OD
Rooted in communities	Re-design of the Forensic Intensive Recovery Support Team (FIRST) community services.	2	Associate Director SCOH
Rooted in communities	Implementation and monitoring of i) Accessible Information Standard ii) Sexual Orientation Standard	2	Associate Director EDI/ OD
Rooted in communities	Meet the Long Term Plan objectives for perinatal services, with a focus this year on: - Assessing 10% of the birth population for Birmingham and Solihull - Implementing and embedding a therapies led pathway into the specialist perinatal community teams. - Evaluating the partner pathway with a view to roll out across the service.	2	Associate Director Specialities
Rooted in communities	Redesign the forensic women's pathway in co-production with staff and service users	3	Associate Director SCOH
Rooted in communities	Strategically and practically embed Asset Based Community Development (ABCD) and asset-based approaches in the way that we work, working with a range of community organisations	3	Head of Community Engagement

Clinical services

Strategic aim	Strategic goal	Priority level	Owner
Recovery focussed	Review and refresh family and carer pathway, ensuring consistent ownership and application across all service areas	1	Associate Director AHPs and Recovery
Recovery focussed	Launch and implement the refreshed Recovery/Experts by Experience 'HOPE Strategy', covering participation, experience and recovery.	2	Lead for Service User Involvement and Recovery
Recovery focussed	Implement recommendations for growing peer support from the Birmingham and Solihull wide review, resulting in a consistent approach to growing peer support across the Trust and wider system.	2	Lead for Service User Involvement and Recovery
Recovery focussed	Refresh of family and carer strategy to improve how we listen to and include families and carers.	2	Lead for Service User Involvement and Recovery
Recovery focussed	Review the effectiveness of Individual Placement Support and understand any gaps to inform future developments.	3	Associate Director ICCR
Recovery focussed	Evaluate and develop the Bedlam partnership of creative and physical activities to support service users' recovery, through a funded and sustainable programme across services.	3	Head of Community Engagement
Recovery focussed	Review our patient information materials, ensuring clarity around what interventions we offer	3	Lead for Service User Involvement/ AD for Comms
Recovery focussed	Involve service users, carers and staff to include caring physical environments in our estates strategy.	3	Deputy Director of Estates

compassionate

Clinical services

Strategic aim	Strategic goal	Priority level	Owner
Prevention and early intervention	Progress urgent care transformation to relieve pressure on Emergency Departments and beds in acute hospitals.	1	Associate Director Acute and Urgent Care
Prevention and early intervention	Continue to deliver transformation plans for children and young people in Solihull.	1	Associate Director ICCR
Prevention and early intervention	Expand and support the Birmingham Healthy Minds workforce and improve waiting times to meet national trajectories by April 2025.	1	Associate Director Specialities
Prevention and early intervention	Development of the psychiatric liaison clinical model, pathways and service at the new Midlands Metropolitan Hospital opening in spring 2024, working in partnership with Black Country Healthcare NHS Foundation Trust and local authority.	2	Associate Director Acute and Urgent Care
Prevention and early intervention	Develop and implement plans for to enhance our substance misuse services in line with the recommendations of the Dame Carol Black review.	2	Associate Director ICCR
Prevention and early intervention	Strengthen our integrated Mental Health Older Adult offer	2	Associate Director Specialities
Prevention and early intervention	Establish an early intervention eating disorders (FREED) pathway for 18-25 year olds	2	Associate Director Specialities
Prevention and early intervention	Review the current provision of psychology-led services within acute hospital partnerships.	2	Associate Director Specialities
Prevention and early intervention	Further develop our services for homeless people including rough sleepers	3	Associate Director ICCR

Clinical services

Strategic aim	Strategic goal	Priority level	Owner
Clinically effective	Improve our offer for service users who also have substance misuse needs through a robust clinical and strategic dual diagnosis interface, policy and pathways.	2	Deputy Medical Director / Associate Director ICCR
Clinically effective	Continue implementation of the action plan for learning disability and autism.	2	Associate Director AHPs and Recovery
Clinically effective	Embed the routine use of outcome measures in clinical practice to inform effective service delivery and improvement and utilise Dialog Plus Care Planning to scope out Care Programme Approach Transition.	2	Clinical Director for ICCR (community)
Clinically effective	Embed the trauma based therapeutic model for working with refugees in clinical services.	3	Head of Community Engagement
Clinically effective	Enhance the eating disorder pathway for adults.	3	Associate Director Specialities
Clinically effective	Review and improve the whole deaf service pathway and work with commissioners to engage primary care colleagues and increase referrals.	3	Associate Director Specialities
Changing how we work	Progress with the developments for Highcroft redevelopment.	1	Associate Director Acute and Urgent Care
Changing how we work	Progress with the developments for Reaside re-provision	1	Associate Director SCOH

Strategic aim	Strategic goal	Priority level	Owner
Shaping our future workforce	Deliver our workforce plan through: • Increasing workforce supply to address workforce gaps across the organisation. • Progressing the retention activities and improve our turnover rate. • Support delivery of service specific recruitment and retention plans. • Deliver the recruitment and retention priorities for BSOL in our partnership arrangements	1	Head of People and Culture
Shaping our future workforce	To develop and implement a comprehensive job matching and job evaluation service that meets the needs of our customers	3	Head of People and Culture
Shaping our future workforce	Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes	1	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Shaping our future workforce	Develop and roll out a package of First Line Management training that supports all aspects of the role and is supported by an action learning set infrastructure	2	Senior L&D Business partner

Strategic aim	Strategic goal	Priority level	Owner
Transforming our culture and staff experience	Continue to embed staff engagement programme to ensure that Flexible Working is routinely promoted throughout the year using data and multiple channels	1	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Transforming our culture and staff experience	Develop and Implement a clear and regular engagement plan that seeks to Improve overall engagement scores to NHS Annual Staff Survey - measures of success via recommendations of a great place to work and receive care.	1	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Transforming our culture and staff experience	Demonstrating improvement in the key areas Identified within the 2022 NHS staff survey which require improvement. Discrimination, recognition, health and wellbeing and Inclusion.	1	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Transforming our culture and staff experience	Provide continuous support to operational divisions in improving the experience of our workforce.	2	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Transforming our culture and staff experience	Ensure every colleague in the organisation has an annual appraisal, which is monitored via data recorded on ESR	2	Senior L&D Business partner

Strategic aim	Strategic goal	Priority level	Owner
Transforming our culture and staff experience	Continually review and update the comprehensive and inclusive health and wellbeing offer (including cost of living) that meets the needs of our diverse workforce.	1	Head of Programmes – Strategy, People & Partnerships
Transforming our culture and staff experience	Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme.	1	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Transforming our culture and staff experience	Coproducing a shared understanding of what psychological safety is and how it shapes organisational culture. Sharing this definition and concept through the trust development and learning.	2	Associate Director for Equality, Diversity, Inclusion and Organisational Development
Modernising our People Practice	Develop a range of digital solutions to streamline or automate people processes	1	Head of People and Culture
Modernising our People Practice	Ensuring that ESR holds accurate and credible workforce data	2	Head of People and Culture
Transforming our culture and staff experience	Ensuring that any colleague who raises a grievance is responded to within the timescales highlighted within trust policies and procedures, monitored via HR casework tracker	2	Head of People and Culture

Strategic aim	Strategic goal	Priority level	Owner
Improving service user experience	Use data to understand health inequalities in relation to incidents	1	AD of Nursing and Governance
Improving service user experience	Complete Expert by Experience (EBE) observer project, utilising EBEs to assess ward culture to reduce restrictive practice and improve quality and experience	1	AD for AHPs and Recovery
Improving service user experience	Empowering patients through inclusion of Patient Safety Partners in the patient safety framework	1	AD of Nursing and Governance
Preventing harm	Implement the Patient Safety Incident Response Framework (PSIRF) to pursue excellence in learning and understanding of incidents including cross-organisational learning	1	AD of Nursing and Governance
Preventing harm	Ensure delivery of the capital programme that supports a reduction in harm	1	AD of Clinical Governance
Preventing harm	Review and implement a safe staffing model across all inpatient wards	1	Deputy Director of Nursing
Preventing harm	Implementation of the Safety Summit Framework to support clinical teams to improve quality of care	2	AD of Nursing and Governance

Strategic aim	Strategic goal	Priority level	Owner
A patient safety culture	Review the organisation's safety culture to understand how safe our staff feel at work and engage with them to provide a safe working environment where they can flourish	1	AD of Nursing and Governance
A patient safety culture	Roll out Learning from Excellence across the Trust to ensure systematic recognition of learning from excellent practice	2	AD of Nursing and Governance
A patient safety culture	Embed a ward accreditation programme to give teams ownership of actions that improve a safety culture	2	Deputy Director of Nursing
Quality assurance	Implementation of new learning from deaths processes aligned with PSIRF	1	AD of Nursing and Governance
Quality assurance	Develop and embed the principles of 'Think Family'	1	Deputy Director of Nursing
Quality assurance	Demonstrate improvement against Care Quality Commission (CQC) action plans	1	AD of Clinical Governance
Quality assurance	Build the foundations for safety through governance processes that drive improvement	2	AD of Clinical Governance
Using our time more effectively	Scope, introduce and embed a Quality Management System, including our strategic approach to Quality Improvement with our new Quality Improvement strategy.	1	AD of Clinical Governance
Using our time more effectively	Use quality improvement approaches to develop our pathways to improve access to services	1	AD of Clinical Governance
Using our time more effectively	Engage colleagues and scope how we can use quality improvement methodologies to release time to care	2	AD of Clinical Governance

Sustainability

Strategic aim	Strategic goal	Priority level	Owner
Transforming with digital	Connect the Trust and the Shared Care record for BSol to all NHS primary and secondary care providers and the local authorities, to improve data sharing across our organisations for direct patient care	1	Deputy Director of ICT and Programmes
Transforming with digital	Embed clinical engagement and influence in relation to ICT and digital strategy, transformation and developments	1	Deputy Director of ICT and Programmes/ Medical Director
Transforming with digital	To ensure all MH service provision is undertaken on a single instance of Rio across BSoL - this will allow any clinician across the MH pathway to see a single patient record regardless of service provision (I.e. FTB / BSMHFT)	2	Deputy Director of ICT and Programmes
Transforming with digital	Implement a new website in conjunction with the requirements of the Trust Communications team	3	Deputy Director of ICT and Programmes
Transforming with digital	Include structured medications and flow discharge medications from Rio into the Shared Care Record	2	Deputy Director of ICT and Programmes
Transforming with digital	Develop our business intelligence capability to improve the information and insights available for developing services and user experience.	3	Associate Director of Information

Sustainability

Strategic aim	Strategic goal	Priority level	Owner
Balancing the books	To implement the framework for transformational change	1	Deputy Director of Finance
Balancing the books	To have identified key components of planning for future years and to start developing framework	2	Deputy Director of Finance
Balancing the books	To have developed and implemented the first set of finance training documents	3	Deputy Director of Finance
Balancing the books	Finance staff to have taken part in training for power BI and for reports to have been developed	3	Deputy Director of Finance
Balancing the books	To have developed a set of finance reports for use across the range of commissioning functions	3	Deputy Director of Finance
Caring for the environment	Implement the Green Plan	1	Deputy Director of Estates, SSL
Changing through partnerships	Deliver strategic priorities agreed by the West Midlands Provider Collaborative	1	Head of Strategy, Planning and Business Developments
Changing through partnerships	Embed the BSOL Mental Health Provider Collaborative including, including clinical engagement and clinically informed models. Incorporate governance, finance, contracts, quality arrangements etc	1	Deputy Director of Commissioning and Transformation

Sustainability

Strategic aim	Strategic goal	Priority level	Owner
Changing through partnerships	Increase knowledge and understanding of population health across BSOL	2	Deputy Director of Commissioning and Transformation
Changing through partnerships	Explore different commissioning / contracting models for Voluntary, Community, Faith and Social Enterprise partners.	2	Deputy Director of Commissioning and Transformation
Changing through partnerships	Enhance Reach Out partnership working	2	Associate Director for Reach Out
Changing through partnerships	Continue to play an active role as clinical lead for the Perinatal Provider Collaborative in readiness for go live on 1 October 2023, including working with partners to develop the clinical model.	2	Head of Strategy, Planning and Business Developments
Changing through partnerships	Finalise, launch and embed the new Business Development and Partnerships Strategy including development of business development and partnership toolkits to support Trust leaders and teams.	2	Head of Strategy, Planning and Business Developments
Good governance	Review of the Trust`s Risk Management arrangements including risk appetite, training, escalation/de-escalation, governance, oversight and assurance.	1	Associate Director for Clinical Governance/ Associate Director for Corporate Governance

Sustainability

Strategic aim	Strategic goal	Priority level	Owner
Good governance	Undertake a review of the governance arrangements of the organisation from ward to Board, including standardisation of reporting mechanisms.	1	Associate Director of Corporate Governance
Good governance	Pilot a refreshed self-assessment matrix and tool for Board committees	3	Associate Director of Corporate Governance
Good governance	Embed a process for succession planning for non-executive director posts to ensure that planning is undertaken well ahead of the end of a NED's tenure.	3	Associate Director of Corporate Governance
Good governance	To review and make necessary changes to the Trust Constitution and Standing Orders to align to the new NHS England Code of Governance for NHS Provider Trusts that comes into effect on 1 April 2023.	2	Associate Director of Corporate Governance
Good governance	Strengthen the process and communication for required declarations of interests and disclosures of second jobs to take account of increased home working and the Trust's commissioning role.	3	Associate Director of Corporate Governance
Good governance	Ensure that the Trust has a robust process in place for a Fit and Proper Persons Test to be undertaken and updated every three years for all staff at Band 9 and above.	3	Associate Director of Corporate Governance
Good governance	Develop a clear Corporate Social Responsibility framework so the Trust is contributing positively to the lives of local people and the environment in which they live.	3	Head of Strategy, Planning and Business Developments

7. QUALITY

7.1. (a) QPES Chair's Assurance Report April

Meeting	BOARD OF DIRECTORS
Agenda item	Item 7.1 (a)
Paper title	CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE
Date	7 June 2023
Author	Dr L Cullen, Non-Executive Director, Chair
Executive sponsor	Mr S Forsyth, Interim Director of Quality and Safety (Chief Nurse)

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

Executive summary

The Quality Patient Experience & Safety committee met on the 19 April 2023. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.

The committee received the following:

- QI framework
- Monthly Quality Report
- Integrated Performance Report
- Complaints and PHSO Updates
- Quality assurance from Provider Collaborative
- CQC Update
- Serious Incidents and Learning

The committee reviewed its Terms of Reference for the Board to approve.

Reason for consideration

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

Strategic objectives

QualityQuality

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

Financial implications

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

Strategic Risks

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

Equality impact

Number of reports received by the committee analyses services along the lines of protected

characteristics. The notes of the meeting reflect an increasing understanding of the equality/ inequality of services. One of the items include a discussion on how the committee addresses Health inequality
Our values
CommittedCommitted Compassionate Inclusive

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

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 CQC Update

The Committee received an update on the activities related. The salient points were noted as follows:

- We are now in receipt of the final report from the CQC following our core and well-led inspections last October through to December. We have also had a response to the factual accuracy and where points were accepted the report has been amended accordingly.
- The report was published on April 14th.
- The service areas and corporate leads have developed their own actions in response to the Must and Should Dos, as detailed in the report. These were all then collated by the Head of Regulatory Compliance and used to create a single action plan, which will be the master document going forward.
- We now need to submit our approved action plan to the CQC by April 28th.
- Action plans will be monitored locally at service area governance committees as well as specialist groups such as Safer Staffing or Clinical Effectiveness Group
- Trust oversight of the action plans will be at QPESC, with monthly updates provided by the Head of Regulatory Compliance.
- The committee is asked to review and approve the action plans to enable submission to the CQC by the deadline of April 28th.
- We have now completed the specific actions as set out in the Section 31 notice and have sought feedback from the CQC as to when the monthly monitoring might end. We are still awaiting feedback on this.
- The door monitoring alarm system has now been installed in all en-suites in Acute Care.
- In Acute Care, a total of 415 Safety Huddles were completed out of a possible 437 for the period.
- In terms of safer staffing, following sign-off at the Safer Staffing Group in March, the Check and Challenge system will be implemented in April. From the international recruitment process, we now have two international nurses in post with a further 5 expected to commence in post in April.
- The monthly audits of MDT standards in Acute Care continue to take place and for this submission, we have seen variability in terms of compliance for the measures.
- The Clinical Educators continue to provide support to our operational staff. They have developed specific support packages for prequalified, existing and Nurse Associates. For the reporting period they have also continued to present their Clinical learning labs.
- In terms of incidents of self-harm, we have seen random variation for these types of incidents for the reporting period with most data points below the median. We have also seen a similar picture for the reporting period for no anchor point incidents.
- We reported no anchor point incidents for the period.
- The team has continued with its programme of Assurance testing and peer reviews for service areas and sharing the findings from these.
- We have now received the final report from the Core and Well-led inspections that took place in October and December last year. We had a response from the CQC to our factual accuracy submission and they upheld a total of 20 points, partially upheld a total of 12 and rejected 24 points. The report was amended accordingly and will be published on April 14th.
- With service areas and corporate staff leading and developing their responses for actions, we have coordinated a comprehensive draft action plan in response to the Must and Should Do points raised in the report.

Chair's assurance comments:

- **Committee noted and approved the action plan in response to the Must and Should Do points raised in the CQC report**
- **QPES will gain monthly regular updates on progress with a clear flow of actions to gain assurance**
- **Committed noted that further review is currently ongoing to benchmark the methodology to be used for the RAG rating scores of the risks and actions and this will come to committee next time for assurance**

1.2 Patient Safety: Complaints, SI Escalation Report

The Committee received the Patient Safety: Complaints, SI Escalation Report.
The report outlined the number of incidents reported within the month and the categories. It outlined the serious incident investigations submitted to our commissioners for closure, the associated action plans and learning together with any emerging themes.
The salient points were noted as follows:

- On review, data evidences an increase in the number of the serious incidents reported ,with 4 incidents reported during January 2023, and 7 serious incidents reported in February to our Commissioners ,which is on the mean and is not considered to be an astronomical data point.
- 3 related to the death of a service user in the community, 1 related to serious self harm following ingestion of a substance, 2 serious physical assaults where one related to the service user as the perpetrator and another as the victim and 1 incident related to a ward closure following a Covid outbreak at one of our sites.
- At the time of writing this report there are 28 live incidents in the review process, excluding infection control reviews, of which 6 exceed 60-day review deadline. This is a reduction from 8 on prior month and evidences a continued reduction month on month. The average time for completion of a review has been evidenced as being 65 days. This is a reduction from 90 days on prior month. Delayed investigation and completion of SI's leads to delayed learning for services and the organisation and increases the risks of a further incident of this type from reoccurring.
- Delays in completion of SI's have been highlighted as being due to a number of cases having been overdue as a result of capacity issues within the Patient Safety Team, delayed meetings with relevant staff or awaiting additional information from other agencies. The Patient Safety Lead and team will be working closely with the Divisional teams to work towards the 60-day KPI.

- In terms of completed reviews, 5 reports were submitted to our commissioners for consideration of closure. Prior to submission the reports were reviewed by our recently re-established serious incident oversight pathway, a group that includes executive membership and divisional representation from senior leaders, which forms part of our PSIRF preparation.
- Most of the complainants are under the age of 44. There are a similar number of female and male complainants. The main ethnic groups for complainants are White-British, Black Caribbean, and Pakistani. Meaningful comparison of this data is not yet enabled as this is the 1st time data of this type has been included quarterly. On-going monitoring of this data, its meaning, and impact will be enabled as more regularly reviewed through this committee. It is anticipated that further information including Religion, Marital Status, and Sexual Orientation will be part of this review process going forward.

- During the month there has been a total of 3 inquests held with 2 concluded as

suicides and one given a narrative verdict concluding that the service user died from a self-tied ligature due to the nature of her serious mental health condition, however her intentions were unclear.

- A PFD has been issued by the Coroner in relation to Mr S with a response due on the 11th of May. The SU was resident in HMP Birmingham and the main concerns relate to lack of psychiatry input into the MDT rounds and absence of risk assessment documentation on the prison system 1. A meeting has been held with the key stakeholders including from HMP Birmingham and actions agreed as follows;
  - A 3-month pilot will be commenced ensuring psychiatrist attendance at all associated MDT rounds – findings of the pilot will be shared through local CGC with recommendations made as to whether this should become regular established practice
  - A meeting will be held with the administrators for System 1 to make the relevant changes on the system. An interim measure is to be implemented by implementation of an SOP standardising the processes around completion of risk assessment documentation on Rio.

- During February there were a total number of 2210 incidents reported, which is a decrease in the number reported in the previous months, however, it is too early to say if this is a trend. The majority of incidents resulted in no harm. There has been a decrease in reporting in the following areas:
  - Self harm behaviours
  - Physical Assault & Attempted Assault
  - Medications

- There are currently 3616 incidents identified as currently awaiting managers sign off. This is a reduction from 3753 on prior month. The delay in timely closure of incidents leads to a lack of assurance regarding lessons learned and leads to a risk of increased incidence of harm, the non-detection of near misses, and missed opportunity for learning.
- A proposed methodology for the closure of overdue incidents was presented and formally agreed by committee for closure of historical incidents and is currently being worked through. The 1st phase of the roll out of this work is almost complete with all incidents from 2011 – 2020 having been reviewed and anticipated to be safely closed by the agreed timeline of the 14th of April.

- 86% of our incidents reported during February resulted in no harm. The Trust remain below the national average for incidents resulting in harm to patients (39%) in accordance with the National Reporting and Learning System benchmark reporting and we also measure favourably in this area in the CQC Insight report.

- During the month of February 150 incidents were reported which is within the mean. Most incidents occurred within the trusts acute inpatient setting. A program of works to support the prevention of self-harm incidents is being rolled out across the trust and include;
- During the month there were 19 ligature incidents reported, 0 of these with an anchor point. This is an area of continued focus for the trust. The Patient Safety team undertake a rapid review to identify if there is any immediate learning for the anchor point incidents.
  - Roll out of en-suite door alarm systems
  - Roll out of bedroom door alarm system on high-risk wards (Larimar, Melissa and Citrine all programmed for this financial year)
  - Reviewing therapeutic observation practice
  - Reviewing safe staffing levels and implementing daily staffing huddles
  - Rolling out additional therapeutic activities

- The total number of actual assaults on staff for the month of February totaled at 95

which is on the median. Previously there were seven consecutive months in reporting above the median showing an upward trend in reported assaults. Operation Stonetthwaite is being expanded within the organisation. Education around the need for prompt completion of appendix 5 and conversations within the medical directorate around RC support for seeking prosecution (where appropriate). This will feature as a quarterly update for RRPSG and Trust H&S committee regarding assurance and updates moving forwards. Review of TRiM and post incident support structures.

- The total number of reported assaults on service users for the month of February is 46. A number of the reported incidents involved the same service users, of the 5 incidents reported on Caffra.

Chair's assurance comments:
Committee noted the report and gained reasonable assurance
We were pleased to note the progress made with continued reduction month on month of the average time for completion of a serious incident review
We noted the first set of baseline data to be presented to committee detailing a thematic review of complaints including protected characteristics and further monitoring and analysis of its meaning and impact will be regularly reviewed through this committee

1.3 Infection, Prevention & Control (IPC)

The Committee received the Infection, Prevention & Control update.

The Committee were assured the IPC team continues to carry out an IPC audit program and IPC spot-checks for outbreak areas. There was only one visit during March to Mary Seacole Ward 1 with an overall score of 81.47%.

The IPC team also conducts spot checks weekly for each outbreak area, with a total of 5 visits and subsequent reports produced.

Since the 1st of March the IPCT has received 7 notifications of alert organisms and/or conditions requiring IPC response (not outbreak related).
During this period an E coli Bacteremia was diagnosed. IPC is currently conducting a post infection investigation to determine if this could have been avoided. The findings will be disseminated with the appropriate stakeholders once the investigation is concluded.

The Committee were assured the Trust keeps a strict policy of isolate, test and investigate the positive cases.
There were no COVID outbreaks where the first detected case was in March.
At the time this report is being produced, there are 3 open outbreaks (less than 28 days but more than 10 since the last positive case.

As in previous months, the most affected group are the service users. This is likely related to the mandatory use of masks by staff, that does not happen with SU were the use of masks is advised but cannot be mandated. Also, in some cases there have been challenges in ensuring SU are compliant with isolation, therefore causing the spread of the outbreak. It is also important to mention that regardless of the ratio, the IPC team continues to identify issues with compliance with PPE.

Chair's assurance comments:
Committee gained limited assurance . We do not currently have a centralized overview across all clinical areas - both inpatient and out patient
We noted the plan for a new audit oversight process and the proposed implementation of a live dashboard which will improve the line of sight for committee

1.4 Clinical Audit

The Committee received the clinical audit and noted the 2023-2024 Clinical Audit Programme has been developed to ensure full participation in all mandated National Clinical Audits for Mental Health NHS trusts as dictated by the Annual Quality accounts list, provided by HQIP.

The annual audit programme will ensure that key practice areas are assessed for compliance against policy and evidence-based standards and is a key part of ensuring trust responsibilities are met. It is built by piecing together our national requirements, requirements from external recommendations such as Prevention of Future Death reports (PFDs), independent reviews, and inspections, plus internal serious reviews or concern over policy implementation issues and NICE guidance.
This work is overseen by the Clinical Effectiveness Advisory Group.

The Committee noted that the team are currently in the process of reporting our national mandated audit participation from 22/23, as part of the NHS Quality Accounts. We are also confirming the status of any new audits for the 2023/24 programme, and reviewing any audits that may need to be carried over to the 23/24 programme.

Key points from the presentation were noted as:
Clinical Effectiveness Advisory Group
- Chaired by Dr Nat Rowe (Deputy Medical Director for Quality and Safety).
- The membership includes clinical leads, pharmacological experts, physical health experts, deputy director of nursing, clinicians, and the effectiveness team.
- Key responsibilities related to audit:
    - Monitoring HQIP and Quality Account audit lists for any relevant audits
    - Reviewing Level 1/2/3 audits in conjunction with relevant directorate
    - Creating action plans (on Eclipse) to monitor process of improving care/experience through reviewing audit reports
    - Developing and sharing learning materials and opportunities resultant from the activities of the Group
    - Lead on the continued development of the Clinical Audit Policy and NICE Policies for the Trust
    - Report to the Clinical Governance Committee any exceptions to the achievement of the annual work plan and resulting risks
    - Governance of the deployment of the annual clinical audit programme

Reporting of Outcomes
- The Clinical Effectiveness Advisory Group and Pharmacological Therapies Committee share responsibility in reviewing POMH (Prescribing Observatory for Mental Health) audits (Level 1s). Other audits in the same category such as NACEL (National Audit of Care at end of Life) are discussed first in their relevant directorate, before coming to CEAG to allow further discussion on actions/outcomes.
- Directorates also have their own audit committees, such as the Acute Care Audit Committee, which allows for focused time on audits with relevance to the service.
- Outcomes are reported on a quarterly basis to Commissioners and on a six monthly basis to Clinical Governance Committee, Audit Committee and the Integrated Quality Committee.
- Outcomes are also reported publicly in our Quality Account.

Audit, QI and Triangulation
- Within the trust the Quality Improvement and Clinical Effectiveness sit under one team - QICE. Having the two together naturally allows for joint working and transitions when fulfilling the Quality domain within the trust.

Audit Training

- Audit training was held on two occasions in 2022, and there was good attendance in both sessions. The upcoming plan is to deliver two to three sessions in 2023. This will be advertised via Connect and is open to anyone who has an interest in Audit / QI, irrespective of their role or position within the trust, showing our commitment to being inclusive.
- Preceptorship Training, which is available to nursing staff. This looks at the background of audit (and QI), and goes into more detail on the process of audit, using Trust examples to help understand why this is an important part of the clinical effectiveness processes.
- Training is reviewed annually to ensure we are offering updated information and continually improving our process, in line with any national or local changes that may have occurred in the last year.

Trainee-Led Audit Group

- In September 2022 a group was set up for psychiatric post graduate doctors in training to attend, to learn about clinical audit and to complete audits in small groups, led by doctors who were more experienced in this, with the opportunity to present to the group. An "audit of audits" was completed initially, looking at the Level 4 audits that had been completed over the last 2 years and these were them reviewed by the group, looking at either the most important clinical topics, or the most robust and repeatable methodology.

Overall the Committee noted there has been a great effort from all directorates to ensure data was collected, and reports were disseminated for high priority audits. The changes in CEAG have also helped create an avenue for audit outcomes to see more effective progress, in part through creating a more inclusive environment for staff to participate.
The Committee were assured the main goal in 2023 is to add the other aspect of inclusivity by looking at how service users can be involved in audits at any level.

Chair's assurance comments:

Committee gained reasonable assurance and noted the ongoing progress .
Next month we will get an update on lessons learnt from all the key audits.
Also Clinical Effectiveness lead will report the annual plan to committee

1.5 PSIRF Implementation

The Committee received the report and were informed that in August 2022 NHS England published the Patient Safety Incident Response Framework (PSIRF). This sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF replaces the Serious Incident Response Framework (SIF) and will remove the 'serious incident' classification.

Organisations are expected to transition to PSIRF within 12 months from September 2022. The preparation has been broken down into six phases to ease transition and provide detail around discrete activities that will set strong foundations for implementation.

Phase 1 – PSIRF Implementation
To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated documents. This phase establishes important

foundation for PSIRF preparation and subsequent implementation.
This phase has been reviewed and identified as complete in that the key components of the phasing have been delivered.

Phase 2 – PSIRF Implementation
To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
This phase has been reviewed and identified as underway and almost complete in that the key components of the phasing have been delivered.

The Committee were assured by the next steps as:

- Inaugural launch of the Implementation Team Meetings
- Monthly updates to CGC and QPES of current position against PSIRF implementation requirements
- Launch of organisational comms to promote understanding of PSIRF – Comms plan has been prepared and will be signed off by the Implementation Team
- Move to Phase 3 of the PSIRF implementation plan.

Chair's assurance comments:

Committee gained good assurance on implementation of PSIRF and were pleased to note the support to this process from the project management team (PMO) and the very active engagement from the divisions

1.6 Integrated Performance Report

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

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

There were 112 reported staff assaults, 2 of which were categorised as medium harm. This is the 7th consecutive month that the data has been above the median showing an upward trend.

11 assaults were reported in Male PICU with 2 on Meadowcroft and 9 on Caffra. 1 of the incidents on Meadowcroft was categorised as moderate harm with the staff member requiring paramedic attendance. Bergamot recorded 27 patient on staff assaults,; 1 person has been recorded in 21 incidents as instigator. On Tazetta the single incident was categorised as moderate harm. This involved an informal service user attempting to punch a staff member leading to physical intervention. Service user was discharged

from services and police contacted in relation to assault.

Chair's assurance comments:

Committee noted the report

1.7 Forward planner

The Committee received the forward planner for approval.

Chair's assurance comments:

Further work is required to pull together the previous feedback and discussion on the content and will be brought to committee next time for approval

1.8 Review of the BAF

The Committee held a detailed discussion in relation to the Board Assurance Framework and noted an update will be bought to the next Committee meeting.

Chair's assurance comments:

The Committee held a detailed discussion in relation to the Board Assurance Framework and noted an update will be bought to the next Committee meeting

1.9 Minutes and Sub Committee escalations from the Clinical Governance Committee

The Committee noted the escalations and recommendations from the Clinical Governance Committee.

Chair's assurance comments:

Clinical governance committee did not meet this month due to lack of quoracy due many staff on leave .We were reasonably assured that members met by exception yesterday to review the CQC action plan and that upcoming CGC will include 2 months reporting

1.10 Matters of escalation to the Board

Committee wished to escalate to board the soft intelligence gained about the impact on staff morale of external media messaging about the CQC report and consideration of internal comms about the positive messages contained within the CQC report

DR LINDA CULLEN
NON-EXECUTIVE DIRECTOR

7.1.1. (b) QPES Chair's Assurance Report May

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: Quality, Patient Experience and Safety Committee**
Report presented at	**BOARD OF DIRECTORS**
Date of meeting	**7 June 2023**
Agenda Item	**7.1 (b)**
Date(s) of Committee Meeting(s) reported	**24 May 2023**
Quoracy	**Membership quorate: Y / N**
Agenda	The Committee considered an agenda which included the following items: 1. CQC Update and Action Plan 2. Patient Safety report including NICHE pathway review 3. Prevent update 4. Learning from Homicides and Suicides incl. NCISH Annual Report 5. Safeguarding update including Deep dive- Think Family 6. Clinical audit- learning 7. Ockenden action plan 8. Integrated Performance Report 9. Clinical services strategic priority 22/23 update and 23/24 goals 10. Quality strategic priority 22/23 update and 23/24 goals 11. FTSU update 12. Updates on review of the Forward planner and ToR 13. Updates on the Review of the BAF 14. Review and scrutiny of risk register 15. Board Committee Annual Self-assessment Survey Questionnaire 16. Quality Account
Alert:	The Committee wishes to alert the Trust Board to the following: • Serious incident Actions : -Following a focused piece of work there are currently a total of 82 overdue actions, which includes our clinical and corporate services. The Patient Safety Team will continue to work with the Divisions to close outstanding actions. This work will be supported by the Clinical Governance Facilitators and the Divisional SLT's where timelines for closure have been requested.

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	• Prone Restraint : The figures evidence there was a significant increase in the number of reported prone restraints for the month of March with 69 incidents being reported, despite this being an increase of the previous month of 36, which is on the median. Increase in reporting has been across all areas.
Assurance:	The Committee was assured on the following: • Following consultation with service areas, subject matter leads and the Executives, we submitted the agreed action plans in response to the Must and Should Do findings to the CQC on May 12th. We have had acknowledgment of receipt of the action plans from the CQC with a request for monthly updates to our lead inspector. The first of which will be provided ahead of our monthly monitoring meeting on June 20th. • There are 26 live serious incidents in the review process, excluding infection control reviews, of which 6 exceed 60-day review deadline. This is a reduction from 6 on prior month and evidences a continued reduction month on month. The average time for completion of a review has been evidenced as being 65 days. This is a reduction from 90 days on previous months. • Prevent training levels are compliant with those required by NHS England and Improvement. • By end of June 2023 sixty safeguarding supervisors will have been trained – these supervisors will support reflective discussions for identified safeguarding cases where children are known to live in the home and are subject to child protection planning The safeguarding team has worked with the communication team to develop a Think Family Standard. Once finalised, this will be shared with clinical teams through the Think Family Launch which is scheduled for June 2023 The safeguarding team have approached the Quality Improvement team and will be working with them to develop systems to monitor how the Think Family system is working trust wide. • The capacity and leadership of the safeguarding team is currently challenged and approval of a recent business case to increase the capacity is going through recruitment processes. • 87.5% of patients had a review of their clinical response to their medication documented based on a sample of 8 patients within the past 3-6 months. Majority of the patients had at least 1 of the physical health measurements conducted in the past year.

Birmingham and Solihull Mental Health NHS Foundation Trust

	• Positive improvements were provided in relation to the updates on our 2022/23 Trust Clinical Audit Planner progress and any learning from the year. • The Committee were assured as an organisation the Trust has developed an action plan against all areas of governance following the publication of the Ockenden report that is being provided through sub-committees to the Trust Board. • For 2022/23 the Clinical Services Strategic Priority had a total of 44 goals spread across 6 strategic aims, 30 of which were prioritised as level 1 or 2. (level 1 report to Board and level 2 report to Committees) There are a total of 38 proposed goals for Clinical Services for 2023/24, of which 27 have been prioritised as level 1 or level 2. The Committee noted good progress has been made in year 2 of the strategy despite continued pressures faced by our clinical services during this period and that plans are in place where goals are not on track against milestones. The Committee approved the proposed goals for 2023/24. • For 2022/23 the Quality Strategic Priority had a total of 11 goals spread across 5 strategic aims, all of which were prioritised as level 1 or 2. There are a total of 16 proposed goals for Quality for 2023/24, all of which have been prioritised as level 1 or level 2. The Committee noted good progress has been made in year 2 of the strategy despite continued pressures faced by our clinical services during this period and that plans are in place where goals are not on track against milestones. The Committee approved the proposed goals for 2023/24. • The Board approved the Champion Network strategy in March 2022 and the first Champion cohort was recruited after a soft communications launch in Speaking Up month in October 2022. Our Guardian, Lucy Thomas leads on the Champion project and has successfully recruited eight Champions in Cohort one Freedom to Speak Up Champions with a further four Champions having submitted an expression of interest for Cohort two.
Advise	The Committee was advised of the following matters: 1. Given the evidence that we have submitted to date (28 monthly submissions to date), we have been advised that the CQC will stand down the Section 31 notice in June. We were requested to submit one final summary report for May in support of this. 2. Following presentation at the Serious Incident Oversight group 12 incidents proceeded to a full RCA review during the month of March. 3. The Independent Review of Prevent was released by the government in February. The government has accepted all of the recommendations. Some of these may have a slight impact on BSMHFT Prevent delivery.

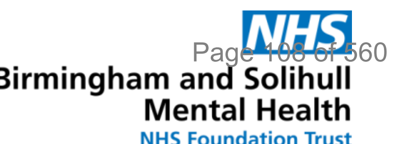
Birmingham and Solihull Mental Health NHS Foundation Trust

	4. Due to increased management arrangements within the last month risks reviewed and updated has increased from 58% to 71% with the number reducing from 149 to 97. It is anticipated that the steps currently being undertaken will continue to drive improvement. All risk holders of overdue risks have been contacted and are requested to provide a review that will be updated at the next Clinical Governance meeting. 5. As part of good governance, it is important for members of Board Committees to annually complete a monkey survey in self-assessing the effectiveness of their committee as this will enable them to identify any learning, gaps and areas for strengthening and improvement.
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: 1. N/A

Report compiled by	Linda Cullen, Non-Executive Director	**Minutes available from:** Lorraine Joyce, Executive PA

DRAFT

7.2. Patient Safety Report



Meeting	**BOARD OF DIRECTORS**		
Agenda item	Item 7.2		
Paper title	Patient Safety and Experience Report		
Date	7 June 2023		
Author (s)	Lisa Pim Interim Associate Director of Nursing and Governance		
Executive sponsor	Sarah Bloomfield, Executive Director of Nursing, Quality and Safety Steve Forsyth, Interim Executive Director of Nursing, Quality and Safety		
Executive sign-off	☐ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

The Board are asked to note the following key highlights from the detailed report;

At the time of authoring this report there are 35 live incidents in the SI review process, excluding infection control reviews. This is an increase from 21 reported to the Board in March 2023, **an increase of 14 incidents**. Whilst the 60-day mandated investigation standard has been removed externally since the COVID pandemic, the trust should still be working to this as an internal standard as deferred investigation and completion of SI's leads to delayed learning for services and the organisation and increases the risks of further incidents of this type from reoccurring.

- It is noted that currently 4 investigations exceed 60 days, **this is a reduction from 8** when this data was presented to Board in March. The average time for completion of a review has been evidenced as being 65 days, **this is a reduction from 90** previously reported.

- The data for serious incidents within the detailed report evidences an upward shift in incidents reported as SI's from December onwards. It is highlighted to the Board that this increase in SI activity is impacting significantly upon the workload of the Patient Safety Team. A paper was submitted to the executive team requesting additional resource to manage the current number of SI

investigations in the interim period awaiting transition to PSIRF. Resource was approved, however current NHSE financial arrangements require additional business cases to be submitted for any agency requirement over 25 days (clinical or on-clinical), to the ICB and then forwards to NHSE for final approval

- A review of themes and trends from SI reporting in this reporting period indicates a fairly broad variation in the type of incidents reported as SI's noting though a sustained high number of investigations relating to patient deaths in community settings and lower levels of inpatient harm reporting. However, reported outcomes from SI's have shown some consistency in themes relating to documentation, specifically lack of regularly updated Risk Assessments and Care Plan documentation, interprofessional communication and referral between teams, and a lack of professional curiosity delaying aspects of care and treatment

- In the previous Board Report, it was noted that there has been a lack of health inequality information submitted as part of regular reporting to CGC and QPESC in respect to serious incidents alongside a broader suite of indicators including quality metric reporting and patient experience data. It has been agreed that quarterly reporting of this important data will now be carried out through formal committee routes and the first analysis for SI's, and Quality Metrics will be completed in July. This will then be shared with the Trust Board in the corresponding Patient Safety Report. Complaints has commenced this process, and this forms part of this board report.

- The report evidences that there are 112 open SI actions currently, the earliest dating back to 2017. It can be seen that the highest performing Division are Secure Care with no open actions. Acute and Urgent Care have the largest volume of open and overdue actions with 55 open SI Actions (49% of all open SI actions) of which 49 are overdue. A meeting is to be arranged with the Divisional Leads to agree a trajectory for closure and what support is required at corporate level to enable this robustly. A prioritized approach on Acute and Emergency Care will be taken first.

- The organisation has a healthy reporting culture with between 2000 and 2250 incidents being reported on a monthly basis. In addition, on average 80-85% of these incidents are reported as no harm

- Data shared as part of the previous Board report indicated that there were a significant number of open incidents on the system (2011-2023), equaling a total of 4535. Furthermore, 82-85% of incidents were overdue for action with 16% of these (708 incidents) predating 2022. As of the end of April, there are 2800 incidents open on Eclipse identified as currently awaiting managers sign off. This is a significant reduction of 1753 in incidents from the prior reporting period. All incidents pre-dating 2020 have been safely closed using agreed methodology.

- The paper draws attention to the recently concluded and published external NICHE Reviews following two historical domestic homicide incidents occurring in 2014, and an independent multi-agency review on behalf of the statutory services involved (mental health, police, probation, and prison services) into the care, treatment, and management of a service user, who committed a number of stabbings in Birmingham city centre in September 2020. In response to the learning points generated as part of the external review process, the Patient Safety Team have now facilitated the formulation of action plans alongside Divisional colleagues. Progress on the action plans will be reported through local CGC and formal committee reporting at Trust level until closure

- There have been some areas of required improvement identified in how the organisation responds to and monitors on-going actions from external reviews. Improvement work has commenced through devising a formal policy and improving the internal process of monitoring and committee reporting

- The paper draws attention to two recent Regulation 28 Ruling issued to the Trust and other health organisations within the Birmingham and Solihull Integrated Care System. The coroner has now received responses in both cases, and these are detailed further within the report.

- There have been some areas of required improvement identified in how the organisation responds to and monitors on-going actions from PFD's. Improvement work has commenced through devising a formal policy and improving the internal process of monitoring and committee reporting

- In the previous Board Report, the key principles and requirements of the Patient Safety Incident Response Framework (PSIRF) were laid out to support the Boards knowledge and enable understanding of associated timelines of transition. The expected timeline indicates that the organisation should by now have progressed to Phase 3 of transition relating to Governance and Quality Monitoring. At this stage, organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF. There is also significant amounts of data analysis to look at the Trusts safety themes and trends and to understand the work already under way to address these supporting a greater understanding of future safety responses moving forwards.

- In line with the move towards the PSIRF way of working, the paper discusses the recently piloted Safety Summit. Broadly this inaugural summit was successful with four QI workstreams emerging from the event. Additional Safety Summits focusing on incident categories are also under way with the first summit of this type focusing on Clozapine toxicity and being chaired by the Executive Medical Director.

- Currently there are 17 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer (total 36 so 47%). **This has increased by 9%** since the last Board report.

- The average age of a case is 76 working days **(this has decreased by 4 days** as the team have closed down some very old cases). The average time it is has taken to allocate a case to an Investigating Officer is 66 working days. These average times exclude Bank Holidays and weekends.

- Both these targets do not meet best practice standards and continued work is being undertaken by the Complaints Lead to improve these KPI's. Similarly, to the Patient Safety Team, additional resource has been requested in a paper to the executive team. Whilst approved, the same financial restrictions remain in place for agency. An additional experienced bank person has been found more laterally in the last week that will offer additional experience to the team

- A review of open complaints actions has been undertaken. The position is detailed in the report vie Division and remains static to that reported to CGC and QPESC in previous months in that there are currently 36 complaints actions open in total with **97% of actions (35) now overdue**. A number of these actions are identified as being over 12 months in age. Reasons identified for this have been multi-factorial in nature and include gaps in reporting transparently and effectively to Divisions and internal process around automatic allocation of timelines for actions, which can potentially appear unrealistic. Work is underway to address these areas within the complaints department and the team will work collaboratively with the Divisions and Clinical Governance Facilitators to close down outstanding overdue actions. A timescale for this piece of work has not yet been established but will be reported on through formal committee reporting

- For the purpose of this month's board paper, as agreed, a focused quarterly thematic review of complaints, including protected characteristics, is shared for information purposes. The Customer Relations Team received 13 formal complaints in Q4 at the time of reporting (01.01.23 – 24.03.23). This is a consistent number over the 12-month period

- The report details the themes for complaints received in the quarter which range from prescribing issues, appointment, and referral delays to issues with communication with the patient, which was the most reported theme in 8 of the 13 complaints received.

- An initial review of protected characteristics reveals most of the complainants are under the age of 44. There are a similar number of female and male complainants and the main ethnic groups for complainants are White- British, Black Caribbean, and Pakistani.

- Meaningful comparison of this data is not yet enabled as this is the 1st time data of this type has been included quarterly. On-going monitoring of this data, its meaning, and impact will be enabled as more regularly reviewed through this report. It is anticipated that further information including Religion, Marital Status, and Sexual Orientation will be part of this review process going forward.

What is the ask? ***(Please state specifically what you like the meeting, committee or Board to do). highlights from***

Board is requested to:
NOTE this report, the information there within it and note the actions underway to support progression on areas of required improvement
GAIN ASSURANCE that patient safety indicators are closely monitored and actions underway to improve performance where required.

Confirm level of assurance demonstrated and evidenced in the report (tick as appropriate):

☐ Substantial Assurance
☐ Reasonable Assurance
☐ Limited Assurance
☐ No Assurance

Previous consideration of report by: (If applicable)

Elements of this report have been consistently discussed at the Clinical Governance Committee and QPESC.

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)*

No additional resource is being requested in terms of this paper.

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

None known currently

Equality impact assessments:

The Patient Safety Quarterly Report is at the early stages and data specifically pertaining to protected characteristics are minimally examined. As identified, work will continue to develop in the coming months in order to identify any health inequalities and to share with committees within BSMHFT and partner organisations.

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

The work outlined within the detailed report has involved engagement with staff, service users and the families of the bereaved. Those families who have been bereaved have been offered the support of the family liaison officer.

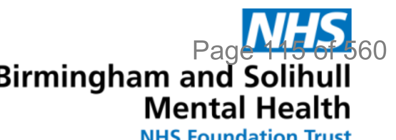
Acronyms *(List out any acronyms used in the report)*

Acronyms have been explained throughout the body of the report

Defining levels of assurance:

Level of assurance	Definition
Substantial Assurance	The evidence provided demonstrates there is a sound system of governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.
Reasonable Assurance	The evidence provided demonstrates there is generally a sound system of governance, risk management and controls in place. However, there are some issues e.g., with quality, non-compliance and performance that have been identified which may put at risk the achievement of objectives in the Division or Department, hence there is scope for improvement.
Limited Assurance	The evidence provided demonstrates there are significant gaps, weaknesses or non-compliance that have been identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the Division/Department.
No Assurance	There is absolutely no evidence to demonstrate, hence immediate action is required to address the fundamental gaps, weaknesses or non-compliance that have been identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the Division or Department.
Assurance (System/process-based assurance & outcome-based assurance)	Provides certainty through the evidence you may triangulate in demonstrating confidence that systems and processes are working properly and what needs to happen is happening (i.e., system/process-based assurance). However, this may not imply that expected outcomes will be achieved as planned (outcome-based assurance).

	It is often useful to stop and ask: • Do we really know what we think we know? • Where does the assurance come from? • How reliable is this assurance? • What is this assurance telling us?
Reassurance	This is the feeling of being assured and may be based on good performance, the lack of contradictory evidence or perhaps because someone with a professional background or expertise or management, tells you that something is so, and so it must be true.
Assurance is defined as - “...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization.” (HM Treasury – 2012).	



MEETING	BOARD OF DIRECTORS
AGENDA ITEM	Item 7.2
PAPER TITLE	Detailed Report – Patient Safety and Patient Experience
DATE	7 June 2023
AUTHOR	Lisa Pim Interim Associate Director of Nursing and Governance
EXECUTIVE SPONSOR	Sarah Bloomfield, Executive Director of Nursing, Quality and Safety Steve Forsyth, Interim Executive Director of Nursing, Quality and Safety

Detailed Summary:

1.0 Serious Incidents

1.1 Reporting Levels

At the time of authoring this report there are 35 live incidents in the SI review process, excluding infection control reviews. This is an increase from 21 reported to the Board in March 2023, **an increase of 14 incidents**. Whilst the 60-day mandated investigation standard has been removed externally since the COVID pandemic, the trust should still be working to this as an internal standard as deferred investigation and completion of SI's leads to delayed learning for services and the organisation and increases the risks of further incidents of this type from reoccurring.

It is noted that currently 4 investigations exceed 60 days, **this is a reduction from 8** when this data was presented to Board in March. The average time for completion of a review has been evidenced as being 65 days, **this is a reduction from 90** previously reported. Continued work is being undertaken on this area working collaboratively with the Patient Safety Team and Divisions to facilitate more timely investigation timelines.

The table below outlines the numbers of incidents reported as Serious Incidents (SI's) from January through to April;

Month	No of Incidents Reported as SI
January 2023	6
February 2023	8
March 2023	12
April 2023	4

The data for serious incidents evidence's an upward shift in incidents reported as SI's from December (1), with the exception of April where a decline in overall numbers occurred.

It is highlighted to the Board that this increase in SI activity is impacting significantly

upon the workload of the Patient Safety Team. A paper was submitted to the executive team requesting additional resource to manage the current number of SI investigations in the interim period awaiting transition to PSIRF. Resource was approved, however current NHSE financial arrangements require additional business cases to be submitted for any agency requirement over 25 days (clinical or on-clinical), to the ICB and then forwards to NHSE for final approval. The ICB Finance Director has advised that a process for this has not yet been worked up including the business case template that will be required. In the meantime, the Interim Executive Director of Nursing and Executive Medical Director have contacted their ICB counterparts to stress the urgency of approval.

Delays in additional resource being made available may impact overall investigation timelines which the team have worked diligently to align with the 60-day standard and may also delay ability to complete incident scoping reports within a timely manner. There has been some early signs of these challenges during May, whereby an inquest had to be delayed due to an incomplete RCA.

1.2 Serious Incident Themes

A review of themes and trends from SI reporting indicates a similar position to the last reporting period in that there remains a fairly broad variation in the type of incidents reported as SI's, noting a continued elevated higher number of reports pertaining to patient deaths in community settings and lower levels of inpatient harm reporting. However, reported outcomes from SI's have shown some consistency in themes relating to documentation, specifically lack of regularly updated Risk Assessments and Care Plan documentation, interprofessional communication and referral between teams, and a lack of professional curiosity delaying care and treatment. It is anticipated that moving forward these trends and themes will be addressed through areas such as the internal clinical audit programme and through QI workstreams.

In the previous Board Report, it was noted that there has been a lack of health inequality information submitted as part of regular reporting to CGC and QPESC in respect to serious incidents alongside a broader suite of indicators including quality metric reporting and patient experience data. It has been agreed that quarterly reporting of this important data will now be carried out through formal committee routes and the first analysis for SI's, and Quality Metrics will be completed in July. This will then be shared with the Trust Board in the corresponding Patient Safety Report.

Complaints has commenced this process, and this will be shared later in the report.

1.3 SI Actions

The table below highlights the current SI actions open as an organisation and per Division;

Year action due	No of SI open actions	No Overdue	Ongoing (In date)
Urgent Care			
2018	1	1	0
2022	6	6	0
2023	5	5	0
Acute Care			
2019	1	1	0
2022	31	31	0
2023	11	5	6
Dementia & Frailty			
2017	1	1	0
2021	6	6	0
2022	7	7	0
Specialties			
2023	2	2	0
HMP			
2022	14	14	0
Secure Care			
No open actions	0	0	0
SOLAR			
No open actions	0	0	0
Recovery			
2021	1	1	0
No date in report	2	0	2
Community			
2020	1	1	0
2021	1	1	0
2022	8	8	0
2023	13	10	3
No date in report	1	0	1
Total Overall			
	112	100	12

It can be seen that the highest performing Division are Secure Care with no open actions. Acute and Urgent Care have the largest volume of open and overdue actions with 55 open SI Actions (49% of all open SI actions) of which 49 are overdue. A meeting is to be arranged with the Divisional Leads to agree a trajectory for closure and what support is required at corporate level to enable this robustly.

2.0 Local Incident Investigation

2.1 Reporting Levels

As reported, a deep dive of open local incident investigations was undertaken in January including all incidents currently open on the system back to 2011 when Eclipse

was 1st integrated into the Trust. Data indicated that there were a significant number of open incidents on the system (2011-2023), a total of 4535. Furthermore, 82-85% of incidents are currently overdue for action with 16% of these (708 incidents) predating 2022.

A methodology and approach for the safe closure of these historic incidents was agreed by the Executive Director of Nursing, Quality and Safety and shared through QPESC. The approach ensured all incidents are safely reviewed and any necessary actions taken forward.

As of the end of April, there are 2800 incidents open on Eclipse identified as currently awaiting managers sign off. **This is a significant reduction of 1753 in incidents** from the prior reporting period. **All incidents pre-dating 2020 have been safely closed** using agreed methodology.

2.2 Themes and Trends

During the period of February to April, it is evidenced that generally incident reporting has been sustained at highest levels within the areas of:

- Self-harm behaviors
- Physical Assault & Attempted Assault
- Workforce and Staffing

There are a number of trust wide workstreams and initiatives in place supporting each of these themes and continued monitoring of themes and the success of these initiatives will be taken through formal committee reporting.

3.0 External Reviews

3.1 Current Position

The Board will have been previously informed that NHS England Midlands & East (NHSE) Regional Investigations Review Group as a proportionate response commissioned NICHE to undertake a pathway review of the organisation’s AOT and FIRST services in response to two historical domestic homicide incidents occurring in 2014.

The report highlights a number of areas of low compliance/performance against the audit criteria which includes;

- The number of service users without an up-to-date CPA care plan.
- The number of service users without an up-to-date risk assessment.
- Difficulty to find information about carers and carers’ assessments.
- Staff adherence to medication plans was not 100%.

In response to the learning points generated as part of the external review process, the Patient Safety Team have now facilitated the formulation of an action plan alongside Divisional colleagues. Progress on the action plan will be reported through local CGC and formal committee reporting at Trust level until closure.

NHSE also commissioned NICHE to carry out an independent multi-agency review on behalf of the statutory services involved (mental health, police, probation, and prison services) into the care, treatment and management of a service user, who committed a number of stabbings in Birmingham city centre on the 6th of September 2020. A pre-publication meeting of that report was held with all key stakeholders on the 25th of May to review the report and its recommendations in full. For BSMHFT specifically this was;

The service description for the BSMHFT Prison Discharge Service is dated 2016 and requires review because it no longer reflects the remit and work of the service. There is lack of clarity about the scope and remit of the CPNs within the prison discharge service or the role of the CMHT care coordinators. It is not clear which role has responsibility for the liaison with prison MHITs and MAPPA.

BSMHFT must develop an up-to-date service description/operational policy for the prison discharge service that:
• clearly defines the service offer;
• describes how the service interfaces with other BSMHFT services;
• describes the roles and responsibilities of each team member; and
• describes the responsibilities, scope and remit of the CPNs within the prison discharge service and care coordinators for service users detained in prison, to ensure effective liaison with prison MHITs and MAPPA.

An initial meeting has been arranged with the Divisional Leads and Prison Services on the 31st of May to agree the timeline for completion of this piece of work. Progress on work will be reported through local CGC and formal committee reporting at Trust level.

NHSE have also commissioned Psychological Approaches to undertake a review of the present-day service provision, governance and quality systems, arrangements for escalating risks in response to a homicide which occurred in 2018, with a focus on;

- Access to AMHP services
- Services listening to relatives.
- Regulation 28 report requirements

The organisation are awaiting the review process to commence. Progress will be reported through formal committee reporting.

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3.2 Monitoring of the External Review Process

As described, there have been multiple areas of improvement identified in how the organisation responds to and monitors on-going actions from external reviews. Work has commenced on devising a formal policy and improving the internal process of monitoring and committee reporting.

4.0 Regulation 28 Coroner Reports

4.1 Current Position

4.11

The Board will recall the previous 28 regulation report following an inquest on the 11th of January, which related to the suicide of one of our service users. The report was issued to a number of organisations which included;

- Birmingham and Solihull Mental health NHS Foundation Trust
- Birmingham and Solihull Integrated Care Board
- University Hospital Birmingham NHS Foundation Trust

The response was compiled and submitted to the Coroner on the 28th of April.

The response highlighted the agreement to establish a system wide clinical oversight group. At BSMHFT this would be facilitated through the Mental Health Collaborative with work on clinical pathways and access to services being streamlined and joined up under one programme linking clinical and operational elements along the whole pathway across all provider organisations. The clinical work programme will also include an immediate adoption of jointly owned care standards across the pathway, with audit and learning against provided care, and exploration of different PDU models to meet ICS need. This group will report into ICS quality governance.

4.12

The Coroner issued a second PFD to the Trust on 15th March 2023. The Service User died at City Hospital on the 28th January 2022 having been admitted after he was found in cardiac arrest in his cell at HMP Birmingham on the 27th January 2022. He had asphyxiated due to placing a bag over his head.

The Coroner identified two concerns in relation the Trust, namely:

- that the prison mental health team multi-disciplinary team (MDT) does not include a psychiatrist; and
- the absence of any ongoing risk assessment documentation for patients with mental illness within the SystemOne records at HMP Birmingham.

A response to the above concerns was agreed and submitted on 26th April 2023.

The Trust has agreed the following actions;

- A 3-month pilot which will ensure a Consultant Psychiatrist attends the MDT meetings at the Prison each week. The Secure Care and Offender Health Clinical Governance Committee (CGC) will review the outcomes for the pilot after 3 months, to ascertain if this is clinically beneficial to patients
- A meeting with the software company on 27 to discuss the concerns raised within the PFD. A risk assessment has been added to the System One software that is accessible for the Trust staff only. This will be rolled out to staff with a dissemination plan. The plan includes a practice alert and a Standard Operating Procedure to be sent to all clinical staff

4.2 Monitoring of the Regulation 28 Process

As described, there have been multiple areas of improvement identified in how the organisation responds to and monitors on-going actions from external reviews. Work has commenced on devising a formal policy and improving the internal process of monitoring and committee reporting.

5.0 Patient Safety Incident Response Framework

In the previous Board Report, the key principles and requirements of the Patient Safety Incident Response Framework (PSIRF) were laid out to support the Boards knowledge and enable understanding of associated timelines of transition.

The expected timeline indicates that the organisation should by now have progressed to Phase 3 of transition relating to Governance and Quality Monitoring. At this stage, organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF. There is also significant amounts of data analysis to look at the Trusts safety themes and trends and to understand the work already under way to address these supporting a greater understanding of future safety responses moving forwards.

This next phase will be supported by the following;

- PSIRF Implementation Group – a cross-organisational MDT supporting the work up to PSIRF transformation including executive and non-executive membership. Inaugural meeting was held in April
- PSIRF sub-working groups focusing on specific elements of the patient safety framework including learning from deaths, just culture and organisational safety, learning and development, patient and carer engagement, and QI
- 2-day per week PMO support agreed by the Executive Director of Nursing, Quality and Safety – work continues to be informed by the PSIRF Implementation Plan

Key decisions will be required from the Board over the coming months in relation to the roll out of PSIRF. This includes;

- Training for PSIRF has mandated requirements from Board to Ward – Agreement of the training methodology to be employed as a trust will be required – An Options Appraisal is currently being prepared.
- Board sign off of the agreed number of Patient Safety Incident Investigations (PSII) we have calculated/forecast as an organisation and agreement of the key safety themes for 2023/24
- Agreement on the methodology/approach towards Organisational Safety Culture Assessment
- Consideration and agreement of oversight arrangements as the Lead Provider of the Provider Collaborative

6.0 Safety Summits

The Safety Summit approach to promoting multidisciplinary engagement and learning was highlighted in the last board report. This has now been piloted in April and was undertaken on Eden PICU. The pilot was a success with four agreed QI workstreams coming out of the 5-hour event. These will focus on;

- Workforce – right staffing, right skills, right environment
- Learning from Incidents – piloting some of the new learning responses from the PSIRF framework on the clinical area
- Devise and implement a comprehensive peer review process
- To increase knowledge and skills in the use of therapeutic observations

Feedback forms will be circulated to the key stakeholders to identify what went well and what could be improved regarding this first summit. Early feedback suggests that participants could be better prepared for the event both by the Divisional leadership and patient safety teams, information packs are much more time consuming and lengthy to prepare and so require longer lengths of time to prepare and read, and an additional and very valuable data source could give participants well-considered and triangulated information, this being staff feedback. It is therefore proposed that a confidential listening event be undertaken in the weeks leading up to the event to ensure the staff voice is heard and acted upon.

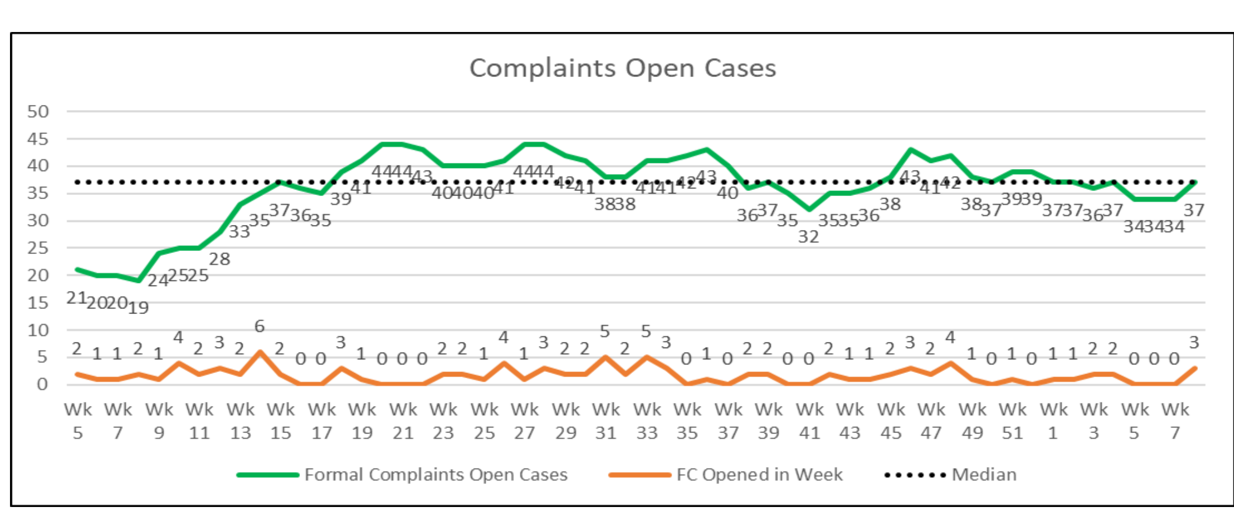
Additional Safety Summits focusing on incident categories are also under way with the first summit of this type focusing on Clozapine toxicity and being chaired by the Executive Medical Director.

7.0 Patient Engagement and Experience

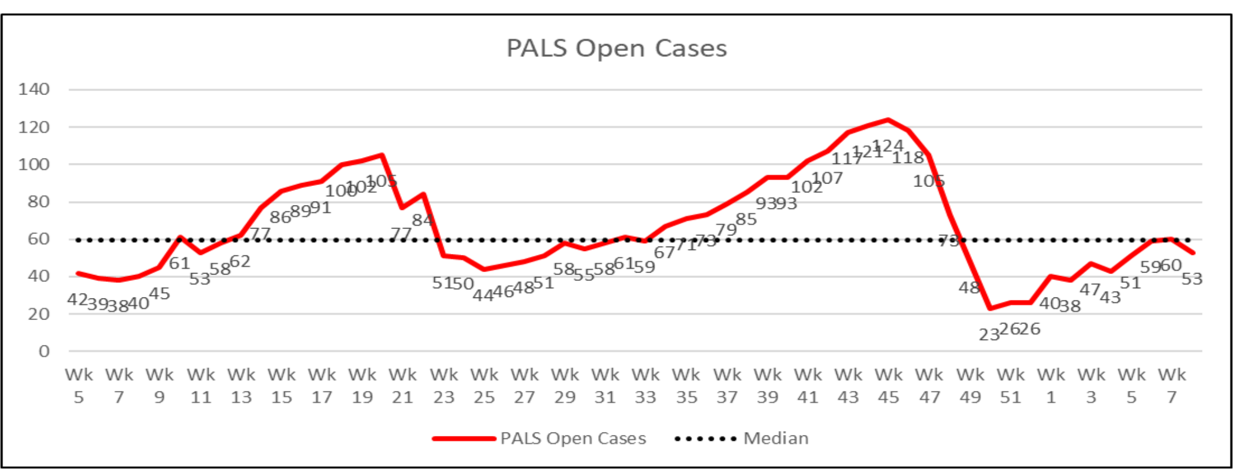
7.1 Monthly Data Complaints and PALS

The graphs below indicate the current run rate for formal complaints and PALS contacts;

Graph 1 Formal Complaints



Graph 2 PALS Contacts



The number of PALS cases has increased since the start of the year. The level of open formal complaints has remained stable at around 37 cases.

Currently there are 17 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer (total 36 so 47%). **This has increased by 9%** since the last Board report.

The average age of a case is 76 working days **(this has decreased by 4 days** as the team have closed down some very old cases). The average time it is has taken to allocate a case to an Investigating Officer is 66 working days. These average times exclude Bank Holidays and weekends.

Both these targets do not meet best practice standards and continued work is being undertaken by the Complaints Lead to improve these KPI's. Similarly, to the Patient Safety Team, additional resource has been requested in a paper to the executive team. Whilst approved, the same financial restrictions remain in place for agency. An additional experienced bank person has been found more laterally in the last week that will offer additional experience to the team.

7.2 Open Complaints Actions

The table below indicates the current numbers of open complaints actions as an organisation;

Directorate	Total	1 month	2 months	3 months +
Acute Care	7	0	0	7
Barberry Specialties	2	0	0	2
ICCR	23	1	4	18
Urgent Care	1	0	0	1
Nursing Directorate	1	0	0	1
Primary Care	2	0	0	2
Total	**36**	**1**	**4**	**31**

The position is static to that reported to CGC and QPESC in previous months in that there are currently 36 complaints actions open in total with **97% of actions (35) now overdue**. A number of these actions are identified as being over 12 months in age. Reasons identified for this have been multi-factorial in nature and include gaps in reporting transparently and effectively to Divisions and internal process around automatic allocation of timelines for actions, which can potentially appear unrealistic.

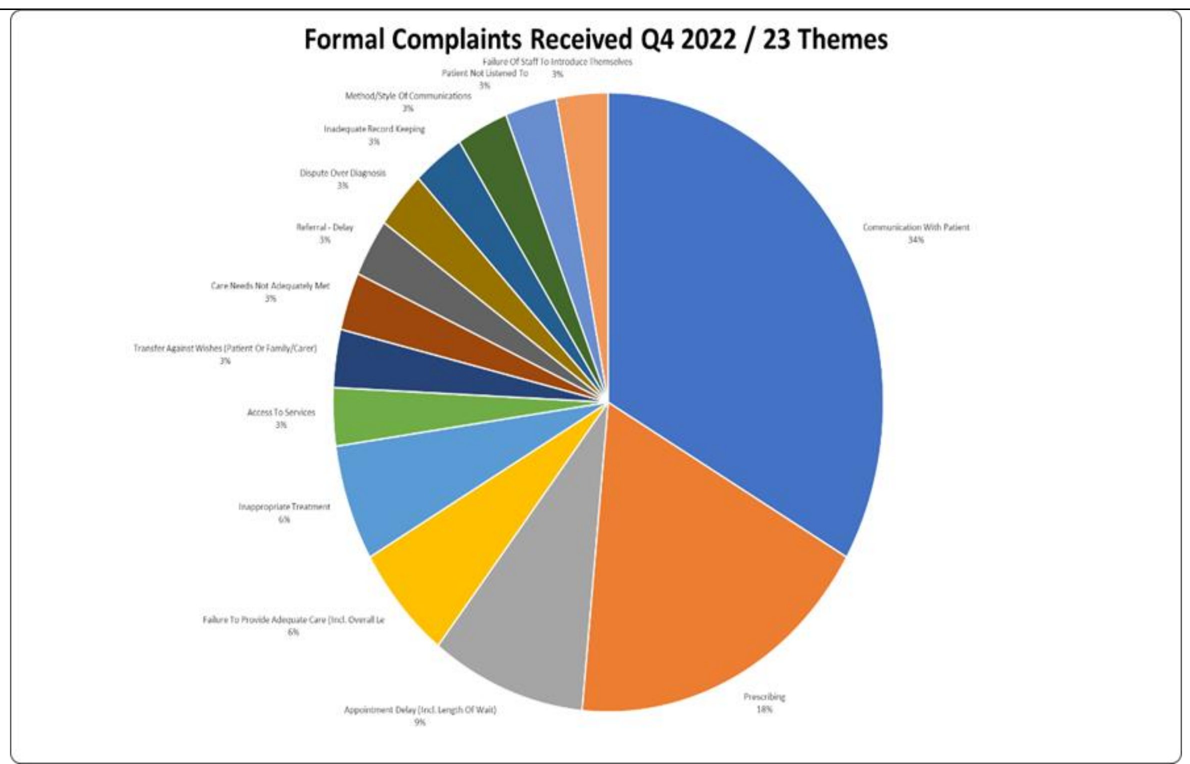
Work is underway to address these areas within the complaints department and the team will work collaboratively with the Divisions and Clinical Governance Facilitators to close down outstanding overdue actions. A timescale for this piece of work has not yet been established but will be reported on through formal committee routes.

7.3 Thematic Review

For the purpose of this month's board paper, as agreed, a focused quarterly thematic review of complaints, including protected characteristics, is shared for information purposes.

The Customer Relations Team received 13 formal complaints in Q4 at the time of reporting (01.01.23 – 24.03.23). This is a consistent number over the 12-month period.

The pie chart below details the themes for complaints received in the quarter which range from prescribing issues, appointment, and referral delays to issues with communication with the patient, which was the most reported theme in 8 of the 13 complaints received.



7.31 Prescribing Issues

This category is broken down into 2 key elements; Access to drugs and treatment; and Prescribing issues. On review in more detail the access to drugs and treatment relates more to treatment and refers to the time the complainant had been on the waiting list to see services and secondly receiving a telephone consultation as opposed to a face to face. The one complaint categorised as being due to prescribing issues relates to delays in drug prescription.

7.32 Appointment and Referral Delays

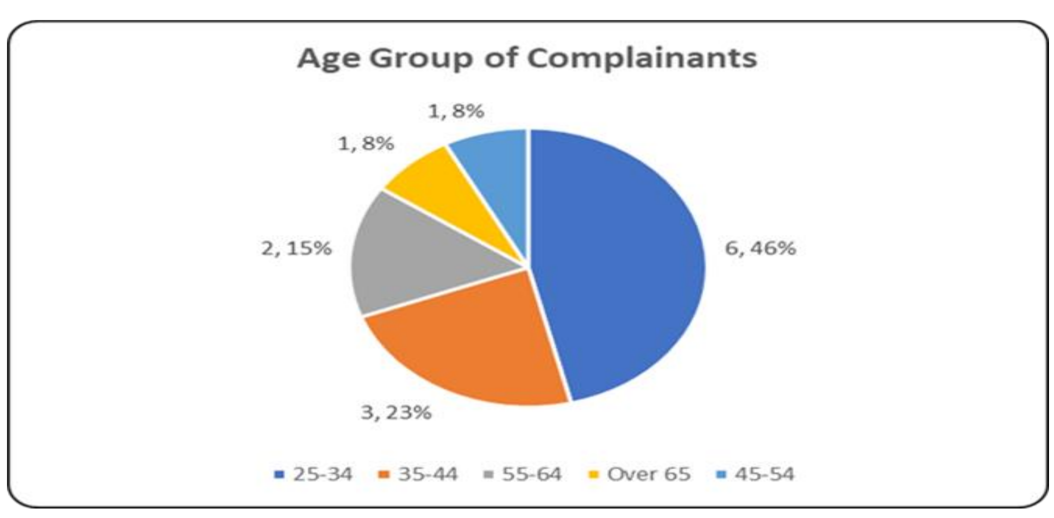
The complaints in relation to this centre on perceived poor standards of care and treatment delay/cancellation of appointments. Delay in referral for therapy. Medication and prescribing issues including lack of medical reviews. Staff attitude and behaviour.

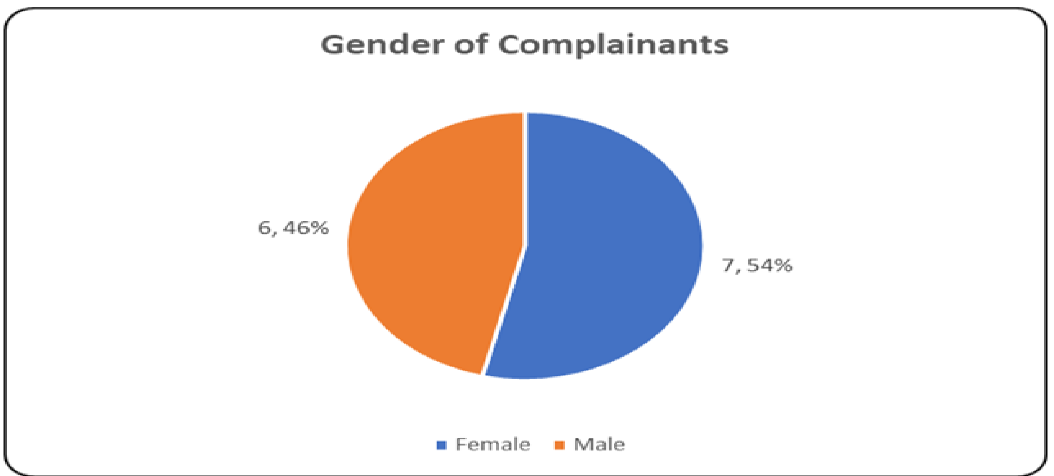
7.33 Communication

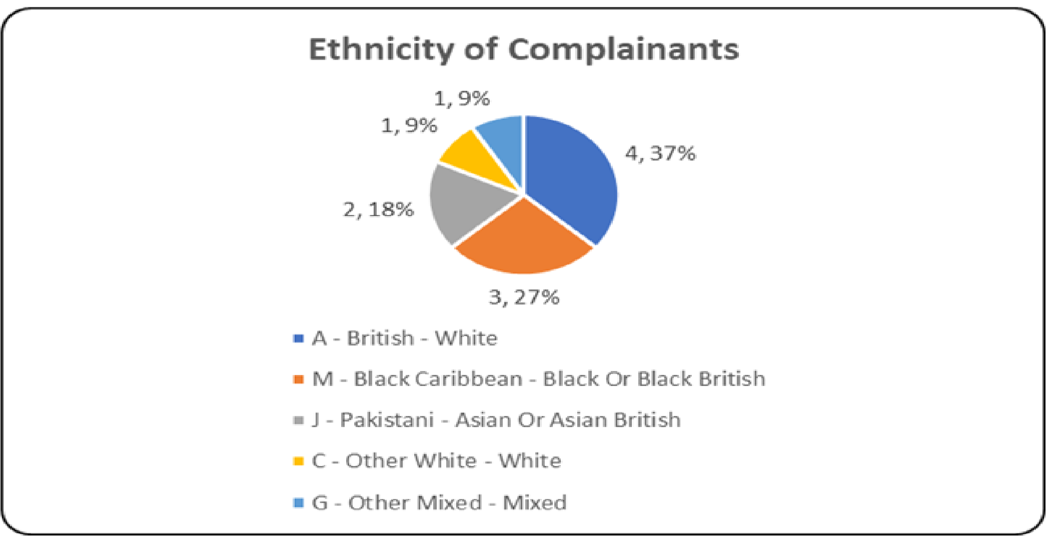
This is the highest category for complaints and themes for this category are varied. A number of complainants identify that they believe staff attitude and behaviour is poor with lack of/delayed follow-through on agreed plans of care. This in some cases has led to delayed treatments impacting on their recovery. One communication complaint relates to a safeguarding issue where a perceived lack of communication led to an out of area patient being allocated a BSMHFT bed. This was seen as a serious concern due to previous history of the patient being groomed whilst resident in Birmingham.

7.34 Protected Characteristics

The following is a breakdown of Q4 complaints by protected characteristics;







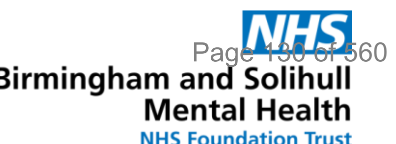
Observations: Most of the complainants are under the age of 44. There are a similar number of female and male complainants. The main ethnic groups for complainants are White- British, Black Caribbean, and Pakistani.

Meaningful comparison of this data is not yet enabled as this is the 1st time data of this type has been included quarterly. On-going monitoring of this data, its meaning, and

impact will be enabled as more regularly reviewed through this committee. It is anticipated that further information including Religion, Marital Status, and Sexual Orientation will be part of this review process going forward.

8. PEOPLE

8.1. (a) People Committee Chair’s Assurance Report April



Meeting	**BOARD OF DIRECTORS**
Agenda item	**Item 8.1 (a)**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**
Date	7 June 2023
Author	M. Shafaq, Non-Executive Director (Vice Chair of Committee)
Executive sponsor	P. Nyarumbu, Executive Director of Strategy, People & Partnerships

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

Executive summary
The People Committee met on the 19 April 2023. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's People agenda and to escalate any key issues.
Strategic objectives/ priorities
People Creating the best place to work and ensuring that we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.
Financial implications
People are the Trust's largest area of expenditure. The committee did not make any key decisions of a financial commitment
Risks
The key risk discussed with the Committee related to safer staffing and the shortage of registered nurses across the Trust.
Equality impact
Non specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM PEOPLE COMMITTEE

ISSUES TO HIGHLIGHT TO THE BOARD

Monthly Key Performance Indicators

The Committee received a detailed report and noted the salient points as:
- The vacancy rate in February has decreased to 12.4% by 1.74% but is still above the KPI target of 6.0%
- Nursing remains a significant issue with 330.82 WTE vacancies across the Trust. We also have a 28.6% vacancy rate for Occupational Therapists
- A number of additional recruitment events are planned at the end of Q4 and into Q1 - Ardenleigh jobs fair, South Solihull Jobs Fair and a Barberry Jobs Fair. This has proven successful in the past as a way of filling vacancies
- A Recruitment Projects and Initiatives meeting has been arranged to look at continuous improvement around process, reporting procedures and delivery and Project Flourish
- The current Recruitment and Selection Policy is being updated by Senior People Partner for Corporate
- The Trust has made offers to 37 Nurses within the last financial year, against a target of 32. Two international nurses have already started in the Trust, with one successfully completing her OSCE and working as a nurse
- Turnover has increased very slightly to 10.7% in February from 10.69% in January
- The number of leavers in a rolling 12-month period have increased to 459 in February from 456 in January - in February there were 24 leavers which is 10 more than January
- The bank and agency fill rate decreased to 81.3% in February from 84.5% in January. The bank fill rate remained relatively stable, as did the agency fill rate
- 18,608 temporary staffing shifts were requested in February. This is a decrease of 529 from 19,137 in January. 15,135 shifts were filled in February (13,387 of these were bank)
- There has been a decrease in agency spend from c.£782k in January 23 c.£667.6K in February 2023. This spend is above the NHSI monthly stretch target by £339K. Year to date expenditure is £7.318m. We are £4.17m over the YTD stretch target
- There has been a significant decreases in spend across areas in medical agency and other clinical agency however increases in admin & nursing agency spend
- As part of enhanced agency expenditure controls, from 1 September, NHSE will be monitoring expenditure at system level against an agency limit. The limit that has been issued to the system for 2022/23 is £60m. This equates to 90% of 2021/22 agency expenditure.
- For BSMHFT the limit is £5.7m which is an average of £0.5m per month. Average monthly expenditure is £0.8m, with total spend year to date being over £4m above the NHSE limit
- Overall, Trust's Fundamental Training compliance figure decreased from 92.7% in January to 90.3% in February 2023
- Bank FT compliance has decreased from 87.5 to 85.5 % at the end of February 2023. However, still over the commissioner's target
- Sickness absence saw an decrease in February 2023 to 5.4% from January 2023 of 6.31%. Non-covid related sickness absence decreased by 0.78% to 4.91% in February and Covid-19 related sickness absence decreased by 0.12% to 0.5% in February from 0.59% in January. Short term sickness absence decreased by 0.87% to 1.98% in February. Long term sickness absence in February 3.43% is a decrease of 0.02% in January 3.45%

Vacancies in certain areas remain a challenge (especially nursing) but assurance is provided around the ongoing work specifically around nursing and medical recruitment to try and reduce rates to close to the KPI.

Assurance is given that we are currently under KPI for turnover and that work is underway to

maintain this level and improve in areas with higher levels. However, this needs monitoring as the SPC charts indicates continuous increase in turnover rates.

There has been significant drop in sickness absence levels for January and February. The People Team and operational areas are working hard to ensure this continues to reach the 3.9% target.

Chair's Assurance Comments:

The Committee were assured that this work was moving in the right direction and acknowledged the progress made to date

Deep dive – focus on the Workforce transformation plan

The Committee received a detailed report on the Deep dive – focus on the Workforce transformation plan.

Over the last 12 months, senior clinical services leaders have come to recognise that with regards to workforce planning within the Trust:

- The ambition set out in the 2022/23 workforce plan to achieve an overall increase in Trust workforce numbers of 7% was overly ambitious in the immediate post COVID-19 pandemic recovery / return to some sort of new normality period;
- The Trust's internal arrangements for the development at pace of workforce recruitment and retention initiatives, the overall co-ordination of implementation activity and impact tracking all required strengthening – as did the depth of workforce planning focused engagement with Divisional clinical service leaders; and
- Whilst system wide working is an essential component of meeting our future workforce needs, the day-to-day practicalities of turning joint working into having new starters physically in our workplace and working with patients requires unrelenting and energetic attention to detail

At the heart of the plan is the ambition to achieve a 3% increase in the overall number of clinical and immediate service support staff in post by the end of March, 2024 (against the number in post at 1st April, 2023). Although outturn figures for the current financial year are not yet available, it is anticipated that this will be slightly more than a 1% increase on the Trust's 2022/23 performance. The core planning assumptions underpinning the achievement of a 3% increase are both:

- A reduction of 2% in the average number of staff leaving over the last 3 years; and
- An increase of 3% in the average number of new recruits joining BSMHT over the last 3 years (plus 40 MH nurses recruited via an extension of the existing international recruitment programme)

Aside from the crucial ambition of seeking to achieve a net increase in the number of staff in post by the end of March, 2024, the really core assumptions behind this workforce plan are:

- That 2023/24 is used as the 'baseline' year on which to build future annual plans. We have carefully captured all of the assumptions upon which the numeric part of the 2023/24 plan has been based and put in place robust monitoring arrangements to enable 'implementation reality' tracking to be done – with lessons subsequently fed into future workforce planning rounds;
- Laying emphasis on encouraging clinical leads / service managers to understand, engage with and focus on the creativity which workforce planning can offer in taking more adventurous approaches to job role design, especially when faced with intractably 'hard to fill' roles. Progressing that requires on our having a competent and respected internal advisory resource – which participation in the current HEE workforce planning training programme will help bolster the established provision within People Services'
- Determinedly getting to grips with known (and in some cases, long standing) weaknesses in

the Trust's internal workforce data collection and reporting systems - most notably ESR - with a view to making the 'fit for purpose' in providing workforce planning information which better needs the needs of planning activity
- That implementation of the myriad action plans highlighted within the plan is progressed at pace – not least so that the proposal to start the 2024/25 planning cycle wef September 2023 can build on 'achievements to date'.

The Committee approved the recommendation that the draft 2023/24 workforce plan is adopted, with the first full 'implementation progress' report being submitted to the Committee in September 2023.

Chair's Assurance Comments:

The committee felt that the workforce plan was ambitious but necessary to identify much needed baseline info and to establish as an agreed framework. It was noted the pace required to identify and implement any recommendations but were assured that with the required focus, the plan was achievable.

Safer Staffing Report

The Committee received a detailed report and noted the salient points as:

Secure Care
There continues to be vacancies across each of the inpatient wards, these are just under 20% per ward for the women's wards and under 25% for the FCAMHS including low secure ward.
We have received positive feedback from students regarding their experience at Ardenleigh and are keen to work there. We have the bespoke recruitment event planned for the 30th March 2023.
90 eclipse forms were completed in the month of few citing staffing/skill mix as a concern, 34 of these being citrine.
Avon currently have 33% of vacancies across the ward, this is currently being mitigated with Blythe staff whilst the site actively recruits into site.
There were 23 eclipse forms completed in February linked to staffing, with 8 of them citing short staffing and 15 stating staff have been unable to take breaks.
Sycamore is funded to have 4 x RMN per shift, Myrtle and Laurel are funded 3 x RMN per shift. It is rare that this is met, due to high levels of vacancies.
Given the low RMN fill rates for the month of February, there was 21 eclipse forms completed in regard to staffing issues for the site.

Acute Care
North Acute wards have now recruited to 2 x Assistant psychologist who are split between Eden PICU and Larimar with the second covering Eden Acute and George ward.
There continues to be estates working across the North and Central patch, that require HCA escort. This is a partial account of why the HCA fill rates are over.
Acute Care continue to mitigate by ward managers working clinically in numbers and matrons providing break cover. There have been occasions where Matrons are leading the MDTs.
Concerns have been raised around the establishment for Solihull HTT. HON an AHP will be presenting at the acute deep dive to request a full review into the establishment.

Dementia/Frailties and Specialties
Cilantro currently sitting on high vacancies, it has been recgonised the Clinical Nurse Manager and Service Manager are starting work at 7am are regularly having to work in numbers to

support, to ensure the ward feels supported and has RMN cover. There was no shift without a RMN, these shifts were the Clinical Nurse Manager and Service Manager.
Reservoir Court isn't funded correctly they have 12 RMNs in the establishment they should by 9 as they now have 18 services users as the bed state was reduced. This will be amended as part of budget resetting and the establishment review.
Vacancy data is currently inaccurate due to when Ashcroft closed staff were redeployed across the service. HCAs are currently oversubscribed due to this.

Steps to Recovery
Forward House continued to be closed throughout February, it has now gradually started to reopen.
Fill rates do appear to be higher but this due to staff from forward house being redeployed across the service. We may see a different picture for March fill rates.
There are vacancies Hertford house these are 5 x B5s, they are all now recruited to but are currently going through the recruitment process. The matron for this are has been regularly working in the numbers clinically to provide continued support for the staff and consistency for the service users.
Dan Mooney House was in a COVID outbreak, this has dropped there fill rates as shifts weren't always picked up and sickness.
It was also noted that there was high annual leave during February half term, HON & AHP will discuss re planning annual leave better across the year.

E – Rostering

The Check and challenge is due to start the week commencing the 1st May 2023, it will be piloted initially at the Oleaster and Ardenleigh. Meetings have already taken place with NHS England - Heads of Clinical Workforce. This is already embedded in other Trusts across the country. The purpose of this is to ensure rosters promote staff welling and are safe, ensuring annual leave is fairly done and that staff availably resources are optimised. The Check and Challenge meeting would take place once the roster is published every 6 weeks. This will be working towards having safe rosters. This would be reported back to Safer Staffing Committee on a quarterly basis. The review of the rosters will be reported to the Board in the annual establishment review.

Chair's Assurance Comments:

The Safer Staffing Report was felt as providing partial assurance in line with the discussions above.

Integrated Performance Report

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

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

- People
  - Bank and agency fill rate
  - Appraisals
  - Sickness absence
  - Vacancies
- QPES
  - Staff assaults

Bank and agency fill rate- There will be little change with the current bank and agency fill rates unless there is a significant decrease in the number of bank shifts being requested. Action to improve recruitment and retention to employ new staff in line with the workforce plan as well as filling existing vacancies will support improvement on this metric.
Demand on bank shifts continues to be high with on average, nearly 18,000 shifts being requested each month.

Appraisals- A new appraisal system has been recently introduced which has had an impact on performance. This also means that appraisals during this year will be recorded in 2 different systems which makes monitoring challenging.
A recovery plan has been developed which will include further targeted work, webinars and support to operational staff in navigating the new process on ESR.
It has also been noted that there are a number of appraisals which have been created but not finalised. L&D staff will be reviewing these to assess levels of completion.

Sickness absence- The trajectory has incorporated seasonal impact variations to reflect previous summer and winter trends.
The Trajectory has also been informed by NHS Digital data for NHS Mental Health Trusts in terms of long term and short-term trends.
The people team are working with managers to support the management of long term sickness cases through a wide range of actions.

Vacancies- The HR lead has confirmed that the workforce plan for 2023/24 is being finalised as part of the national planning round. Once growth figures are established a phased trajectory will be developed and will be provided to FPPC on completion.

Chair's Assurance Comments:

The committee acknowledged the proactive progress being made and assurance was received.

Oversight Framework - BSOL draft

The Committee received the Oversight Framework letter and noted that the Midlands Regional Support Group made a decision to maintain segment 3 for BSMHFT.

Chair's assurance comments:

The committee noted the content of the report

Review of Board Assurance Framework

The Committee held a detailed discussion in relation to the Board Assurance Framework and noted an update will be bought to the next Committee meeting.

Chair's Assurance Comments:

The committee noted the content of the report

Matters of escalation to the Board

There were no matters of escalation to the Board.

MONICA SHAFAQ
NON-EXECUTIVE DIRECTOR

8.1.1. (b) People Committee Chair’s Assurance Report May

9. SUSTAINABILITY

9.1. (a) Finance, Performance & Productivity Committee Chair’s Assurance Report April

Meeting	BOARD OF DIRECTORS
Agenda item	Item 9.1 (a)
Paper title	CHAIR'S ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE
Date	7 June 2023
Author	B. Claire, Non-Executive Director, Chair
Executive sponsor	D. Tomlinson, Executive Director of Finance

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

Executive summary

The FPP Committee met on the 19 April 2023. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.

Reason for consideration

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

Strategic objectives/ priorities

Sustainability

Financial implications

Detailed within the report

Risks

Equality impact

Non specific.

Our values

Committed
Compassionate
Inclusive

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

1. Integrated Performance Report

Reasonable Assurance

Headlines:

- The committee received the Integrated Performance Report.
- As requested at the February FPP meeting, the committee was presented with the specific plans and recovery trajectories for the following performance metrics;
  - Inappropriate out of area bed days
  - IAPT waiting times 6 and 18 weeks
  - New referrals not seen within 3 months
  - CPA 12 month reviews
  - 7 day follow up

  and the following People metrics;
  - Vacancies
  - Sickness
  - Appraisals
  - Bank and agency fill rates
- The committee welcomed the clarity in the reporting, as well as the forward views of the recovery trends based upon the current action plans and the likely impacts.
- The level of influence the accountable Performance Delivery Group has, as well as the role the broader ICB system must play to ensure success were also discussed.

Key Highlights and Lowlights:

- **CPA 12 months reviews**
  - ICCR performance for March at 88.5% and Specialties at 82.6% (Target 95%).
  - ICCR and older adults CMHTs – improvement trajectory to achieve 95% by Sept '23.
  - Known staffing issues will make this a challenging target to achieve.
- **IAPT waiting times 6 and 18 weeks**
  - March 2023 performance in 6 weeks = 40.75% (Target = 75%).
  - The aim is to reach 75% by Jan '25 (based on current/budgeted staffing profiles).
  - Key dependency: the Trust's ability to successfully recruit within this staffing group due to existing national shortages.
- **Inappropriate out of area bed days**
  - March 2023 performance = 1302 occupied bed days (Target 561)
  - Recovery trajectories agreed as part of the national planning round for 2023/24.
  - Trajectories agreed with commissioners remain in place for March 2023, i.e. new improvement trajectory does not apply until April 2023
- **New referrals not seen within 3 months**
  - March 2023 performance = 3201 referrals. No target has been set, i.e. it is a local metric, which is important, but there is now a view on the standard to apply.
  - Due to the high number of patients waiting to be seen over 18 weeks for a first appointment, initial focus for the ICCR CMHTs is to this cohort of patients.
  - The recovery trajectory is based on achieving a 20% reduction in the 18 week plus

cohort by the end of October 2023. At March 2023 there were 1119 such referrals.

- **Monthly agency expenditure**
  - March 2023 performance = £755k (Target £479k)
  - Historically, BSMHFT has been successful in driving down agency spend against the NHSE targets. A different approach to target setting is in place for 2023/24 and BSMHFT is already performing ahead of the target.
  - Demand on bank shifts continues to be high – c18,000 shifts requested per month.
  - A key behavioral shift needed is to reduce the number of bank shifts being requested.
  - Action being taken is to fill current vacancies as quickly as possible and to improve recruitment and retention in line with the Trust's workforce plan.

Next Month:

- The committee looks forward to the continued clarity in the reporting and the continued impact of the respective recovery action plans underpinning the services.
- The committee also looks forward to the introduction of a much broader conversation around financial sustainability through the Trust's strategic/transformation agendas.

Chair's Assurance Comments:
The Trust remains challenged across a number of known operational pressures points impacting the Trust's current financial sustainability. The committee welcomed the greater clarity and therefore assurance on the 'get well' plans that indicated a forward view of the impact trajectories. Also welcomed was the acknowledgement of the dependency on challenging the Trust's services through a transformational lens as a vital key to unlock future financial sustainability.

2. <u>Business Development and Partnerships Report – Q4 22/23</u>

Substantial Assurance

Headlines:

- The committee received the detailed report.
- A summary of the contract awards and work in progress was presented;
  - The mobilisation plan for the BSOL Mental Health Provider Collaborative was progressed in Quarter 4, with approval given for go live from 1 April 2023.
  - Contract awarded by Health Education England for the Trust to continue to provide IAPT Psychological Wellbeing Practitioner training across the Midlands.
  - The Trust was successful in a bid with Practice Plus for prison healthcare at HMP Foston Hall and HMP Sudbury, for provision of psychiatry input.
  - The Trust is in the middle of a procurement process for the Vulnerability Support Hubs (replacing our current Prevent In Place pilot service) by Counter Terrorism Policing Headquarters, working in partnership with the two other existing providers.
  - The Trust is currently assessing tenders for prison healthcare at HMP Long Lartin and HMP Hewell.
  - Appraisals of the options available to the Trust when Midlands Metropolitan Hospital opens in Spring 2024 are currently underway, as the psychiatric liaison services provided by us at City Hospital and Black Country Healthcare at Sandwell Hospital will need to move to the new hospital.
  - Progress is being made on the development of the Perinatal Provider Collaborative business case including the clinical model, for a go-live later this financial year.
  - Work continues on the Trust's refreshed Business Development and Partnerships strategy.

Key Highlights/Lowlights:
- See Executive Summary above.

Chairs Assurance Comments:
The committee received a well-presented report and substantial assurance. All business development work is carefully assessed and dimensioned, with the assurance that existing services and service user experience will not be adversely impacted.

3. <u>Financial Position</u>

22/23 – Substantial Assurance

Headlines:
- The 2022/23 full year Group position is a surplus of £14k, this is in line with forecast and the break-even plan as submitted to NHSE on 20.6.22.
- The full year position comprises:
  - £0.7m deficit for the Trust,
  - £44k deficit for Summerhill Services Limited (SSL) and
  - £250k surplus position for the Reach Out Provider Collaborative.
- Key run rate pressures: slippage on recurrent savings delivery, out of area pressures and staffing pressures, with a significant level of temporary staffing expenditure have been offset in year by non-recurrent benefits predominantly release of deferred income.
- Across the BSOL system agency spend is currently at 4.2% and as such, NHSE have requested the system to provide a planned trajectory of reductions in 23/24.
- Group capital expenditure totaled £8.8m, this is in line with the original plan of £7.3m plus additional expenditure covered by £1.5m PDC funding received in March 2023.
- The Group cash position at the end of March 2023 is £59m.
- Consideration is being given to placing a long-term deposit with the National Loan Fund (NLF) in April/May 2023.

Key Highlights/Lowlights:
- Bank expenditure £31.1m – the majority of bank expenditure relates to nursing bank shifts - £28.3m.
- Agency expenditure £8.7m – the majority of agency expenditure relates to medical agency - £5.8m.
- Total agency spend is £3m above the ceiling set by NHSE. It is £2.3m (36%) above 2021/22 spend and £3.4m (64%) above 2020/21 spend.
- Operational Planning guidance indicates a new KPI for agency expenditure, being a limit of 3.7% of the pay bill. Current BSMHFT 2022/23 agency spend equates to 3.3%.
- There were 17 above agency price cap bookings in 2022/23 and no framework breaches. It is proposed that these key KPIs will be reported monthly from 2023/24.
- The out of area plan set for 2022/23 was £5m above plan (£8m), based on an agreed contract with The Priory for provision of 22 out of area beds (10 Acute and 12 PICU).

Chair's Assurance Comments:
The committee welcomed the report and thanked the team for their dedication and efforts throughout the year in achieving the surplus position, notwithstanding the challenges going into 20/24, that were duly noted.

4. Financial Plan for 2023/24

23/24 – Reasonable Assurance

Headlines:

- The committee received the financial plan for 2023/24.
- Draft financial plan submission to NHSE on 30.3.23:
  - BSMHFT £3.1m deficit,
  - BSOL System £41m deficit.
- Given that BSMHFT and the BSOL System have not submitted break even plans, it is anticipated that further iterations will be required, likely in early May.
- As such the committee was asked to endorse the upload of budgets based on the current £3.1m deficit plan in order to allow month 1 reporting – approved.
- The 2023/24 capital plan submitted to NHSE on 30.3.23 was £7m.
- In the absence of confirmed capital envelopes, for the following 4 years, the plan for each year has been submitted at £6.2m in line with our 2023/24 capital envelope.

Key Highlights/Lowlights:

- See Executive Summary above.

Chair's Assurance Comments:

The committee welcomed the update and was pleased that the deficit both at Trust and System level was reducing, at the same time recognising the challenges around achieving financial sustainability in 23/24 and beyond. Picking up on previous conversations, the need for a joined-up system-wide transformation agenda was clear – this was a discussion for this and the two subsequent agenda items. From a Trust perspective, the committee discussed the various initiatives driving change that would need to align to achieve strategic financial assurance – eg Quality Improvement Plans, Productivity Plans, Service Transformation Plans, BAU CIPs, Performance Improvement Plans (eg OOA) and MH Provider Collaborative direction.

5. Trust Strategy – Sustainability Strategic Priorities 2022/2023 Achievement and 2023/2024 Goals

The Committee received a verbal update to provide assurance and set the expectation ahead of the update planned for the May FPP that will subsequently go to the June Trust Board.

6. Trust Strategy – Clinical Services Strategy Priorities 2022/2023 Achievement and 2023/2024 Goals

The Committee received a verbal update to provide assurance and set the expectation ahead of the update planned for the May FPP that will subsequently go to the June Trust Board.

7. Board Assurance Framework

Headlines:

- The committee received the Board Assurance Framework update.
- Two new risks are recommended to be included and allocated to the FPP Committee.
  - FPP5: The Trust fails to live within the financial resources available to it.
  - FPP6: The Trust fails to comply with regulatory requirements.

Chair's Assurance Comments:

Committee was assured by the BAF and agreed the new risks, subject to ongoing review at future meetings.

8. FPP ToR– Annual Review

Headlines:

- The Committee received the terms of reference for approval.

Chair's Assurance Comments:
The committee approved the terms of reference on the basis it receives clarity on the Trust's Financial and Investment Strategies. Based upon the strategic conversations earlier in the meeting, these documents will be prepared and ready for review by Sept '23.

9. FPP Forward Planner for 2023/24

Headlines:

- The Committee received the terms of forward planner for approval.

Chair's Assurance Comments:
Committee approved the forward planner.

BAL CLAIRE
CHAIR OF FINANCE, PERFORMANCE AND PRODUCTIVITY

9.1.1. (b) Finance, Performance & Productivity Committee Chair's Assurance Report May

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: Finance, Performance & Productivity Committee**
Report presented at	**BOARD OF DIRECTORS**
Date of meeting	**7 June 2023**
Agenda Item	**9.1 (b)**
Date(s) of Committee Meeting(s) reported	**24 May 2023**
Quoracy	**Membership quorate: YES**
Agenda	The Committee considered an agenda which included the following items: 1. Integrated Performance Report (IPR) 2. Sustainability strategic priority 22/23 update and 23/24 goals 3. Clinical services strategic priority 22/23 update and 23/24 goals 4. Finance Report 5. Financial Plan for 2023/24 6. Perinatal Provider Collaborative Business Case 7. Digital Strategy, Improvement and Assurance 8. Board Committee Annual Self-Assessment Survey Questionnaire
Alert:	The Committee wishes to alert the Trust Board to the following: • BSMHFT have submitted a financial breakeven plan to NHSE for 2023/24. Additional system income was allocated to the Trust following the creation of a negative risk reverse by the ICB, moving the BSMHFT position from the previously estimated deficit of £3.1m • Month 1 agency expenditure is £801k - £82k above previous average monthly expenditure and almost double the average for 2020/21 • NHSE have introduced a new key performance indicator for agency expenditure, with the limit being 3.7% of the pay bill. Month 1 expenditure is 3.8% • Month 1 bank expenditure is £2.7m - £149k above previous average monthly expenditure and 50% higher than the average for 2020/21

Birmingham and Solihull Mental Health NHS Foundation Trust

Assurance:	The Committee was assured on the following:
	
	• There is little change in performance against the core metrics included in the IPR. Of the metrics considered by the Committee, there remain ongoing issues with:
	  o CPA with formal review in last 12 months
	  o IAPT seen within 6 and 18 weeks
	  o Out of area bed days
	  o CPA 7-day follow up
	  o Referrals over 3 months with no contact
	  o CIP delivery
	• The process for monitoring the core metrics remains sound and the supplementary detail on movement against agreed improvement trajectories is useful vehicle to track progress.
	• The out of area performance metric relates to inappropriate admissions and there is some improvement in this respect. From the financial perspective, even some appropriate admissions out of area create a financial pressure and this is detailed in the Finance Report.
	• The Committee reviewed the Sustainability Strategic Priorities for 2022/23 and was assured by the progress made against the plan.
	• The Committee approved the Sustainability Strategic priorities and plan for 2023/24.
	• The Committee reviewed the Clinical Services Strategic Priorities for 2022/23 and was assured by the progress made against the plan.
	• The Committee approved the Clinical Services Strategic priorities and plan for 2023/24.
	• The month 1 financial position for the Group (includes SSL and the two Provider Collaboratives) is a deficit of £59k, compared to the break-even plan. Key run rate pressures include slippage on recurrent savings delivery, out of area expenditure and temporary staffing.
	• Capital expenditure for the first month is slightly ahead of plan based mainly on door set expenditure.
	• A new provider collaborative is being rolled out to perinatal services. BSMHFT provides a 10 bedded perinatal inpatient service and an outreach service commissioned by NHS England, as well as community perinatal services commissioned by BSol ICB.
	We are currently going through NHSE Gateway Process, assessing our readiness to Go Live from October 2023.
	The Committee approved the business case and endorsed the Partnership Agreement.
	• Positive assurance was noted in relation to the Digital Strategy. Good progress has been made across all areas of digital and the Committee were assured the Trust is aligned with the

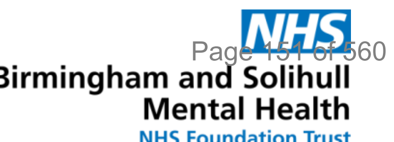
Birmingham and Solihull Mental Health NHS Foundation Trust

	National and Regional direction of travel and are leading on several pieces of work in these areas.
Advise	The Committee was advised of the following matters: • Of the metrics included within the IPR some (e.g. Eating Disorders) are less important, while some others, not currently included (e.g. length of stay), are now more important. This will be reviewed across the three main Committees and modified to ensure the most relevant metrics are included going forward. At the same time this will ensure that there is consistency of priority across the Trust committees. • The Committee agreed the format for a survey to self-assess its effectiveness.
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: 1. None this month

Report compiled by	Bal Claire, Non- Executive Director	**Minutes available from:** David Tita, Associate Director of Corporate Governance

DRAFT

9.2. Finance Report



Meeting	BOARD OF DIRECTORS		
Agenda item	9.2		
Paper title	Month 1 2023/24 Finance Report		
Date	07 June 2023		
Author (s)	Emma Ellis, Head of Finance & Contracts		
Executive sponsor	David Tomlinson, Executive Director of Finance		
Executive sign-off	☒ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

Revenue position

The month 1 2023/24 Group position is a surplus of £59k, this is £59k adverse to the break-even plan as submitted to NHSE on 5.4.23. The position comprises a £73k deficit for the Trust, £4k surplus for Summerhill Services Limited (SSL), a £21k deficit position for the Reach Out Provider Collaborative and a break-even position for the Mental Health Provider Collaborative (MHPC).

Key run rate pressures: slippage on recurrent savings delivery, out of area expenditure and temporary staffing.

Capital position

Month 1 2023/24 Group capital expenditure is £0.5m. This is £0.5m adverse to plan due to works progressing ahead of plan, mainly related to door set expenditure.

Cash position

The month 1 Group cash position is £68m.

What is the ask? (Please state specifically what you like the meeting, committee or Board to do).

Review month 1 financial position.

Confirm level of assurance demonstrated and evidenced in the report (tick as appropriate):

☒ Substantial Assurance

☐ Reasonable Assurance
☐ Limited Assurance
☐ No Assurance

Previous consideration of report by: (If applicable)

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)*

FPP overall risk: there is a risk that the Trust fails to make best use of its resources

Equality impact assessments:

N/A

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

Ongoing financial briefings via Operational Management Team and Sustainability Board.

Acronyms *(List out any acronyms used in the report)*

Defining levels of assurance:

<table>
<tr><td>Level of assurance</td><td>Definition</td></tr>
<tr><td>Substantial Assurance</td><td>The evidence provided demonstrates there is a sound system of governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.</td></tr>
<tr><td>Reasonable Assurance</td><td>The evidence provided demonstrates there is generally a sound system of governance, risk management and controls in place. However, there are some issues e.g. with quality, non-compliance and performance that have been identified which may put at risk the achievement of objectives in the Division or Department, hence there is scope for improvement.</td></tr>
<tr><td>Limited Assurance</td><td>The evidence provided demonstrates there are significant gaps, weaknesses or non-compliance that have been identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the Division/Department.</td></tr>
<tr><td>No Assurance</td><td>There is absolutely no evidence to demonstrate, hence immediate action is required to address the fundamental gaps, weaknesses or non-compliance that have been identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the Division or Department.</td></tr>
<tr><td>Assurance

(System/process-based assurance & outcome-based assurance)</td><td>Provides certainty through the evidence you may triangulate in demonstrating confidence that systems and processes are working properly and what needs to happen is happening (i.e. system/process-based assurance). However, this may not imply that expected outcomes will be achieved as planned (outcome-based assurance).

It is often useful to stop and ask:

• Do we really know what we think we know?
• Where does the assurance come from?
• How reliable is this assurance?
• What is this assurance telling us?</td></tr>
<tr><td>Reassurance</td><td>This is the feeling of being assured and may be based on good performance, the lack of contradictory evidence or perhaps because someone with a professional background or expertise or management, tells you that something is so, and so it must be true.</td></tr>
<tr><td colspan="2">Assurance is defined as - “...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization.” (HM Treasury – 2012).</td></tr>
</table>

Finance Report

Financial Performance:

1st April 2023 to 30th April 2023

Month 1
Group financial position

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Healthcare Income	331,164	27,597	26,989	(608)
Other Income	253,775	21,148	19,660	(1,488)
Total Income	**584,940**	**48,745**	**46,649**	**(2,096)**
Expenditure				
Pay	(270,113)	(22,509)	(21,198)	1,312
Other Non Pay Expenditure	(277,385)	(23,115)	(22,528)	587
Drugs	(6,077)	(506)	(553)	(46)
Clinical Supplies	(795)	(66)	(60)	6
PFI	(12,611)	(1,051)	(1,033)	17
EBITDA	**17,959**	**1,497**	**1,276**	**(220)**
Capital Financing				
Depreciation	(9,906)	(825)	(823)	3
PDC Dividend	(1,717)	(143)	(143)	-
Finance Lease	(5,693)	(474)	(470)	4
Loan Interest Payable	(1,060)	(88)	(93)	(4)
Loan Interest Receivable	797	66	226	160
Surplus / (Deficit) before taxation	**380**	**32**	**(27)**	**(58)**
Impairment	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-
Taxation	(380)	(32)	(32)	(0)
Surplus / (Deficit)	**(0)**	**(0)**	**(59)**	**(59)**

Month 1 2023/24 Group Financial Position

The month 1 consolidated Group position is a deficit of £59k. This is £59k adverse to the break even plan as submitted to NHSE on 5.4.23.

Key run rate pressures: slippage on recurrent savings delivery, out of area expenditure and staffing pressures including a significant level of temporary staffing. There has been slippage on new investment in month, with some income deferred in relation to this.

Following NHSE guidance, the month 1 position includes an accrual for 2.1% pay award for 2023/24 as funded within national tariff planning assumptions. The NHS Staff Council recommended the following pay deal for implementation on 2.5.23 and the government has subsequently confirmed that the deal will be implemented for all staff on the NHS terms and conditions of service, with payments expected to be made in June 2023:

- Two one off non-consolidated awards on top of the 2022/23 pay award: one 2% award and one NHS backlog bonus. The cost and funding for this was accrued in 2022/23 at £8.3m based on guidance from NHSE received on 29.3.23.
- A consolidated award for 2023/24 worth 5% increase in basic pay. It is anticipated that funding will be received to cover the top up of the pay award from 2.1% (as per planning assumptions) to 5%.

The Group position includes a £73k deficit for the Trust, £4k surplus for the wholly owned subsidiary, Summerhill Services Limited (SSL), a £21k surplus position for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads and a break even position for the Mental Health Provider Collaborative (MHPC). For a segmental breakdown of the Group position, please see page 3.

Month 1 Group position
Segmental summary

Group Summary	Trust	SSL	Reach Out	MHPC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Healthcare Income	26,989	-	-	-	-	26,989
Other Income	1,927	2,187	11,130	29,845	(25,428)	19,660
Total Income	**28,915**	**2,187**	**11,130**	**29,845**	**(25,428)**	**46,649**
Expenditure						
Pay	(20,127)	(875)	(116)	(102)	22	(21,198)
Other Non Pay Expenditure	(6,312)	(567)	(10,993)	(29,743)	25,087	(22,528)
Drugs	(599)	(240)	-	-	286	(553)
Clinical Supplies	(60)	-	-	-	-	(60)
PFI	(1,033)	-	-	-	-	(1,033)
EBITDA	**783**	**505**	**21**	**(0)**	**(33)**	**1,276**
Capital Financing						
Depreciation	(548)	(266)	-	-	(8)	(823)
PDC Dividend	(143)	-	-	-	-	(143)
Finance Lease	(469)	(32)	-	-	31	(470)
Loan Interest Payable	(93)	(171)	-	-	171	(93)
Loan Interest Receivable	397	0	-	-	(171)	226
Surplus / (Deficit) before Taxation	**(73)**	**36**	**21**	**(0)**	**(11)**	**(27)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(32)	-	-	-	(32)
Surplus / (Deficit)	**(73)**	**4**	**21**	**(0)**	**(11)**	**(59)**

Temporary staffing expenditure

2023/24 Agency & Bank Spend by Type

£000s

4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-

April May June July August September October November December January February March

Bank

Agency

Agency Medical
Agency Nursing
Agency Other Clinical
Agency Admin & Clerical
Bank Nursing
Bank Other Clinical
Bank Admin & Clerical
2021/22 Bank & Agency
2020/21 Bank & Agency
2022/23 Bank & Agency

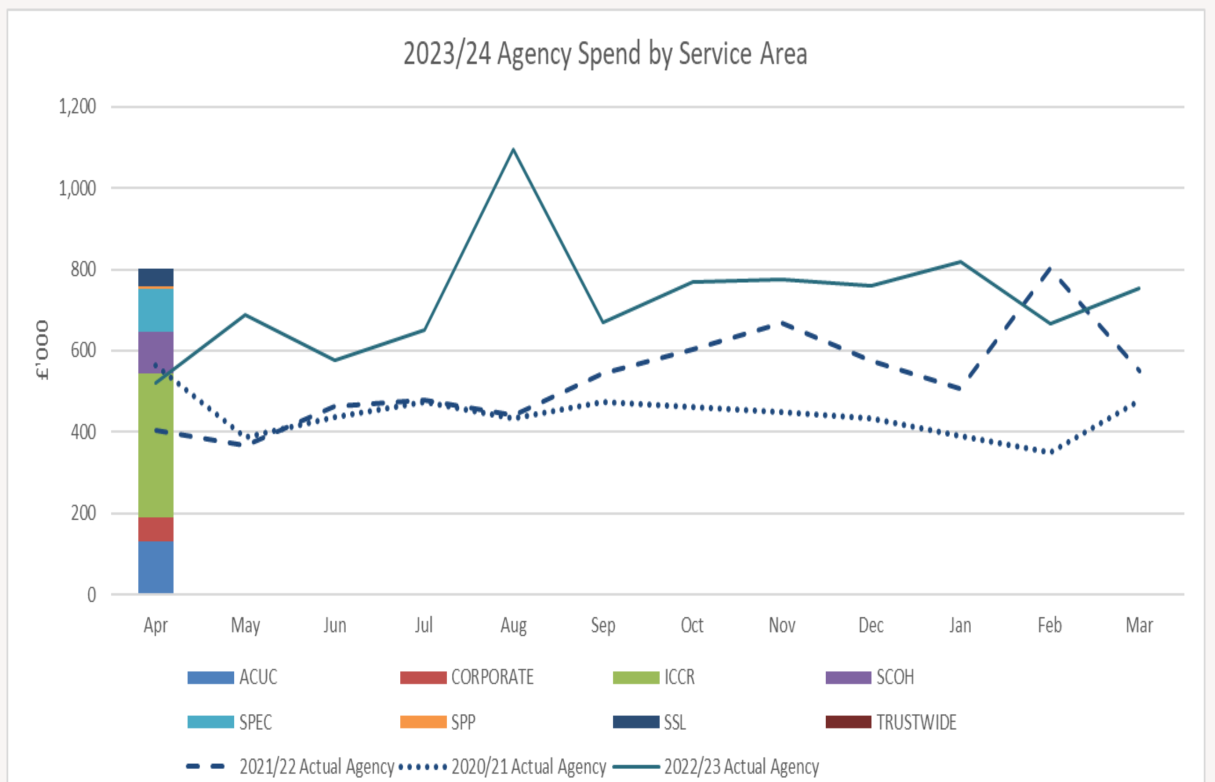
The month 1 2023/23 temporary staffing expenditure is £3.6m. The graph above shows a breakdown of the temporary staffing expenditure by type.

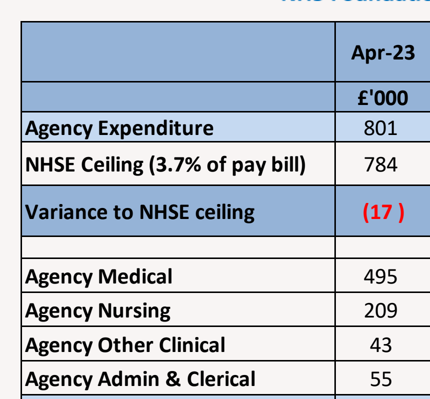
Bank expenditure £2.7m (77%) – the majority of bank expenditure relates to nursing bank shifts - £2.5m.

Agency expenditure £0.8m (23%) – the majority of agency expenditure relates to medical agency - £0.5m.

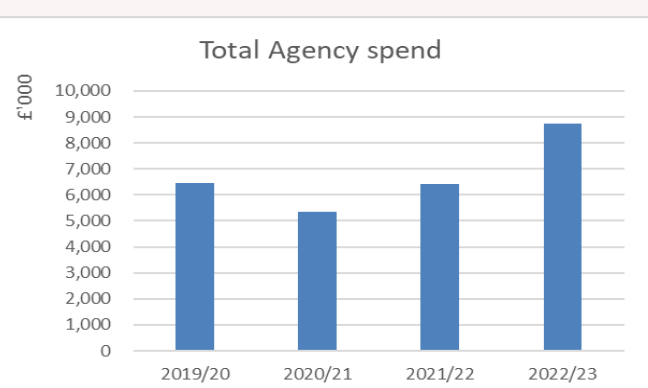
For further analysis on bank and agency expenditure, see pages 5 to 6.

Agency expenditure analysis





	Apr-23
	£'000
Agency Expenditure	801
NHSE Ceiling (3.7% of pay bill)	784
Variance to NHSE ceiling	(17)
Agency Medical	495
Agency Nursing	209
Agency Other Clinical	43
Agency Admin & Clerical	55
Agency Expenditure	801



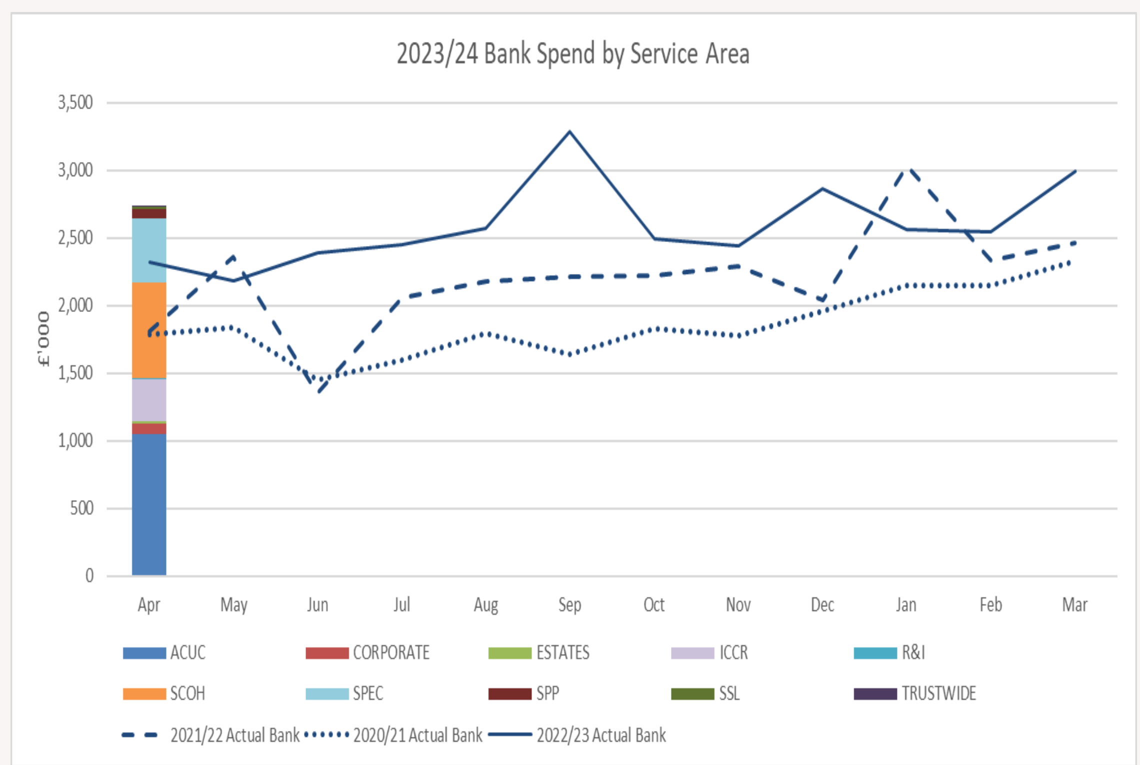
Agency expenditure

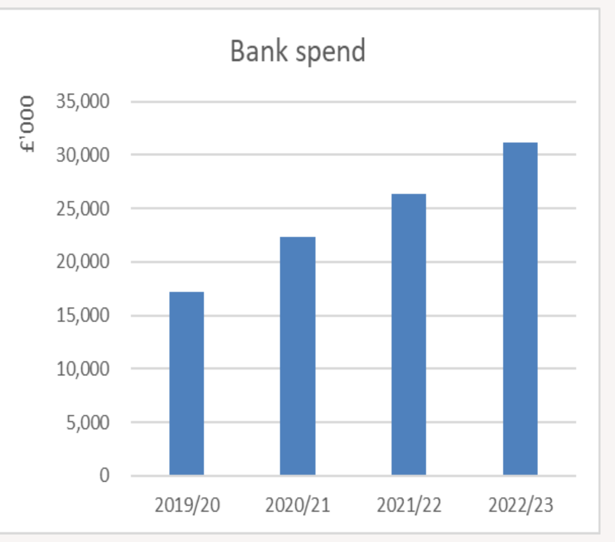
Month 1 2023/24 agency expenditure is £801k, this is £82k above the 2022/23 average monthly expenditure and almost double the average for 2020/21 (during the height of the COVID pandemic). Almost half of the month 1 expenditure was incurred by the Integrated Community Care & Recovery (ICCR) service area and 62% of total spend relates to medical agency.

For 2023/24, NHSE have introduced a new key performance indicator (KPI) for agency expenditure, with the limit being 3.7% of the pay bill. Month 1 expenditure is slightly above this at 3.8%. Performance against KPIs are shown in the table opposite.

KPIs	Target	Apr-23
Agency framework breaches	0	0
Above price cap agency bookings	0	22
Agency spend as % of pay bill	3.7%	3.8%

Bank expenditure analysis





Type	April
Bank Nursing	2,458
Bank Other Clinical	45
Bank Admin & Clerical	239
Grand Total	**2,742**

Bank expenditure

Month 1 2023/24 bank expenditure is £2.7m, this is £149k higher than the 2022/23 monthly average and 50% higher than the average for 2020/21 (during the height of the COVID pandemic). 90% of the month 1 bank spend relates to nursing and it has predominantly been incurred within the following service areas: Acute & Urgent Care £1.1m, Secure and Offender Health £0.7m and Specialities £0.5m.

Deep dive meetings in April and May have been set up to review inpatient ward spend, particularly temporary staffing. These meetings will be lead by Executive Director of Operations, Deputy Director of Finance, Deputy Director of Nursing and Deputy Director of People. The meeting with Acute & Urgent Care has already taken place, some of the drivers of spend were explored and the service will be doing some more work with teams.

Out of Area overspend

Out of Area

2500000
2000000
1500000
1000000
500000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

23/24 Actuals
22/23 Actuals
23/24 Budget less savings target
22/23 Average

Efficiency target £5m

Out of area expenditure for month 1 of 2023/24 is £1.4m, which is £0.3m above the 2022/23 average. If spend were to continue at this rate for the full year, total expenditure would be £17m. Total 2023/24 plan for out of area, including a £5m savings target is £8m.

Efficiencies

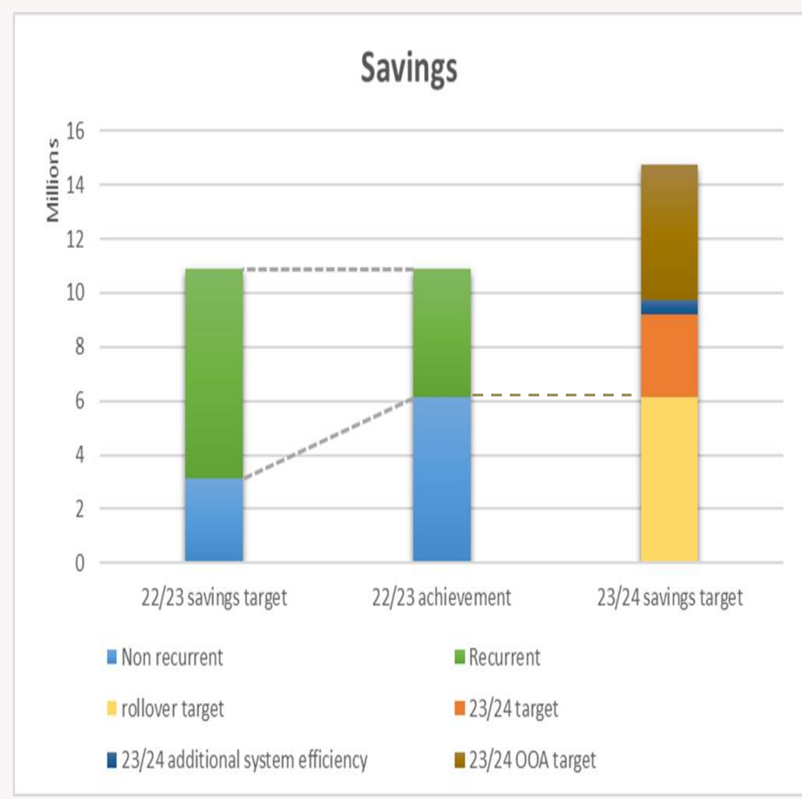
2023/24 Efficiency Target - £14.7m

The 2023/24 efficiency target is £14.7m, built up as follows:
- £6.1m rollover savings target
- £3.1m national efficiency target of 1.1%
- £5.0m out of area reduction target
- £0.5m additional system savings requirement

The savings plan submitted to NHSE as part of the financial plan submission on 5.4.23, comprised £9.6m recurrent savings plans and £5.1m non recurrent (including £2.4m unidentified plans) as shown in the table below.

Savings achieved at month 1 is £484k, which is a shortfall of £742k (mainly due to slippage on out of area £417k and unidentified target £197k).

	Non-recurrent	Recurrent	Grand Total
Fully Developed	**250**	**4,609**	**4,859**
Budget setting non pay review		1,250	**1,250**
Budget setting pay review (not wte)		1,059	**1,059**
Estates budget for Ross House (disposal)		150	**150**
Interest receivable (@2.25%)		200	**200**
Interest receivable (1%)	250		**250**
OH contribution		1,950	**1,950**
Plans in Progress	**2,500**	**5,000**	**7,500**
Budget setting pay review (not wte)	500		**500**
Budget setting pension review	1,400		**1,400**
Out of Area reduction		5,000	**5,000**
PFI - commercial performance settlement	600		**600**
Unidentified	**2,358**		**2,358**
Unidentified	2,358		**2,358**
Grand Total	**5,108**	**9,609**	**14,717**



Efficiencies				
	Annual Plan	YTD Plan	YTD Actuals	YTD Variance
Recurrent Efficiencies	9,609	801	305	496
Non Recurrent Efficiencies	5,108	425	179	246
Total Efficiencies	14,717	1,226	484	742

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - *'Draft'* 31-Mar-23 £m's	NHSI Plan YTD 30-Apr-23 £m's	Actual YTD 30-Apr-23 £m's	NHSI Plan Forecast 31-Mar-23 £m's
Non-Current Assets				
Property, plant and equipment	214.2	214.0	213.9	211.3
Prepayments PFI	1.3	1.3	1.4	1.3
Finance Lease Receivable	-	-	-	-
Finance Lease Assets	0.0	-	0.0	-
Deferred Tax Asset	(0.1)	-	-	-
Total Non-Current Assets	215.4	215.3	215.3	212.6
Current assets				
Inventories	0.6	0.6	0.4	0.6
Trade and Other Receivables	28.2	28.2	25.5	28.2
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	59.0	58.4	68.2	56.8
Total Curent Assets	87.9	87.3	94.1	85.7
Current liabilities				
Trade and other payables	(55.9)	(56.0)	(57.9)	(55.9)
Tax payable	(5.0)	(5.0)	(5.2)	(5.0)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.1)	(1.2)	(1.1)	(1.2)
Provisions	(1.5)	(1.5)	(1.4)	(1.5)
Deferred income	(40.4)	(40.4)	(45.6)	(40.4)
Total Current Liabilities	(106.5)	(106.7)	(113.7)	(106.6)
Non-current liabilities				
Deferred Tax Liability	-	(0.1)	(0.1)	
Loan and Borrowings	(25.1)	(24.4)	(24.4)	(23.0)
PFI lease	(45.7)	(45.5)	(45.5)	(43.8)
Finance Lease, non current	(7.9)	(7.8)	(7.7)	(6.8)
Provisions	(3.7)	(3.7)	(3.7)	(3.7)
Total non-current liabilities	(82.4)	(81.6)	(81.5)	(77.2)
Total assets employed	114.4	114.3	114.3	114.5
Financed by (taxpayers' equity)				
Public Dividend Capital	114.5	114.5	114.5	114.5
Revaluation reserve	41.7	41.7	41.7	41.7
Income and expenditure reserve	(41.9)	(41.9)	(41.9)	(41.9)
Total taxpayers' equity	114.4	114.3	114.3	114.3

SOFP Highlights

The Group cash position at the end of April 2023 is £68.2m, this includes Reach Out and the Mental Health Provider Collaborative.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 10 to 11.

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	94.1
Current Liabilities	-113.7
Ratio	0.8

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

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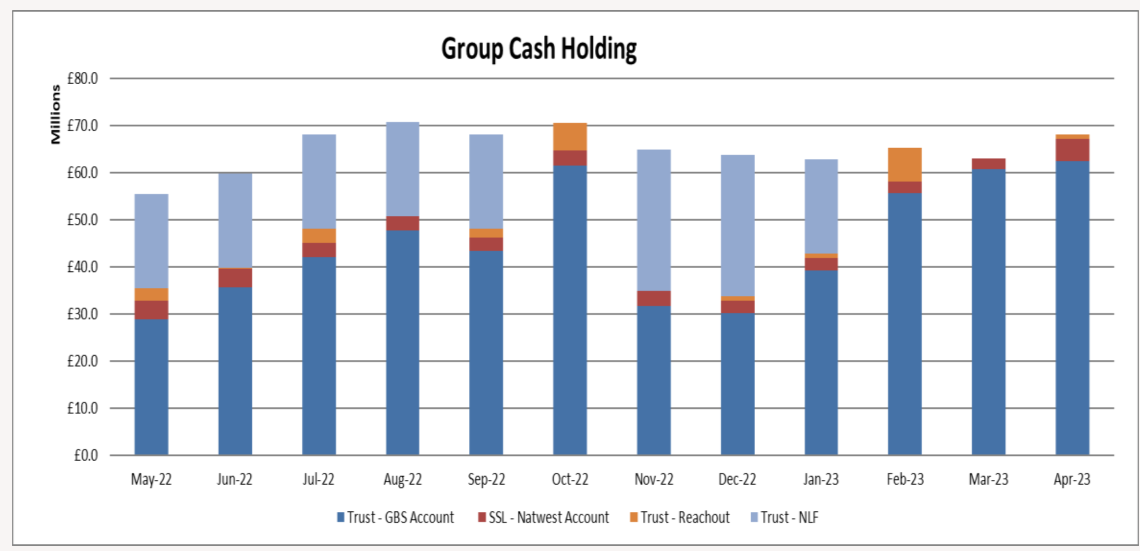
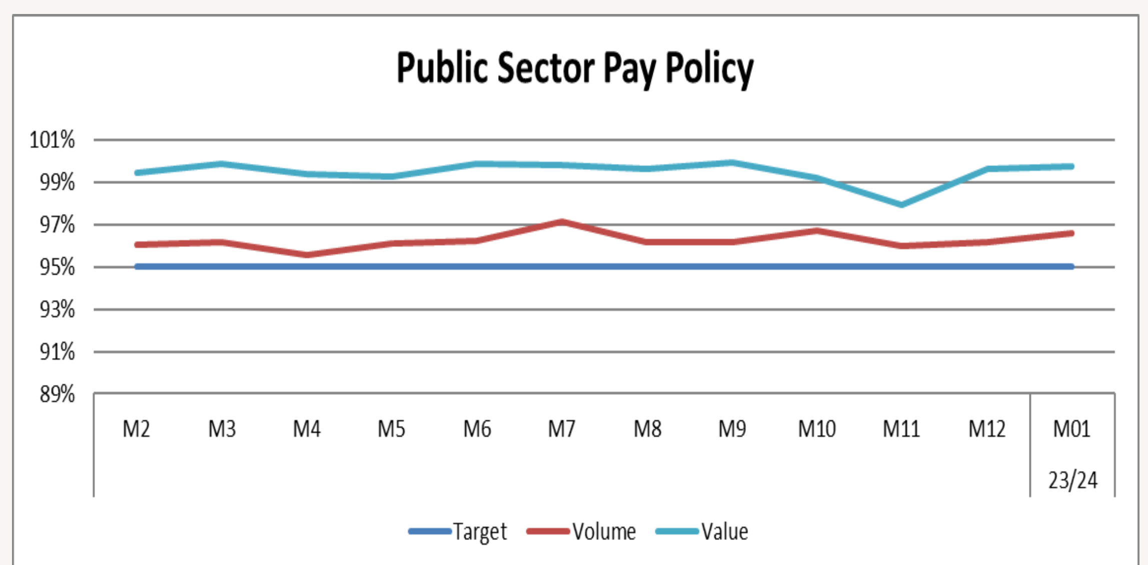
Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of April 2023 is £68.2m.

Following the movement in interest rates, consideration is being given to place a longer term deposit with the National Loan Fund in May/June 2023.

Better Payments

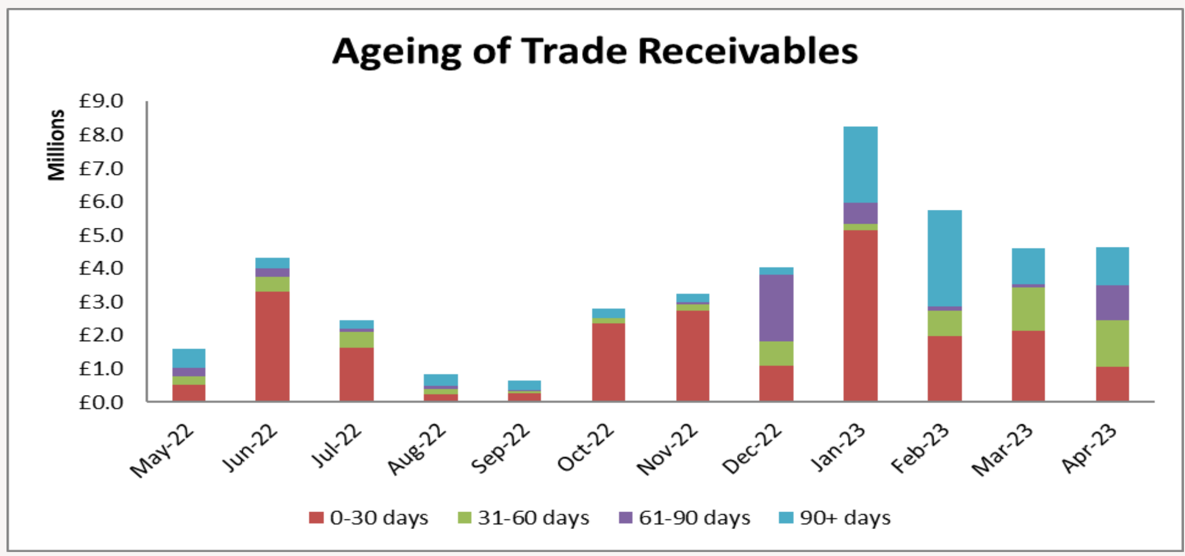
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

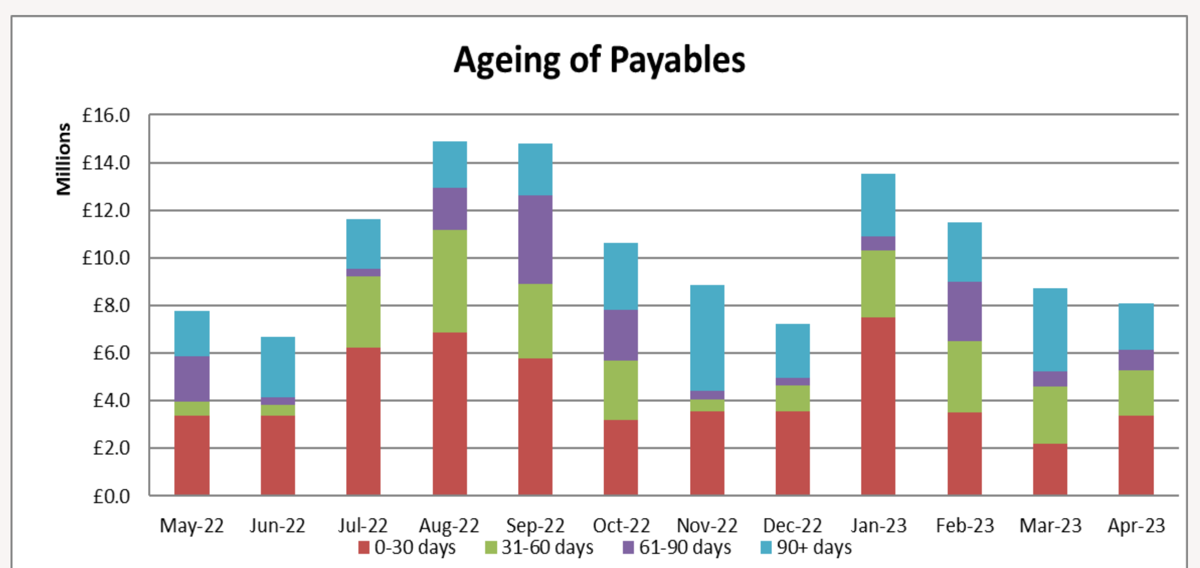
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables & Payables

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

Receivables :

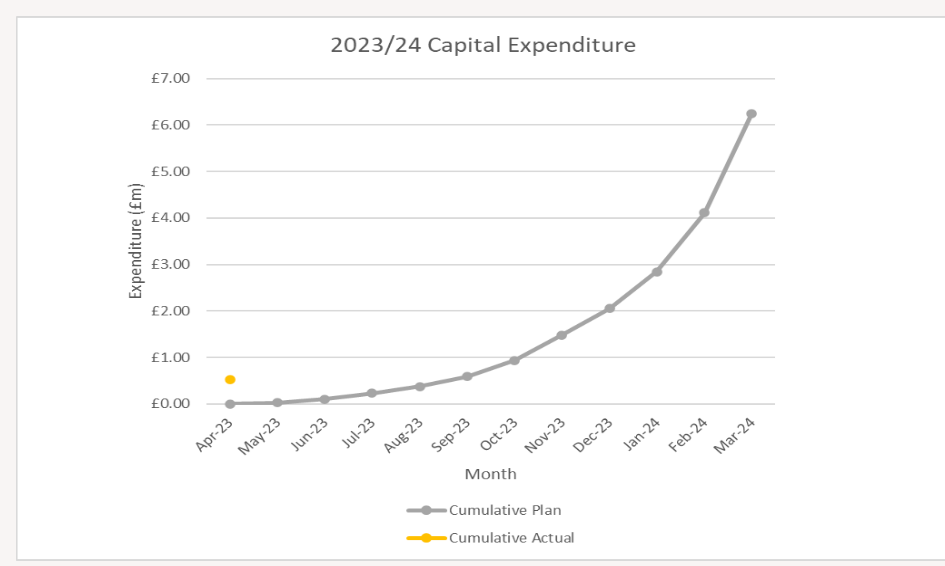
- **0-30 days-** balance for scheduled monthly and year-end invoices with no known disputes at present.
- **31-60 days-** Slight increase in balance due to £688k UHB under review due to services not fully provided (22/23), the remainder of the balance relates to staff overpayments (on payment plans)
- **61-90 days-** overall increase in month-main balance relates to BWC £949k (requires more info to validate), balance mainly staff overpayments (on payment plans)
- **Over 90 days –**UHB £638k under query due to services not fully provided (provision made for non-payment), South Warwickshire Partnership Trust £165k, DOH £57k still under review, staff overpayments (on payment plans).

Trade Payables:
Over 90 days -

- Sussex Partnership-£300k. Reach Out in query.
- Non-NHS Suppliers (61+) £1.3m – mainly bed fees invoices in query, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in May 2023.

Month 1 Capital Expenditure

Capital schemes	Annual Plan	YTD Plan	Total Actual	Variance to plan
	£'m	£'m	£'m	£'m
Approved Schemes:				
Minor Projects (inc Carry-Forward)	1.7	0.0	0.1	0.1
SSBM Works	2.0	0.0	0.0	0.0
ICT Projects	0.9	0.0	0.0	0.0
Risk Assessment Works	0.4	0.0	0.3	0.3
CAMHS Seclusion Suite (PDC Funded)	1.3		0.0	0.0
Total	6.3	0.0	0.5	0.5



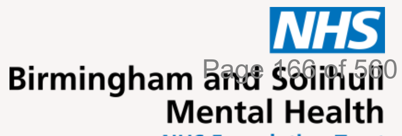
Group Capital Expenditure

As at month 1, group capital expenditure is £0.5m. This is £0.5m adverse to plan due to works progressing ahead of plan, mainly related to door set expenditure.

Capital Plan

The 2023/24 capital plan submitted to NHSE was £7m. This is based on a capital envelope of £6.25m plus notional allocation of £0.7m system capital investment fund (SCIF) which has been split across all system partners on a fair share basis. The actual allocation of SCIF is still to be agreed by the system and therefore, expenditure is being monitored against the £6.25m envelope. It is anticipated that as in prior year, there will be a bidding process to be undertaken for any additional funding from the SCIF .

Trust Service Area analysis



Group Summary	Annual Budget	YTD Budget	YTD Actual	YTD Variance
	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000
Acute and Urgent Care Services				
Other Income	(148)	(12)	(42)	30
Pay	41,672	3,473	4,062	(589)
Non Pay	17,077	1,423	1,773	(350)
Acute and Urgent Care Services Total	**58,602**	**4,884**	**5,793**	**(910)**
ICCR				
Other Income	(3,526)	(294)	(261)	(33)
Pay	56,195	4,683	4,143	540
Non Pay	9,649	804	824	(20)
ICCR Total	**62,318**	**5,193**	**4,706**	**487**
Specialties Services				
Other Income	(3,375)	(281)	(273)	(8)
Pay	42,839	3,570	3,643	(73)
Non Pay	3,243	270	284	(13)
Specialties Services Total	**42,707**	**3,559**	**3,654**	**(95)**
Secure Serv & Offender Health				
Other Income	(479)	(40)	(172)	132
Pay	53,731	4,478	4,221	257
Non Pay	8,712	726	665	61
Secure Serv & Offender Health Total	**61,964**	**5,164**	**4,714**	**450**
Corporate Services				
Other Income	(12,852)	(1,071)	(1,180)	109
Pay	43,278	3,606	3,544	62
Non Pay	38,376	3,198	3,393	(195)
PFI	12,611	1,051	1,033	17
Capital Financing	12,335	1,028	856	172
Corporate Services Total	**93,746**	**7,812**	**7,648**	**164**
HCI Total	**(331,164)**	**(27,597)**	**(26,989)**	**(608)**
Trustwide total	**12,271**	**1,023**	**546**	**476**
Surplus / Deficit - Trust	**444**	**37**	**73**	**(36)**

The month 1 Trust position is a £73k deficit, this is £36k adverse to plan. The breakdown of the Trust financial position is shown in the table opposite. Key variances are as follows:

Acute and Urgent Care Services (ACUC) £0.9m overspent

- Pay is £0.6m overspent, mainly on Inpatient wards £0.5m. £1.2m temporary staffing spend (£1m bank) is partly offset by £0.6m substantive underspend.
- Non pay is £0.4 overspent, predominantly due to out of area expenditure pressures.

Integrated Community Care & Recovery (ICCR) £0.5m underspent

- Pay is £0.5m underspent, mainly in Community Mental Health Teams (CMHT) £0.2m. £1.2m substantive underspend, including Service Development Funding (SDF) is partly offset by £0.7m temporary staffing spend (£0.3m bank, £0.4m agency).

Secure Care and Offender Health (SCOH) £0.5m underspent

- Other Income is £0.1m ahead of plan, mainly relating to specialling income.
- Pay is £0.3m underspent. £0.8m substantive underspend is partly offset by £0.5m temporary staffing overspend.

Corporate £0.2m underspent

- Over recovery of other income and interest receivable are offsetting non pay overspend mainly relating to estates expenditure.

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9.3. Audit Committee Chair`s Assurance Report April

Birmingham and Solihull Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	Item 9.3
Paper title	CHAIR'S ASSURANCE REPORT FROM AUDIT COMMITTEE
Date	7 June 2023
Author	Mr B Claire, Non-Executive Director, Chair
Executive sponsor	Mr D Tomlinson, Executive Director of Finance

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

Executive summary

The Audit committee met on the 20 April 2023. The attached Assurance Report is provided by the Committee Chair for the attention of the Council of Governors.

The committee received the following:

- Internal Audit Progress Report and Technical Updates
- LCFS Progress Report
- Single Tender Waivers/Losses and Special Payments
- External Audit and Technical Update
- Refreshed Audit Committee ToR
- Commissioning Board suite of governance documents: -
  - SFIs
  - Scheme of Reservation and Delegation
  - Standing Orders
- Commissioning BAF &
- Draft Annual Governance Statement
- Audit Committee Self-Assessment Survey proposal
- Audit Committee Work Programme for 2023/24

Reason for consideration

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

Strategic objectives

Sustainability

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

Financial implications

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

Strategic Risks

Equality impact

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

Our values
CommittedCommitted Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM AUDIT COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Internal Audit Progress Report and Technical Updates

The Committee received an update on the activities related.
During 2022/23 to date, the following reports were issued:

- Financial Sustainability (1.22/23) – Agreed upon procedures
- Care Quality Commission - Areas Requiring Improvements (2.22/23) – Good progress
- IT Healthcheck (3.22/23) – Reasonable assurance
- Data Quality – Staff Vacancies Performance Measure (4.22/23) – Reasonable assurance
- Key Financial Controls – Payroll and Procurement (5.22/23) – Split opinion: Payroll – Substantial assurance, Procurement – Reasonable assurance
- Recruitment and Retention (6.22/23) – Advisory
- Follow Up of High and Medium Priority Management Actions (7.22/23) – Good progress.

There are three assignments yet to be completed and reported in final and this will be taken into consideration when the draft for the full end of year head of internal audit opinion. Auditors' opinion may therefore change between now and the year-end dependent on the findings of these reviews:

- Board Assurance Framework – fieldwork completed, draft report to be issued.
- Data Security Protection Toolkit – in progress.
- Provider Collaboratives Governance Arrangements – in progress.

The 23/24 plan was discussed and approved.

Chair's assurance comments: Reasonable Assurance
It was good to note that the Trust at an overall organisational level was classed as 'adequate and effective', at the same time noting the additional work and plans that need to take place/developed in Procurement (single tender waivers) and Recruitment & Retention.
The 23/24 plan was discussed and approved. However the challenge that the team should consider how the Trust is delivering against its strategy was noted.

1.2 LCFS Progress Report

The Committee received an update on the activities related.
The salient points were noted as:

- The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green. The green rating assesses the Trust as fully compliant with the requirements, with demonstrable evidence of the impact of counter fraud work undertaken available.
- A fraud, bribery risk assessment (FBRA) was undertaken in 2022/23 to assess and
- identify your fraud risks. The risks identified, once scored, will be added to the Trust's risk management system, Eclipse and will monitored throughout the year. Twenty-nine risks have been identified and reviewed this year. The risk areas are highlighted within the fraud risk section of this report along with details of the actions taken to mitigate against those risks.
- A total of 13 referrals were received during the year, from which 11 were accepted for investigation, in accordance with the NHSCFA Anti-Fraud Manua.
  One referral has resulted in dismissal, following a HR investigation, however this is currently being appealed.

- Management have agreed actions to address all the findings reported by the LCFS service during 2022/23.

Chair's assurance comments: Good Assurance
No further comments.

1.3 Single Tender Waivers/Losses and Special Payments

The Committee received an update on single tender waivers.

The volume of STWs that are in Areas of Potential Concern increased significantly during the second year of the pandemic.

This increase was partly driven by the impact of the pandemic, but also relates to new managers coming into post in departments ordering goods and high levels of orders at year end 21/22 to ensure all available funding was used in year.

Further training and guidance will be delivered to improve compliance in this area.

The volume of STWs that are in Areas of Potential Concern has reduced noticeably since Sep-22 and is in line with historic trends.

Chair's assurance comments: Reasonable Assurance
Whilst it was noted that many decisions were necessary and expedited during the Covid period, the assumed trend down in numbers didn't appear to be happening. It was agreed that the committee would monitor the ongoing trends as we progress through 23/24.

1.4 External Audit and Technical Update

The committee received a detailed updated from the external auditors'.

The Committee were assured the assessment of what is material is a matter of professional judgement and is affected by Auditors' perception of the financial information needs of the users of the financial statements.

In making assessments Auditors' assume that users:
- Have a reasonable knowledge of business, economic activities and accounts;
- Have a willingness to study the information in the financial statements with reasonable diligence;
- Understand that financial statements are prepared, presented and audited to levels of materiality;
- Recognise the uncertainties inherent in the measurement of amounts based on the use of estimates, judgement and the consideration of future events;
- Will make reasonable economic decisions on the basis of the information in the financial statements.

Auditors' consider materiality whilst planning and performing our audit based on quantitative and qualitative factors. Whilst planning, we make judgements about the size of misstatements which we consider to be material and which provides a basis for determining the nature, timing and extent of risk assessment procedures, identifying and assessing the risk of material misstatement and determining the nature, timing and extent of further audit procedures.

The materiality determined at the planning stage does not necessarily establish an amount below which uncorrected misstatements, either individually or in aggregate, will

be considered as immaterial. Auditors' revise materiality for the financial statements as our audit progresses should we become aware of information that would have caused auditors' to determine a different amount had we been aware of that information at the planning stage.

The provisional materiality is set based on a benchmark of total operating expenditure. Auditors' will identify a figure for materiality but identify separate levels for procedures designed to detect individual errors, and also a level above which all identified errors will be reported to Audit Committee.

Chair's assurance comments: Good Assurance
No further comments.

1.5 Refreshed Audit Committee ToR

The Committee noted the Commissioning Committee ("CoCo"), as the Board in Committee, has been established to lead the commissioning arm of the Trust. As such, it holds certain powers and has certain duties that require independent assurance and scrutiny. This will be discharged by the Audit Committee.

The Audit Committee's existing Terms of Reference, as approved in October 2022, have been refreshed to incorporate appropriate mentions of the Trust's commissioning/Lead Provider role.

The terms of reference were received for approval.

Chair's assurance comments: Reviewed and approved.

1.6 **Commissioning Board suite of governance documents**

The committee were informed the Trust's designation as Lead Provider for the BSol Mental Health Provider Collaborative, taken in conjunction with the same responsibility for the West Midlands Reach Out Provider Collaborative, has occasioned strengthening of the Trust's governance arrangements. This has included establishment of a Commissioning Committee (CoCo – Board in Committee) and appointment to new roles and officers. It has also involved refresh of and amendment to the Trust's three principal governance instruments – the Constitution (incorporating new Standing Orders), the SFIs and the Scheme of Delegation.

The details within the reports received were noted for approval.

Chair's assurance comments: Reviewed and approved.

1.7 Draft Annual Governance Statement

The Committee received the Draft Annual Governance Statement for approval.

Chair's assurance comments: Reviewed and approved.

1.8 Audit Committee Self-Assessment Survey proposal

There Committee noted there is not currently an effective Audit Committee survey tool in place in the Trust for assessing and evaluating the effectiveness and functioning of

the Audit Committee.

The Committee noted the proposal for developing a monkey survey which will comprise 18 questions grouped under seven broad themes that reflect the statutory and core responsibilities of the Audit Committee as defined by the FRC Audit Guide, our Audit Committee Terms of Reference, best practice and the Chartered Governance Institute Guidance Note on Audit Committee Terms of reference. Questions 19 and 20 give respondents the opportunity to provide further qualitative input which will be triangulated in establishing a comprehensive and better understanding of the `health status` of our Audit Committee.

Chair's assurance comments: Noted

1.9 Audit Committee Work Programme for 2023/24

The Committee received the work plan for approval.

Chair's assurance comments: Approved – see additional comments above (Section 1).

BAL CLAIRE
NON-EXECUTIVE DIRECTOR

9.4. Charitable Funds Chair`s Assurance Report April

Committee Chairs Escalation and Assurance Report

Name of Committee	Report of: Charitable Funds Committee
Report presented at	BOARD OF DIRECTORS
Date of meeting	7 June 2023
Agenda Item	9.4
Date(s) of Committee Meeting(s) reported	30 March 2023
Quoracy	Membership quorate: Y / N
Agenda	The Committee considered an agenda which included the following items: 1. Purpose of Caring Minds 2. Caring Minds Business Case Outcome 3. Caring Minds and Fundraising Update 4. Cazenove (Schroders) Update 5. Fund balances update
Alert:	The Committee wishes to alert the Trust Board to the following: • The Committee agreed Caring Minds need to be relaunched and will hold an away day with key stakeholders to refocus the purpose of the charity. • The business case for Caring Minds was not approved, alternative options for resources for the charity team are being explored.
Assurance:	The Committee was assured on the following: • The Events and Engagement officer post has secured funding in place for a 12-month fixed term contract, from NHS Charities Together. Intended Start date = 1st July 2023 • As at 28th February 2023 the Birmingham and Solihull NHS portfolio was valued at £570,542 (£563,121 as at 31st December 2022- split between the multi asset fund and cash). This is compared to a historic cost value of £332,618. To date for the financial year investment income has been received of £21,615. In the previous financial year (2021/22) investment income of £17,983 was received. • Over the past 12 months the fund has made a cumulative return of 0.5%. • The returns on the funds are significantly more than would be received through holding pure cash investments. Given the

	current limited level of donations into the charity it is important to maximise the return from investments.
Advise	The Committee was advised of the following matters: 1. A short promotional film to showcase the charity has been filmed and will premiere at the Value awards in April. 2. Fund Balances total £433k 3. Donations to 28th February 2023 £33k 4. Expenditure to 28th February 2023 £97k 5. Cash Balance as at 28th February 2023 is £30k
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: 1. N/A

Report compiled by	Monica Shafaq, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

DRAFT

9.5. Integrated Performance Report - Front sheet

Enclosure 1: Integrated Performance Report

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	Item 9.5
Paper title	Integrated Performance Report
Date	7 June 2023
Author	Richard Sollars, Deputy Director of Finance Gill Mordain, Associate Director of Clinical Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

Data is not yet available in a number of areas, mainly Sustainability, but also in terms of vacancies and sickness absence.

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

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

At the January 2023 FPPC meeting, members requested a detailed update on key factors affecting performance, actions and improvement trajectories for several metrics. These have been considered by the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. Relevant Leads have provided an update on each area for FPPC

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

All SPC-related charts and detailed commentaries can be accessed if you are on the Trust network via

http://wh-info-live/PowerBI_report/IntegratedDashboard.html - please copy and paste this link into your browser.

Charts and commentaries for key areas of under performance are attached as appendices.

At the January 2023 FPPC meeting members requested a more detailed update on the key themes, factors affecting performance, actions and improvement trajectories for the following metrics:

- Inappropriate Out of Area Bed Days
- IAPT – service users seen within 6 and 18 weeks
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months
- CPA 7 day follow up
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

The above areas have been considered by the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. Relevant Leads have provided an update on each area for FPPC.

Appendix 1 provides an update against improvement trajectories for these metrics.

Performance in April 2023

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

- **Out of Area Bed Use** – Some process improvements have helped us address underlying issues and allowed some patients to be repatriated, but the impact of COVID-19 and the closure of beds has significantly impaired our ability to eliminate use of out of area beds. April's figure is 34.4 patients
- **IAPT** – As discussed at FPP, there is a range of issues which require a system approach to resolve this and additional investment.
- **New referrals not seen** – As discussed at FPP, there are a range of issues here, including the level of Neuropsychiatry waits.
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. This has deteriorated as a result of COVID, but the overall divergence between individual teams has long been a concern:
- **YTD financial position** is a deficit of £59k against a planned breakeven.

Quality

- Incidents resulting to harm to patients have increased to 16.5% in April
- Ligature incidents with no anchor point have increased to 29 in April
- **Key concerns:** Incidents resulting from harm and ligature incidents.

Performance

- The level of Out of Area Patients remains a concern. The figure increased from 894 OBD in October to 1153 in January (up from 34.2 patients to 37.2), up from Apr-22 416 OBD (13.9). The figures have reduced to 1202 OBD (40.1 patients) in April 2023, however this will be reduced to 1034 OBDs (34.4 patients) due to additional acute bed capacity being provided locally in Kings Norton and reporting will be updated to reflect this next month. Based on recent trends, a continued reduction in the use of inappropriate PICU bed days is anticipated in the next month or so, though inappropriate Acute Out of Area stays will remain problematic
- CPA 7-day follow up is at 87.9%, the lowest level since May-22
- CPA with formal review in last 12 months up sustained at 88.5%
- IAPT patients seen within 6 weeks of referral has declined to 33% the lowest position since July 2022. This is being discussed across BSol to identify how to address underperformance. Performance for within 18 weeks has slipped to 71.18%,
- New referrals not seen within 3 months are little changed at 3,409, the highest figure in five years. Of this, adult CMHT and Neuropsychiatry represents the most significant issues.
- **Key concerns: Out of Area, CPA 7-day follow up, IAPT waiting times, CPA 12-month review and new referrals not seen in 3 months.**

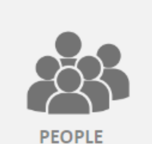
People

- The People domain has shown a small improvement 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 at 4.8% have improved- the lowest since September 2020, although remains at 7% with Acute and Urgent care.
- Rolling 12-month turnover has been sustained at 9.9%
- Vacancy data – at 11.8% compared to 11.5% the previous month
- Staff appraisals down to 68.8%, lowest level in five years
- Bank and Agency fill down from 84.6% to 84.1%
- **Key concerns: Appraisals, bank and agency fill rate, vacancies, sickness**

Sustainability

- Financial position for month 1 of 2023/24 is a deficit of £59k against a breakeven plan.
- Key pressures are:
  - temporary staffing: month 1 expenditure is £3.6m, this is £0.3m higher than the 2022/23 average. Spend is 3.8% of the month 1 pay bill, this is just above the NHSE ceiling which is set at 3.7% for 2023/24.
  - out of area beds: month 1 expenditure is £1.4m. If straight lined for the year this would equate to £17m. An ambitious savings target has been set for a £5m recurrent reduction in out of area spend.
  - efficiencies: £14.7m savings target for 2023/24 (including £6.1m rollover target from prior year and £5m OOA target). Need to identify cash releasing, recurrent savings schemes. The lack of a pipeline of savings schemes is a key risk.
- Capital expenditure for month 1 of 2023/24 is £0.5m, with works progressing ahead of plan.
- **Key concerns: efficiencies, temporary staffing, out of area**

Integrated Performance Dashboard



Top Line Commentary (Trust level)

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

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

April 2023

Performance

Measure	Value	Trend
CPA 7 day FU	87.9%	↓
CPA with Formal Review last 12 mths	88.5%	↓
Data Quality Maturity Index (DQMI)	97.5%	↑
Delayed Transfer Bed Days	991	↘
Delayed Transfer, percent of bed days	6.6%	
Eating disorders routine	100.0%	
Eating disorders urgent	100.0%	
First episode psychosis	100.0%	↑
IAPT into recovery	51.8%	
IAPT seen in 18 weeks	71.2%	↓
IAPT seen in 6 weeks	33.0%	↓
Out of Area Bed Days	1202	↓
Referrals over 3 mths with no contact	3409	↓

People

Measure	Value	Trend
Bank & Agency Fill Rate	84.1%	↓
Fundamental Training	91.4%	↓
Rolling 12m Turnover	9.7%	↑
Staff Appraisals	68.8%	↓
Staff Sickness	4.8%	↗
Staff Vacancies	11.8%	↓

Quality

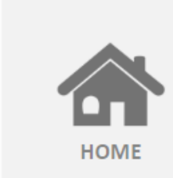
Measure	Value	Trend
Absconsions from inpatient units	6	
Commissioner reportable incidents	2	
Community confirmed suicides	0	
Community suspected suicides	1	↓
Failure to return	10	↑
Incidents of self harm	169	↑
Incidents resulting in harm (other)	13.8%	↑
Incidents resulting in harm (patients)	16.5%	↑
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	29	
Ligature with anchor point	1	
Patient assaults	45	
Patient ssaults / 1000 OBD	2.5	
Physical restraints	285	
Physical restraints/ 1000 OBD	15.8	
Prone restraints	84	
Prone restraints/ 1000 OBD	4.7	
Reported incidents	2117	↑
Staff assaults	100	
Staff assaults / 1000 OBD	5.5	↓

Sustainability

Measure	Value	Trend
CAP Ex	£517k	
Cash	£68,159k	↑
CIP	£483k	↓
Info Governance	83.9%	
Monthly Agency	£801k	↓
Operating Surplus	£59k	↓
SOF rating	3	↑

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

Integrated Performance Dashboard


HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

A: All

Measure	Latest Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
CPA 7 day FU	95.00	89.0%	90.2%	91.0%	91.2%	89.2%	87.9% ↓
CPA with Formal Review last 12 mths	95.00	86.8%	86.5%	86.8%	88.2%	88.8%	88.5% ↓
Data Quality Maturity Index (DQMI)	95.00	97.2%	97.8%	97.7%	96.6%	96.6%	97.5% ↑
Delayed Transfer Bed Days		746	730	838	896	937	991 ↘
Delayed Transfer, percent of bed days		4.8%	4.6%	5.4%	6.3%	6.0%	6.6%
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Eating disorders urgent	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% ↑
IAPT into recovery	50.00	49.6%	54.8%	43.7%	49.9%	50.5%	51.8%
IAPT seen in 18 weeks	95.00	68.5%	74.2%	74.9%	73.7%	74.2%	71.2% ↓
IAPT seen in 6 weeks	75.00	36.5%	38.3%	35.8%	40.2%	40.8%	33.0% ↓
Out of Area Bed Days	493.00	949	1061	1153	991	1302	1202 ↓
Referrals over 3 mths with no contact		3058	3310	3273	3277	3201	3409 ↓

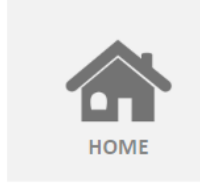
Top Line Commentary (Trust level)

KEY CONCERN:

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

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

Integrated Performance Dashboard



A: All

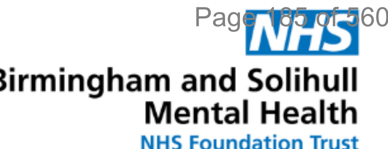
Measure	Latest Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Staff Vacancies		13.6%	13.8%	13.0%	12.3%	11.5%	11.8% ↓
Staff Sickness	4.28	6.7%	7.2%	6.3%	5.4%	5.2%	4.8% ↗
Staff Appraisals	90.00	76.8%	72.3%	73.4%	71.3%	69.0%	68.8% ↓
Rolling 12m Turnover		10.7%	10.8%	10.7%	10.7%	9.9%	9.7% ↑
Fundamental Training	95.00	93.5%	93.5%	92.7%	90.3%	90.2%	91.4% ↓
Bank & Agency Fill Rate		83.6%	83.3%	84.5%	81.3%	84.6%	84.1% ↓

Top Line Commentary (Trust level)

KEY CONCERNS

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

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



Birmingham and Solihull Mental Health NHS Foundation Trust

Integrated Performance Dashboard

compassionate inclusive committed

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

A: All

Measure	Latest Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	
Absconsions from inpatient units		5	5	11	2	4	6	
Commissioner reportable incidents		8	4	5	6	9	2	
Community confirmed suicides		0	0	0	0	0	0	
Community suspected suicides		2	2	1	1	4	1	↓
Failure to return		20	21	11	12	18	10	↑
Incidents of self harm		155	144	158	150	165	169	↑
Incidents resulting in harm (other)		12.1%	13.6%	14.5%	13.9%	14.0%	13.8%	↑
Incidents resulting in harm (patients)		13.8%	13.4%	19.3%	16.2%	14.4%	16.5%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	0	
Ligature no anchor point		29	43	36	19	14	29	
Ligature with anchor point		0	0	0	0	1	1	
Patient assaults		54	49	42	46	42	45	
Patient ssaults / 1000 OBD		2.9	2.6	2.3	2.7	2.2	2.5	
Physical restraints		238	246	316	277	297	285	
Physical restraints/ 1000 OBD		12.9	13.2	17.1	16.5	15.9	15.8	
Prone restraints		35	37	62	36	69	84	
Prone restraints/ 1000 OBD		1.9	2.0	3.4	2.1	3.7	4.7	
Reported incidents		2285	2370	2412	2282	2453	2117	↑
Staff assaults		99	112	121	95	121	100	
Staff assaults / 1000 OBD		5.4	6.0	6.6	5.7	6.5	5.5	↓

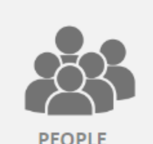
Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard



A: All

Measure	Latest Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
CAP Ex		£382k	£360k	£487k	£3,830k	£1,748k	£517k
Cash		£64,736k	£63,751k	£62,889k	£65,242k	£59,020k	£68,159k ↑
CIP		£655k	£655k	£656k	£656k	£3,662k	£483k ↓
Info Governance		93.6%	91.9%	96.7%	94.5%	94.9%	83.9%
Monthly Agency		£774k	£760k	£817k	£668k	£755k	£801k ↓
Operating Surplus		-£34k	-£60k	-£16k	-£7k	-£2,873k	£59k ↓
SOF rating		3	3	3	3	3	3 ↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

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

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

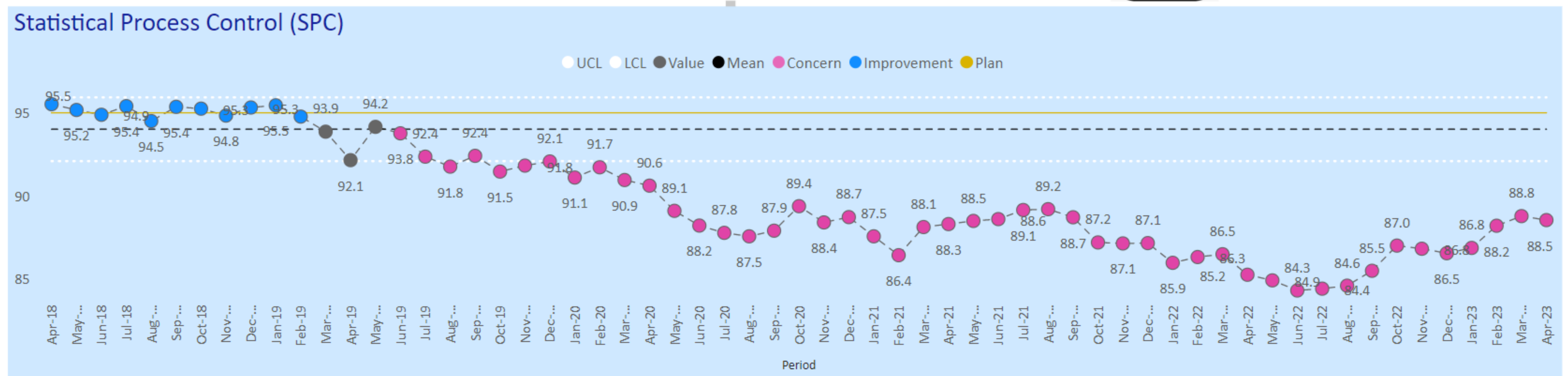
April 2023

CPA 7 day FU

Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 87.90% for April 2023. April 2023 performance is below the target of 95%. This relates to 15 outstanding follow ups from 124 discharges in April of which, 8 patients were discharged to the care of FTB, 2 patients were discharged to another mental health trust, 1 patient was discharged to an acute hospital and contact was with staff only, attempts were made to see 1 patient but were unsuccessful, 2 patients were seen outside 7 days and 1 case will be a pass when data entry has been completed. Of the 15 exceptions 8 were adult acute and 4 in ICCR and 1 in older adults and 2 in secure services. When Rio data entry has been completed this will increase compliance to 88.7%.
B: Why has it happened?	Where service users have been discharged to other mental health services to undertake the follow up, this requires BSMHFT to check with them to see if this has taken place. To reduce the burden we have not asked staff to undertake this and this has affected the performance this month as 10/15 patients were discharged to FTB or another trust. Recording has been challenging for a number of months as a number of staff have undertaken bank shifts with teams they do not normally work in and therefore were not set up to record contacts. Teams have had additional support to rectify where this has occurred. Late data entry within services is also a factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD.
C: What are the implications and consequences?	Early follow up of patients post discharge prioritised by HTT in line with evidence based practise to reduce the risk of suicide or self harm. Service users are at a higher risk of suicide or self harm within the first 3-7 days of discharge and follow up is important to minimise this risk.
D: What are we doing about it?	Daily notifications of discharges are sent to the responsible team to alert them to plan follow up and this is monitored by the CSM for Home Treatment. Teams continue to require support from the information team regarding data entry on RIO. The addition of FTB data to the shared care record will also enable staff to check if patients have been followed up, however this has been affected by FTB's patient record system issues.
E: What do we expect to happen?	We expect 7 day follow up standard of 95% to be maintained with HTTs acting on the daily discharge notification received.
F: How will we know when we have addressed issues?	Standard is being maintained with minimal or no input required from the information team to review data entry.

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths



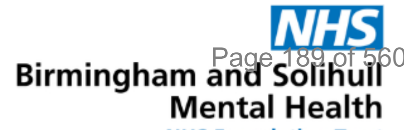
Break down by Division (with pink background where target not met)

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	86.8%	86.5%	86.8%	88.2%	88.8%	88.5%
B: Acute and Urgent Care	38.5%	12.5%	14.3%	50.0%	100.0%	66.7%
C: ICCR	87.0%	85.6%	85.1%	87.7%	88.5%	87.8%
D: Secure Serv & Offender Health	97.4%	97.4%	97.7%	98.4%	97.8%	97.8%
E: Specialties	80.5%	85.2%	82.5%	84.3%	82.6%	85.7%

Commentary

The number of reviews taking place has consistently declined over the last year and has been outside control limits since July 2019. The rate was maintained at an average of 89% from April 2021 until October and then declined to 87%. November 2021 onwards showed an overall decline until July 2022, where the trend was reversed, and performance has started to increase with April 2023 being sustained at 88.52%. Within divisions and teams there is variation in performance with between 1-50 reviews outstanding. 2 adult CMHTs have more than 30 reviews outstanding. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 20 outstanding and Adult CMHTs have 220 outstanding. Adult CMHT account for 48%, older adult CMHT for 5%, Secure for 16% and AOT for 25% of the total outstanding.

Detailed Commentary



Birmingham and Solihull Mental Health NHS Foundation Trust

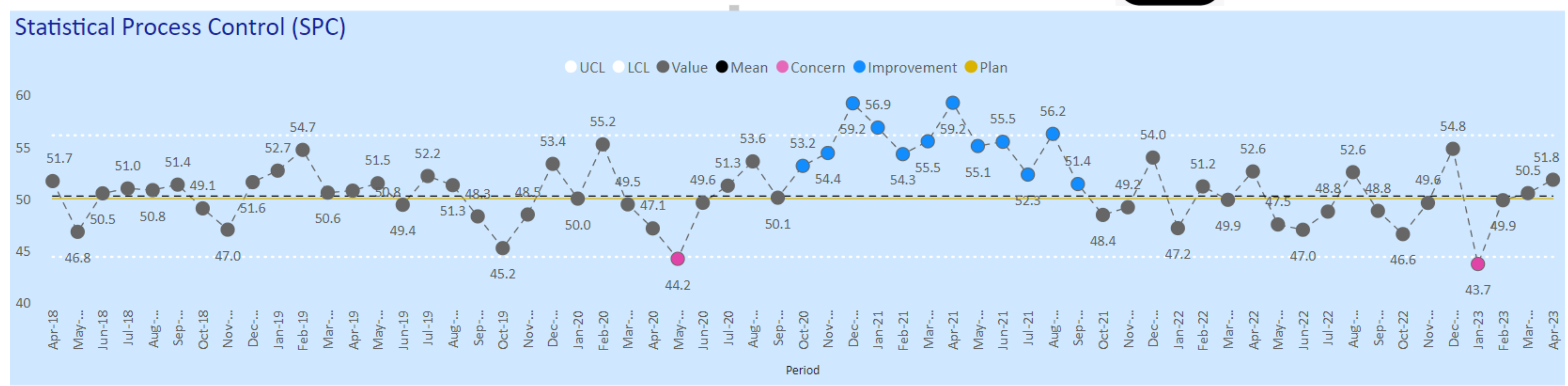
April 2023

CPA with Formal Review last 12 mths

Question	Answers
A: What has happened?	The number of reviews taking place has consistently declined over the last year and has been outside control limits since July 2019. The rate was maintained at an average of 89% from April 2021 until October and then declined to 87%. November 2021 onwards showed an overall decline until July 2022, where the trend was reversed, and performance has started to increase with April 2023 being sustained at 88.52%. Within divisions and teams there is variation in performance with between 1-50 reviews outstanding. 2 adult CMHTs have more than 30 reviews outstanding. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 20 outstanding and Adult CMHTs have 220 outstanding. Adult CMHT account for 48%, older adult CMHT for 5%, Secure for 16% and AOT for 25% of the total outstanding.
B: Why has it happened?	During the COVID period face to face contacts have reduced with staff using digital solutions such as AccuRx and telephone calls to conduct appointments. Meetings with multiple people remains challenging at the moment. There is a reluctance for some older adults to attend face to face. ICCR: The AD has advised that there are a high number of vacancies and lack of capacity in medical clinics to book in CPA reviews. There are difficulties in recruiting medical staff and where there is a change in doctor, appointments are cancelled or rescheduled. A deep dive has shown that a number of service users should have been placed on care support. Specialties: Face to face contacts are increasing, however, caseloads of care coordinators are currently very high (some CPNs have 50+ against an ideal maximum of 35) it is felt that the scheduling and recording of formal CPA reviews has not been as robust as it should be. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged.
C: What are the implications and consequences?	Carrying out as a minimum an annual CPA reviews is key to ensuring that the service user's care plan is updated to reflect changes in service users' needs, care and support requirements.
D: What are we doing about it?	Exception reports outlining service users coming up for their annual CPA review are available to all teams to enable proactive action in advance of the 12 months expiring. Work has taken place to address data quality issues in HTT, specialties and secure care. A plan to strategically review the CPA process including care plans has commenced and will start with the introduction a new care plan in line with changes outlined in national guidance. Changes to the process in the community will be based on clinical models developed as part of the transformation work and in line with the NHSE statement on CPA. ICCR The AD has advised that a deep dive has commenced to review whether service users should be on CPA or care support. Clinical leads are working with the medical staff and CPNs to arrange reviews. Progress will be reviewed on a weekly basis. Specialties: Team managers are being encouraged to use MyDashboard so staff are aware of reviews outstanding. These will also be discussed in supervision and managers meetings. Review for service users transferred back from CERTs will take place to see whether they need to remain on CPA or not.
E: What do we expect to happen?	ICCR and Specialties: A target has been set to reach the 95% target by the end of September 2023.
F: How will we know when we have addressed issues?	When reviews are undertaken in a systematic way and performance increases and is maintained although it is noted that the system will change and is part of a wider strategic review

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

IAPT into recovery



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	49.6%	54.8%	43.7%	49.9%	50.5%	51.8%
E: Specialties	49.6%	54.8%	43.7%	49.9%	50.5%	51.8%

Commentary

The MTR rate has fluctuated and largely meets the 50% national target. MTR is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. April 2023 position in line with the 50% target at 51.82%.

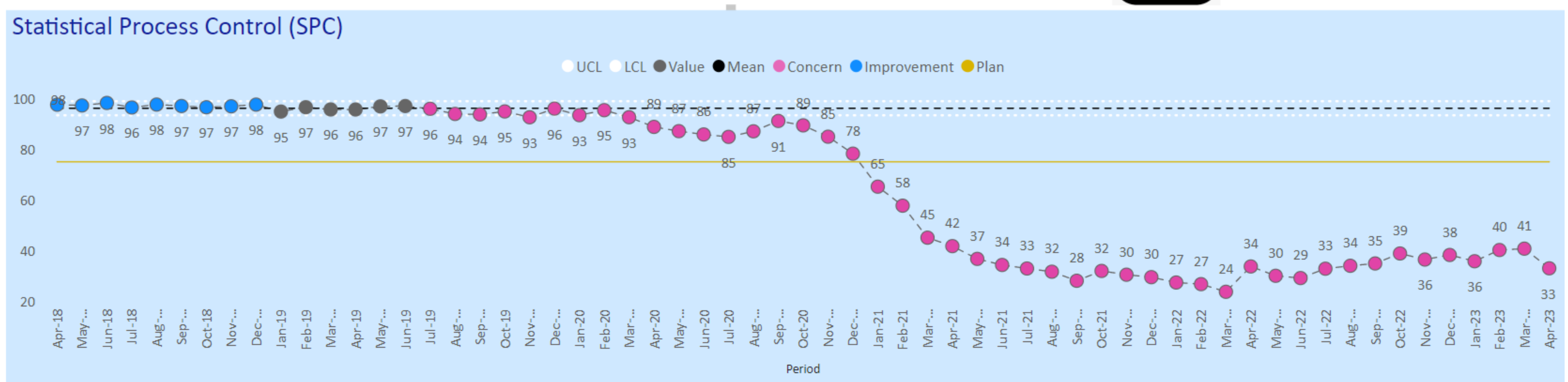
Detailed Commentary

IAPT into recovery

April 2023

Question	Answers
A: What has happened?	The MTR rate has fluctuated and largely meets the 50% national target. MTR is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. April 2023 position in line with the 50% target at 51.82%.
B: Why has it happened?	The MTR rate remains within control limits. There are a range of reasons (outside trust control) that do impact on maintaining the 50% target including; financial or housing difficulties, domestic violence, gang violence, failure to have asylum applications approved, which apply to some areas of Birmingham. Due to language difficulties, staff have to work through interpreters which can impact on the effectiveness of therapies through translation. Working with staff, the service aims to ensure that patients are seen at the step for the right treatment and BHM staff with language offer psychological therapy to the patients in their preferred language as much as possible. The Implementation of evidence based practise to support good quality recovery outcomes.
C: What are the implications and consequences?	In response to the COVID impact, NHSE and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time.
D: What are we doing about it?	Working with staff, the service aims to ensure that patients are seen at the right step for the right treatment to maintain and increase MTR rates. Action is also taken to contact patients who have disengaged from the service whilst at caseness. BHM staff with languages offer psychological therapy to the patients in their preferred language as much as possible.
E: What do we expect to happen?	Maintain/exceed the 50% MTR rate.
F: How will we know when we have addressed issues?	Routine monitoring within service and monthly reporting at Trust level.

IAPT seen in 6 weeks



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	36.5%	38.3%	35.8%	40.2%	40.8%	33.0%
E: Specialties	36.5%	38.3%	35.8%	40.2%	40.8%	33.0%

Commentary

Performance has been on a reducing trend since March 2020 below the 75% target. July 2022 onwards has shown a steady increase until April 2023 which saw a decrease to 33%.

Detailed Commentary

IAPT seen in 6 weeks

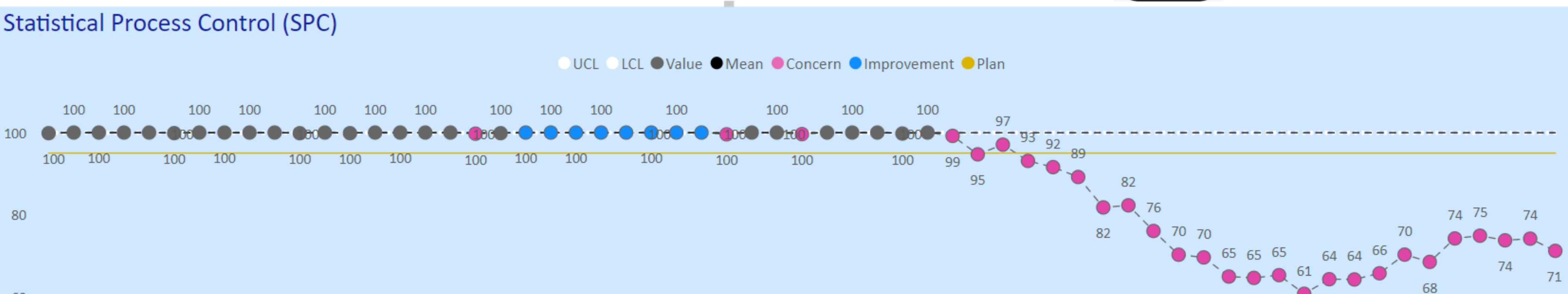
April 2023

Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 below the 75% target. July 2022 onwards has shown a steady increase until April 2023 which saw a decrease to 33%.
B: Why has it happened?	The reduction in activity in April was due to staff leaving, sickness and annual leave. The ability to see patients face to face was impacted by Covid as access to GP surgeries and access to community facilities stopped. Face to face groups also stopped and, whilst these have now increased in BHM premises since easing of restrictions, they have needed to be undertaken in a COVID secure way and capacity is therefore reduced in the number of participants per group. The iAPT model relies on large group interventions to see the majority of patients at Step 2, with smaller numbers then requiring Step 3 - 1:1 intervention. The service also has a large number of vacancies following staff retirements and leavers. Over the past 5 years significant challenges have been faced around retention of staff who have left to take up further training, work outside of the NHS or move to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. High intensity Therapist training is now only available in canterbury and requires staff to travel to Canterbury and London on regular basis and may not be attractive to staff
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. Internally: funding agreed to offer all High Intensity therapist at Band 7 bringing in line with other Trusts. This has already had an impact whereby the service has recently retained 10 of the 11 trainees, who started in October 2022. A communications strategy and social media campaign has commenced to support the rolling adverts for both qualified and future trainee posts. A review has taken place of clinical space in order to increase group capacity and GP premises have reopened to BHM. The removal of masks and social distancing from 12th September have allowed a further increase in group participants. Online groups are also well established, which show lower numbers of DNAs. An additional quality oversight managerial role is being recruited to free up clinicians from management duties and increase clinical contact hours. A team manager post has also been recruited to. Allocation of trainee places for 'new to IAPT' posts have been agreed and plans are in place to recruit to these, for both CBT and non-CBT modalities. Drop in sessions have been reinstated.
E: What do we expect to happen?	The service expects to see a continuing in the reversal of the downward trend against this KPI with a sustained improvement against the target to reach the 75% target by January 2025. This is based on the current staffing available and will be adjusted for improvement as staff are recruited. A further 3 intakes of trainees and the successful retention of these staff on completion of their training will help to address this.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 75% target.

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

IAPT seen in 18 weeks

Divisions



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	68.5%	74.2%	74.9%	73.7%	74.2%	71.2%
E: Specialties	68.5%	74.2%	74.9%	73.7%	74.2%	71.2%

Commentary

Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 12 months. Levels have been increasing from July 2022 with April showing a decline at 71.18%.

Detailed Commentary

IAPT seen in 18 weeks

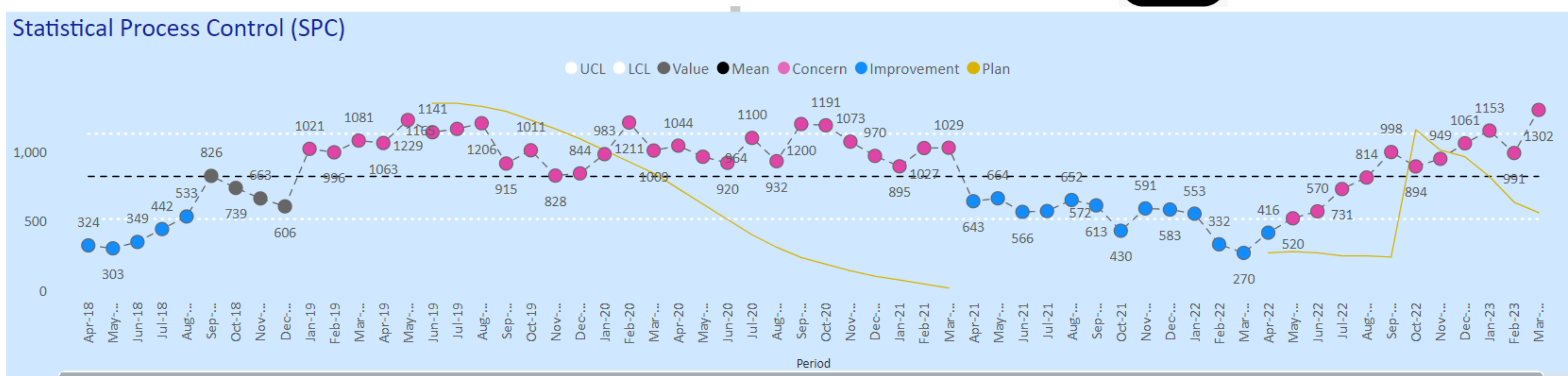
April 2023

Question	Answers
A: What has happened?	Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 12 months. Levels have been increasing from July 2022 with April showing a decline at 71.18%.
B: Why has it happened?	The reduction in activity in April was due to staff leaving, sickness and annual leave. The ability to see patients face to face was impacted by Covid as access to GP surgeries and access to community facilities stopped. Face to face groups also stopped and, whilst these have now increased in BHM premises since easing of restrictions, they have needed to be undertaken in a COVID secure way and capacity is therefore reduced in the number of participants per group. The service also has a large number of vacancies following staff retirements. Significant challenges have been faced around retention with staff leaving to take further training, work outside of the NHS or moving to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. High intensity Therapist training is now only available in canterbury and requires staff to travel to Canterbury and London on regular basis and may not be attractive to staff
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. Internally: funding agreed to offer all High Intensity therapist at Band 7 bringing in line with other Trusts. This has already had an impact whereby the service has recently retained 10 of the 11 trainees, who started in October. A communications strategy and social media campaign has commenced to support the rolling adverts for both qualified and future trainee posts. A review has taken place of clinical space in order to increase group capacity. The removal of masks and social distancing from 12th September has allowed a further increase in group participants. Online groups are also well established, which show lower numbers of DNAs. An additional quality oversight managerial role is being recruited to free up clinicians from management duties and increase clinical contact hours. Allocation of trainee places for 'new to IAPT' posts have been agreed and plans are in place to recruit to these, for both CBT and non-CBT modalities.
E: What do we expect to happen?	The service expects to see a continuing in the reversal of the downward trend against this KPI with a sustained improvement against the target to reach the 75% target by November 2023. This is based on the current staffing available and will be adjusted for improvement as staff are recruited. A further 3 intakes of trainees and the successful retention of these staff on completion of their training will help to address this.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 95% target

OOA

Out of Area Bed Days

Divisions



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	949	1061	1153	991	1302	1202
B: Acute and Urgent Care	949	1061	1153	991	1302	1202

Commentary

Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January 2022 at 575 bed days. Numbers started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease continued in March 2022 to 270 OOA bed days. April 2022 onwards has seen a significant increase until April 2023 at 1,202 days a decrease of 100 days from March, however this will further decrease to 1,034 days when taking account of the patients admitted to Kings Norton. There were 9 admissions to PICU beds, 9 to an acute bed. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 53 OOA placements. A revised trajectory has been agreed with commissioners from April 2023 to March 2024 to reach 328 bed days by April 2024, which will focus on removing acute out of area placements and reducing PICU usage. The target for April 2023 is 893 OOA bed days and has been exceeded this month.

Detailed Commentary

Out of Area Bed Days

April 2023

Question	Answers
A: What has happened?	Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January 2022 at 575 bed days. Numbers started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease continued in March 2022 to 270 OOA bed days. April 2022 onwards has seen a significant increase until April 2023 at 1,202 days a decrease of 100 days from March, however this will further decrease to 1,034 days when taking account of the patients admitted to Kings Norton. There were 9 admissions to PICU beds, 9 to an acute bed. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 53 OOA placements. A revised trajectory has been agreed with commissioners from April 2023 to March 2024 to reach 328 bed days by April 2024, which will focus on removing acute out of area placements and reducing PICU usage. The target for April 2023 is 893 OOA bed days and has been exceeded this month. From the 1st October 2021 NHSE have agreed a Standard Operating Protocol (SOP) with the Trust to enable 10 Priory acute beds based in Willenhall to be classified as 'appropriate placements', in addition to the same classification for the MERIT beds.It has also been agreed by NHSE that any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements' from the 1st January 2022. Internal reporting and commissioner reporting from 1st October 2021 has been amended to reflect these changes. NHSE have also agreed that up to 10 patients admitted to an acute bed at the Active Care Group in Kings Norton from February 2023 will also be classed as 'appropriate placements' and internal reporting will reflect this change from May 2023 (backdated to February 2023). However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHS Digital currently does not recognise the bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The increases over the last 10 months are a combination of a number of issues and risks. Taking into account the procurement of 22 additional beds with the Priory, for 12 PICU and 10 acute beds, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. The additional beds in Kings Norton have enabled 3 pateints to be transferred from other OOA plaements in April to be closer to home. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has also increased with high acuity and high levels of observations required. It is also noted that all of the admissions are on an emergency basis. Staffing has also remained a challenge in terms in recruiting to vacancies and sickness. DTOCS accounted for 557 lost bed days and remains an issue.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans receive national and commissioner scrutiny which will increase if the Trust is unable to demonstrate continuing progress.

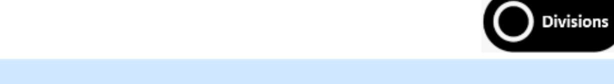
Detailed Commentary

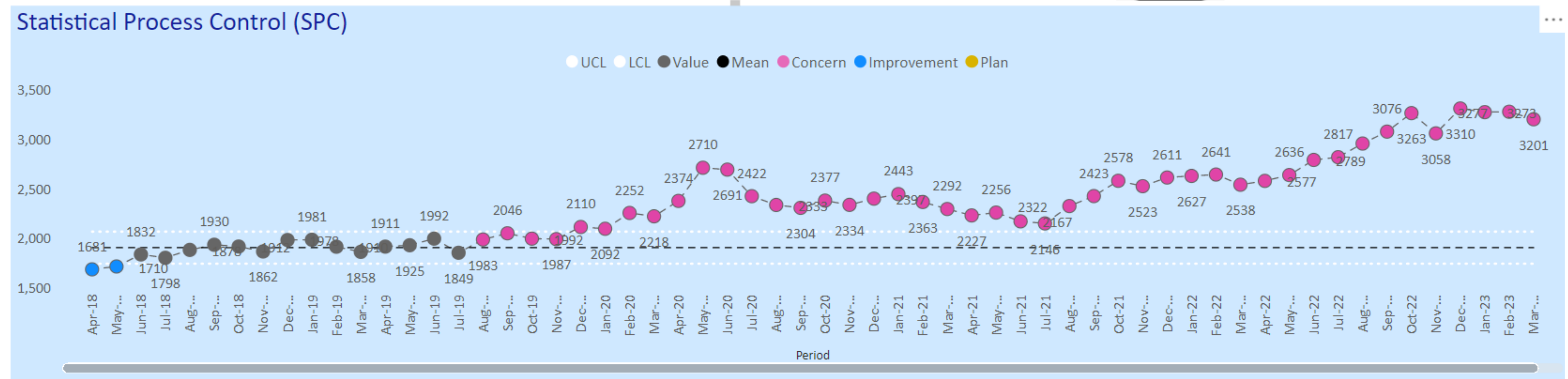
April 2023

Out of Area Bed Days

Question	Answers
D: What are we doing about it?	The Performance Delivery Group deep dive took place in August and outlined the pressures and actions being taken to try and reduce OOA activity, in addition to those steps already in place. A task and finish group will be established to identify issues and solutions which will help reduce the current high levels of out of area placements. Actions currently include: Length of stay- To try and address the outlier length of stays for those patients placed out of area to be supported by a dedicated discharge manager whose focus will be on managing the needs of out of area patients with a view to supporting transfers back to their home localities where possible. Joint bed management meetings with FTB are in place. Work is also being undertaken to reduce delayed discharges by care planning with a focus on discharge and MDT review and with a focus on the OOA patients with the longest lengths of stay. Within the trust the acute day hospital capacity will be increased. Additional bed capacity- A standard Operatoing Proceddure (SOP) hs been agreed with Active Care Group a in King's Norton Birmingham-which has allowed us to bring patients closer to home which also leads to a shorter length of stay. Use of these local beds would also be classified as 'in area'. Longer term options include the potential for a capital build solution which is at an exploratory stage. Supported Accomodation for OOA patients- dedicated for OOA placements to support discharge has been scoped and awaiting agreement and funding Focus on DTOC's - Focus on reducing DTOCs and LOS to reduce the LOS on wards. A revised trajectory has been agreed to reach 328 OOA bed days by the end of March 2024.
E: What do we expect to happen?	Monthly use of Out of area beds is expected to continue but reducing as the range of actions get implemented and embedded and more recently as a result of the SOP agreed with NHSE. However, it should be noted that the service is currently facing Covid-19 pressures in terms of impact on staff sickness absence levels. Out of area trajectory being reviewed for 2023/24 national planning submission and is currently being discussed.
F: How will we know when we have addressed issues?	When the numbers of OOA bed days reduce in line with the trajectory submitted in the action plan. Operational meetings have continued to take place to maintain the implementation of the actions required to support the actions on a sustainable basis. Stabilisation in terms of inpatient capacity and the Trust's plan to review new ways of working will further assist in taking forward this workstream.

Referrals over 3 mths with no contact





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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	3058	3310	3273	3277	3201	3409
C: ICCR	1505	1521	1630	1527	1419	1312
D: Secure Serv & Offender Health	122	127	130	126	120	119
E: Specialties	1395	1403	1585	1585	1618	1679

Commentary

The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular.
The number of patients who have not been seen after 3 months of referral has shown an increase from August 2021 reaching a peak in in April 2023 of 3409. This measure has been above the upper control limit since December 2019.
The number of referrals not seen within 3 months of referral has decreased in SOLAR but has increased in Memory Assessment and Oaks group therapy programmes.
Neuropsychiatry service accounts for 23% and Adult CMHTs 24% of referrals open for over 3 months without a contact.

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Referrals over 3 mths with no contact

April 2023

Question	Answers
A: What has happened?	The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular. The number of patients who have not been seen after 3 months of referral has shown an increase from August 2021 reaching a peak in in April 2023 of 3409. This measure has been above the upper control limit since December 2019. The number of referrals not seen within 3 months of referral has decreased in SOLAR but has increased in Memory Assessment and Oaks group therapy programmes. Neuropsychiatry service accounts for 23% and Adult CMHTs 24% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts have reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. Based on available research, it is expected that the backlog of service users not seen or choosing not to access services during the Covid period together with new demand arising as a result of the impact from Covid -19 will result in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. This indicator also relies on teams outcoming appointments on Rio and work is being undertaken with services on an ongoing basis to reduce the number outstanding. ICCR: have undertaken a deep dive of those with longer waits and have identified that there are a number with future appointments in place. Where there were no appointments a number themes were highlighted which has shown that a number are transfers from another BSMHFT/FTB team so are still actively under these teams, a number are recurrent DNAs and that actions from MDT are not followed through e.g. discharging patients. Regular caseload reviews not taking place as frequently as needed due to staff capacity issues. Specialties: We currently have an aging population and better awareness of mental health concerns within the population and at primary care level. This has led to a consistent increase in number of referrals to our Older Adult CMHT, particularly for patient with dementia, but has not been accompanied with any increase in the Older Adult CMHT workforce. Caseloads of care coordinators are currently high (some CPNs have 50+ against an ideal maximum of 35) reducing CPN capacity to see new assessments and take new patients on. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There are discrepancies in medical workforce numbers between the teams causing higher waits for medical outpatient clinics in some teams. There is also a significant number of patients in care homes where, due to pandemic restrictions, our service was unable to see or communicate with directly however, through carers were able to provide consultation and commence treatment, however these have remained on the waiting list. For all service it is important to note that where patients DNA, they are likely to have been provided with an appointment within 3 months - this is a particular issue for perinatal patients where due to having an infant patients frequently cancel or DNA appointments prior to eventually being seen. In bi-polar service, patients will already be under a CMHT in order to access their service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred.
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2023

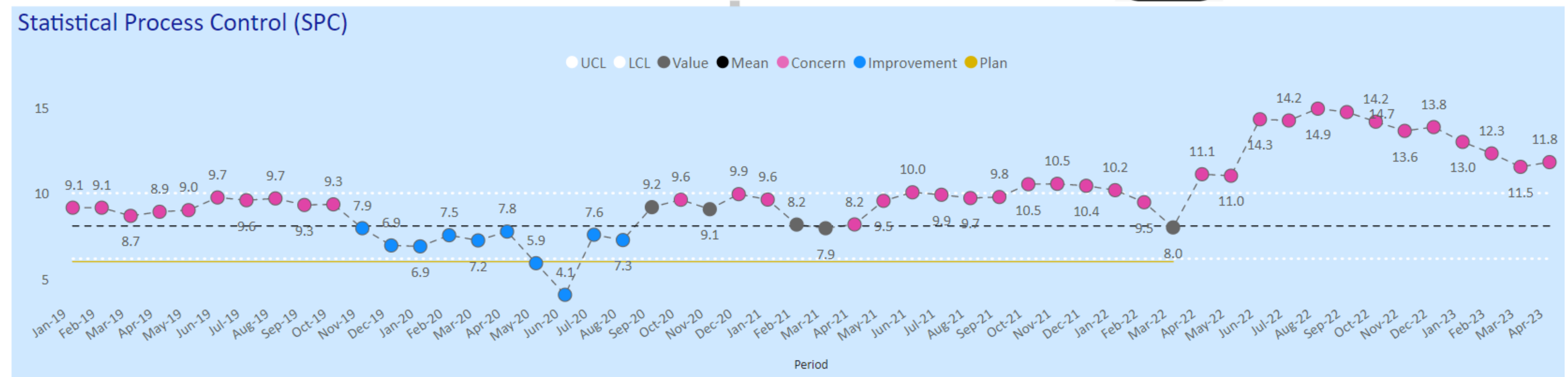
Referrals over 3 mths with no contact

Question	Answers
D: What are we doing about it?	ICCR: Reviewing patient flow and activities as part of strategic management of demand and capacity informed by service user need and staffing levels/skill mix to support. New ways of working and alternative methods of contact are being taken into account to manage the demand and services are drawing up plans to agree the appropriate level of face to face contact for each service. Face to face activity has continued to increase over the past few months. Adult CMHTs have set up some Saturday clinics to help address backlog, however this relies on clinicians to support these. As Primary Care Liaison teams grow suitable patients will be moved from Secondary to primary care teams with eventual GP only care – This will generate capacity in CMHT to manage SMI. Solar are introducing additional group work initiative's to manage capacity where appropriate and have introduced peer volunteer support counselling roles which have been positively evaluated. Validation of caseloads is underway as part of the transformation of services. Temporary staff taken on to help with capacity to see service users. Specialties: A caseload audit is currently being undertaken picking up patients who have been waiting longer than 3 months. Regular contact (every 2 weeks) is being made with these patients by the duty clinician, offering telephone support and prioritising appointments if there has been a deterioration in presentation. Regular management supervision is focussing on care coordinator capacity, looking at where patients could be stepped down from care coordination to free staff up to do new assessments. Admin lead supporting the management of care support patients using Rio to identify where patients do not have follow up appointments (where they have missed the appointment) and booking these in through med secs. A new role of Clinical Development Lead is being recruited to provide a focus on sustaining improvement and performance and provide support to hotspot areas, improve the quality of care and develop the pathway for Older People. A small proportion of new referrals will be rerouted to primary care hub via the establishment of Community Transformation Primary Care hubs (only for Serious Mental Illness, not Dementia patients) and current caseloads will be referred to primary care teams where possible through reconciliation audits. Plans for weekend clinics to commence, particularly in hotspots like Solihull team - 3 staff commenced Saturday home assessments in October.
E: What do we expect to happen?	For Adult CMHTS we would expect to see changes over the next 24 months as community transformation develops and is embedded across all BSOl Primary care Networks. The aim is to work towards reducing the wait for first appointment, with a 20% reduction in those not seen within 18 weeks by October 2023. Within older adult CMHTs we expect there to be some improvement in waiting lists, however staffing in Solihull is challenging and will affect their ability to improve. The service however expects any improvement to be limited across the service due to the small number of patients suitable for community transformation development and the rising demand for dementia care in secondary services, with no additional funding in this area. January and March 2023 have seen the highest levels of referrals to older adult CMHTS in the last 3 years. It is unlikely that Neuropsychiatry waiting times will be improved.
F: How will we know when we have addressed issues?	Where national access standards are in place e.g. Eating Disorders, First episode psychosis, these are consistently met by services. For adult and older adult community services success will be meeting the national 4 week target which has yet to be formally introduced. The delivery of this standard is part of the community services transformation work plan and planned revised pathways to support service users.

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Staff Vacancies

Divisions



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	13.6%	13.8%	13.0%	12.3%	11.5%	11.8%
B: Acute and Urgent Care	12.1%	12.6%	10.5%	10.9%	12.1%	13.3%
C: ICCR	19.5%	20.5%	18.5%	16.8%	16.1%	15.3%
D: Secure Serv & Offender Health	10.2%	10.9%	10.7%	10.2%	14.1%	14.7%
E: Specialties	10.5%	11.0%	11.1%	10.6%	11.1%	12.3%
F: Corporate	14.7%	12.9%	10.9%	10.1%	0.5%	-0.4%

Commentary

The vacancy rate in April has incresed to 11.8% by 0.2% and is above the KPI target of 6.0%. In April, new budgets were set and additional budget provided to the Trust allowing growth in our establishment. This large increase reflects the new allocation of additional budget.

Vacancy rates have fluctuated over the last 12 months with an overall increase in vacancies since April 2020 when vacancies stood at 7.8%. The vacancy breakdown by division is as follows:

Acute and Urgent Care – 13.9%,
Chief Executive Locality – 15%,
Exec Director - Medical Locality – 3%,
Exec Director - Nursing Locality – -1.5%,
Exec Director - Resources Locality – -6.8%,
Exec Director - Strategy People and Partnerships Locality – -7.9%,
ICCR – 15.6%,
Specialties – 13.6%,

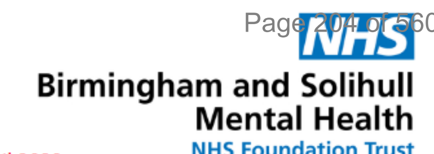
Detailed Commentary

Staff Vacancies

April 2023

Question	Answers
A: What has happened?	The vacancy rate in April has incresed to 11.8% by 0.2% and is above the KPI target of 6.0%. In April, new budgets were set and additional budget provided to the Trust allowing growth in our establishment. This large increase reflects the new allocation of additional budget. Vacancy rates have fluctuated over the last 12 months with an overall increase in vacancies since April 2020 when vacancies stood at 7.8%. The vacancy breakdown by division is as follows: Acute and Urgent Care – 13.9%, Chief Executive Locality – 15%, Exec Director - Medical Locality – 3%, Exec Director - Nursing Locality – -1.5%, Exec Director - Resources Locality – -6.8%, Exec Director - Strategy People and Partnerships Locality – -7.9%, ICCR – 15.6%, Specialties – 13.6%, Secure Services and Offender Health – 14.9%
B: Why has it happened?	Our establishment has grown by 99.57 WTE for this financial year.
C: What are the implications and consequences?	The national shortage of registered nurses particularly band 5 has not changed as and this is reflected in our local data. BAF Risk Fails to develop an inclusive and compassionate working environment, resulting in failure to attract talent.
D: What are we doing about it?	The 2023 RCN NEC job's fair was attended by Workforce, Recruitment and Clinical Managers which proved successful. Numerous RMN's were interviewed on the day and 15 are subsequently in the process of being offered positions within the trust. A North and Central Acute and Urgent care Jobs fair, did prove fruitful with 14 RMN offers being made (all of which have now started) and the template used is being rolled out to plan and orchestrate the Barbery Centre Job's Fair occurring on May 22nd 2023. An ICB NHS Mental Health Job's Fair at Birmingham's ICC, which was jointly hosted with BSMHFT, was attended by over 1500 people interested in employment within the sector, mostly admin and HCA's but 11 RMN's were interviewed on the day and are subsequently in the process of being offered positions within the trust. BSMHFT hosted a stand at Sense's Pans Disability Job's Fair in May, promoting BSMHFT in general as an employer of choice and more specifically The Barberry Jasmine Suite's National Mental Health Deaf Service. Essential relationships were built / re-established with the Job Centre, Sense, BID and various community engagement leads.

Detailed Commentary



Staff Vacancies

April 2023

Question	Answers
	Partly due to comms raising the fear (and seeing tangible effects) of a lack of "buzz" around many, smaller localised and more frequent job fair events, a face-face Recruitment Events Strategy Planning morning was attended incorporating Safer Staffing, Nursing, Recruitment, Communications and Operational Leads with a view to (whilst ensuring the vested interests of each areas' needs are met) arranging more regular, (potentially quarterly) targeted fairs for all nurses which will hopefully prove more fruitful. After a successful application process, BSMHFT was selected in October 2022 , along with 15 other Trusts nationwide, to be part of the NHSE Overhauling Recruitment project working collaboratively with each other to collate ideas and improve the Selection section of each Trust's Recruitment Process. This work started in December 2022 and 4 workshops so far have been productive with a view to streamlining the process. This has led NHSE to being able to collate strategies with a view to being able to roll out amendments and guidance for improvement over the coming months. BSMHFT's EDI Lead and The People Partner for Resourcing hosted a Listen-Up-Live explaining the Trust's newly updated Recruitment Panel Guidance, incorporating Equity Panel members and updated Visible Diversity policies. This followed 2 Inclusive Recruitment Sessions at the start of January 2023 attended by Recruitment members with the Trust's EDI lead. The sessions concentrated on interview panels (and the recruitment process in general) maximising (visible) diversity and ensuring an even more equitable process, which will also ensure that the Trust's Recruitment and Selection Training will be more comprehensive and fully up to date with current guidance and legislation. The sessions explored in detail, how, at every step of the recruitment process, there is a need to refrain from the potential of unconscious bias. An intensive training project plan for 2 relatively newly appointed band 4 Recruitment Advisors is being worked through to ensure that they are fully trained by mid June 2023 - which will significantly provide increased capacity for BSMHFT's Band 5 Recruitment Team Leader to work through essential Recruitment Initiatives. The Trust is working with local universities to attract second and third year students to consider the Trust as future employer. The Trust successfully participated in 'BSol Love Our Learners' event in December 2022. This event targeted second year students to consider BSol as a choice arear to work when they complete their degree. BSMHFT offered help with interview techniques, how to complete application forms. A Focus was on benefits such as flexible working when one works for the Trusts. A further Recruitment Projects and Initiatives meeting has been arranged to look at continuous improvement around process, reporting procedures and delivery and Project Flourish. The current Recruitment and Selection Policy is being updated by Senior People Partner for Coorporate with a view to it being ratified in June 2023. The Trust's International Recruitment Department(s) made offers to 40 Nurses within the last financial year, against a target of 32. The trust's aim is to recruit 60-70 for this financial year.

Detailed Commentary

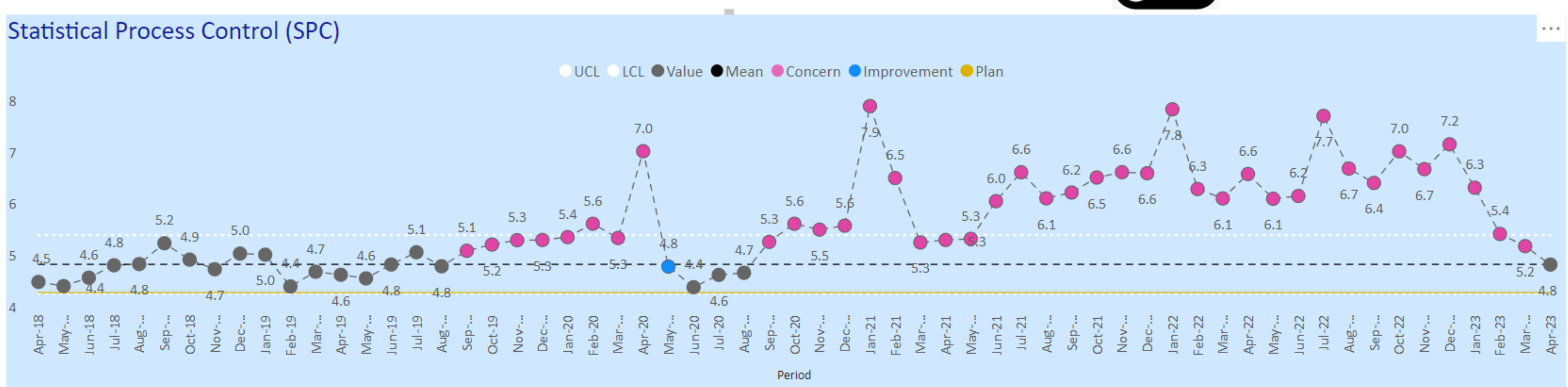
Staff Vacancies

April 2023

Question	Answers
	As part of the continued bank to substantive initiative, processes are being arranged to ensure Job adverts are sent to all relevant bank workers at the same time as being posted – to endeavour to place bank workers that have expressed an interest. This may be without the need for the (complete) recruitment process to occur in order to hire, and thus expediting vacancies being filled.
E: What do we expect to happen?	There are national supply issues in relation to certain staff groups e.g., registered nurses and IAPT meaning we do need to recognise that this will limit the improvements that can be made in relation to vacancy rates. We are beginning to compete with private hospitals in the BSol areas who are prepared to offer significant financial attraction package which we currently are not able to match. However targeted work ongoing across the Trust should mean we see a reduction in vacancy rates over time.
F: How will we know when we have addressed issues?	Reduction in vacancy rate and maintenance of the vacancy rate at below the 6% Trust target.

Staff Sickness

Divisions



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	6.7%	7.2%	6.3%	5.4%	5.2%	4.8%
B: Acute and Urgent Care	7.6%	8.5%	7.7%	6.5%	7.0%	6.8%
C: ICCR	6.7%	6.2%	5.1%	3.6%	3.9%	4.3%
D: Secure Serv & Offender Health	9.8%	10.8%	9.4%	8.2%	6.9%	6.0%
E: Specialties	5.7%	6.4%	5.2%	5.0%	4.8%	4.2%
F: Corporate	2.8%	3.1%	3.6%	3.3%	3.0%	2.8%

Commentary

Sickness absence saw a decrease in April to 4.82% from 5.18% in March 2023. Non-covid related sickness absence decreased by 0.31% to 4.46% in April and Covid-19 related sickness absence decreased by 0.05% to 0.36% in April from 0.41% in March. Short term sickness absence decreased by 0.26% to 1.97% in April. Long term sickness absence in April 2.85% is a decrease of 0.09% from March.

Overall sickness absence rates by division for April are as follows:

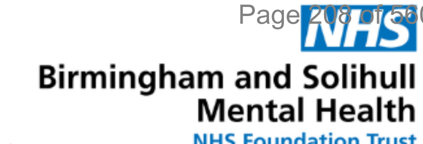
Acute and Urgent Care – 6.86%
Chief Executive Locality – 0.00%,
Exec Director - Medical Locality – 2.24%,
Exec Director - Nursing Locality – 3.23%,
Exec Director - Resources Locality – 2.32%,
Exec Director - Strategy People and Partnerships Locality – 4.37%,
ICCR – 4.16%,

Detailed Commentary

Staff Sickness

April 2023

Question	Answers
A: What has happened?	Sickness absence saw a decrease in April to 4.82% from 5.18% in March 2023. Non-covid related sickness absence decreased by 0.31% to 4.46% in April and Covid-19 related sickness absence decreased by 0.05% to 0.36% in April from 0.41% in March. Short term sickness absence decreased by 0.26% to 1.97% in April. Long term sickness absence in April 2.85% is a decrease of 0.09% from March. Overall sickness absence rates by division for April are as follows: Acute and Urgent Care – 6.86% Chief Executive Locality – 0.00%, Exec Director - Medical Locality – 2.24%, Exec Director - Nursing Locality – 3.23%, Exec Director - Resources Locality – 2.32%, Exec Director - Strategy People and Partnerships Locality – 4.37%, ICCR – 4.16%, Specialties – 4.33%, Secure Services and Offender Health – 5.89%
B: Why has it happened?	Cold, Cough, Flu - Influenza Gastrointestinal problems Anxiety/stress/depression/other psychiatric illnesses Coughs, cold flu is the highest reasons for sickness absences, which can be attributed to the seasonal Influenza . Anxiety, stress, depression, other psychiatric illnesses are the second highest reason for sickness absence, which to a large extent mirrors the concerns relating to the increase in cost-of-living expense. This will continue to be monitored and the potential impact of this on staffing levels.
C: What are the implications and consequences?	Continuity of care for patients is affected and reliance on bank and agency staff increases. Lower staffing levels due to high sickness absence also has an impact on safe staffing levels, workload and health and wellbeing of staff. BAF Risk: Fails to develop an inclusive and compassionate working environment, resulting in increase levels of sickness. Fails to look holistically at flexible and transformative workforce models used across all services, resulting in a failure to take opportunities where positive gains are possible Fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multidisciplinary values-based leadership framework developing the right capabilities, resulting in an underperforming workforce



Detailed Commentary

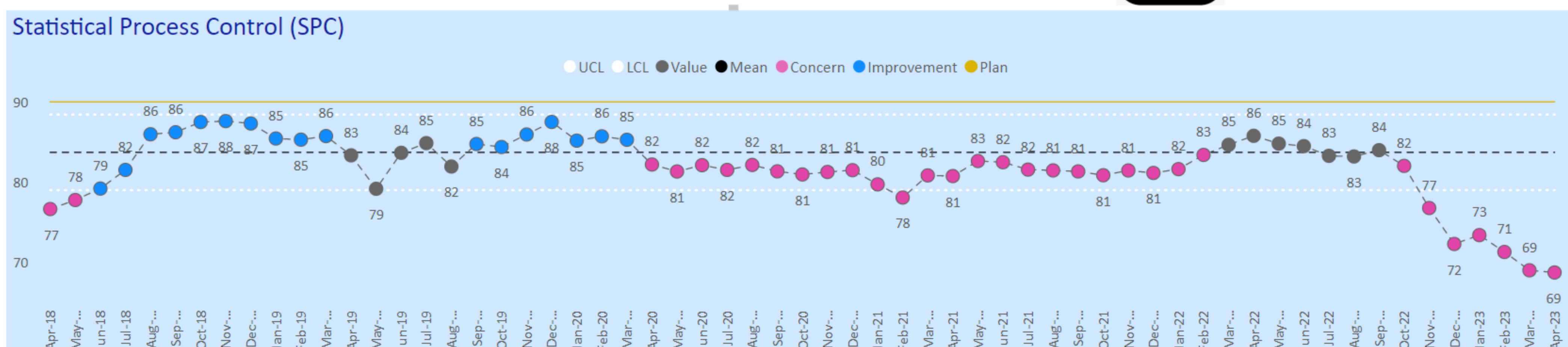
Staff Sickness

April 2023

Question	Answers
D: What are we doing about it?	The People team continue to drill down to hotspot areas to support the efforts of the areas to reduce long term sickness. Long Team sickness cases are discussed at FPP and at local level through HR Clinics. There is a greater emphasis in holding regular (monthly) meetings with individuals off on long term sick in order to suppoer them with various options with a view to being the absence to a close. Continuous audit of Directorate sickness. Data to be presented in monthly FPP meetings with comparisons undertaken against previous months data. General areas of concerns will be highlighted and actions formulated to address them are communicated. More detailed conversations to be held with CMS/Team Leaders in clinics. Promotion of health and wellbeing initiatives across the directorate to support physical health, mental health and wellbeing of staff. The health and wellbeing page on Connect provides information on initiatives such as Occupational Health support (PAM), Physiotherapy provided by PAM, Workstation Assessments (DSE), and the Employee Assistance Programme (EAP) which is available 24 hours a day by phone. Stress assessments are being promoted across the Trust to support earlier intervention. Information to be fed back to CMS who will provide updates in HR clinics. All long-term sickness cases that reach 16 weeks have a formal review to ensure that the appropriate plans are in place to enable a return to work and/or consider other options available, linking in with OH regarding redeployment/Ill Health retirement. The People Team have developed a new Health, Wellbeing and Attendance Policy which is going through the ratifiction process with a view to going live in June along with a new toolkit and package. The People Team are focussing on coaching managers through good practice initiatives and exploration of alternatives in managing sickness such as: - Wellbeing meetings/return to work - Final Review Meetings - Redeployment - Ill-health retirements - Refreshing a sickness absence FAQ - A new how to guide has been developed for managers and started to be circulated - Development of a sickness absence training package should go live by April/May 2023 and will link into the new Health, Wellbeing and Attendance Policy
E: What do we expect to happen?	Sickness absence rates will come within the Trust's target percentage as we move out of the winter period. The People Team will also support increasing knowledge of supportive best practice for managers.
F: How will we know when we have addressed issues?	A sustained reduction in sickness levels reaching the Trust's target figure and bank/agency bookings for sickness which will be monitored and reported monthly.

Staff Appraisals

Divisions



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	76.8%	72.3%	73.4%	71.3%	69.0%	68.8%
B: Acute and Urgent Care	72.2%	67.3%	64.6%	55.2%	54.8%	53.9%
C: ICCR	80.0%	76.2%	77.0%	75.8%	74.6%	73.8%
D: Secure Serv & Offender Health	81.6%	74.4%	76.4%	77.5%	75.3%	75.1%
E: Specialties	76.4%	73.1%	77.2%	75.7%	72.6%	75.4%
F: Corporate	70.9%	69.1%	70.6%	69.7%	64.5%	61.6%

Commentary

Appraisal rates have decreased to 66.9% at the end of April. The appraisal rate had been maintained consistently above the 85% CCG target from November 2019 to March 2020, however fell below this in April 2020 due to the impact of Covid-19. The appraisal rate breakdown by division for April is as follows:

Acute and Urgent Care – 50.2%,
Chief Executive Locality – 66.7% ,
Exec Director - Medical Locality – 79.0%,
Exec Director - Nursing Locality – 47.5%,
Exec Director - Resources Locality – 61.1%,
Exec Director - Strategy People and Partnerships Locality – 42.6%,
ICCR – 72.4%,
Specialties – 71.8%
Secure Services and Offender Health – 72.3%
This data only relates to AfC appraisals and not medical workforce.

Detailed Commentary

April 2023

Staff Appraisals

Question	Answers
A: What has happened?	Appraisal rates have decreased to 66.9% at the end of April. The appraisal rate had been maintained consistently above the 85% CCG target from November 2019 to March 2020, however fell below this in April 2020 due to the impact of Covid-19. The appraisal rate breakdown by division for April is as follows: Acute and Urgent Care – 50.2%, Chief Executive Locality – 66.7% , Exec Director - Medical Locality – 79.0%, Exec Director - Nursing Locality – 47.5%, Exec Director - Resources Locality – 61.1%, Exec Director - Strategy People and Partnerships Locality – 42.6%, ICCR – 72.4%, Specialties – 71.8% Secure Services and Offender Health – 72.3% This data only relates to AfC appraisals and not medical workforce.
B: Why has it happened?	The decline in appraisal compliance is due to an increase in the numbers of staff that have expired with their appraisal across the trust.
C: What are the implications and consequences?	We have not met our contractual requirements – this stands at an 85% target for completion from the CCG. Non-completion of appraisals and/or poor-quality appraisals has an impact on staff experience and development, potentially leading to reduced engagement from staff and increased turnover. BAF Risk: Fails to develop an inclusive and compassionate working environment, resulting in demotivated workforce
D: What are we doing about it?	Targeted compliance work of 'hot spots' that is tailored to individuals and teams; Completed support sessions for each directorate; scheduling of Appraisal demonstration sessions ongoing (communication of sessions to all staff through different comms methods). Increasing the profile of Appraisal support/materials available to staff via ongoing discussions with the Comms Team and Listen Up Live Events scheduled in May (23rd May Effective compassionate coaching conversations). Regular updates regarding the new system to AD's and through Appraisal drop ins to maintain engagement. Weekly targeted emails to AD's identifying hot spot areas (below 75% compliance)
	BAU activities: Targeted compliance work- an L&D Administrator and support from the wider team are utilising the draft Appraisal Completion report (provided by the Informatics Team) to target those staff that are not completing their appraisals and support them in the completion of the new appraisal process. This approach has been reviewed to support and assist managers in quickly identifying those staff that are yet to complete their appraisal. We will review our current resource and identify additional support. Support sessions for all staff are scheduled to support the new appraisal process and a dedicated resource page via Connect.

Detailed Commentary

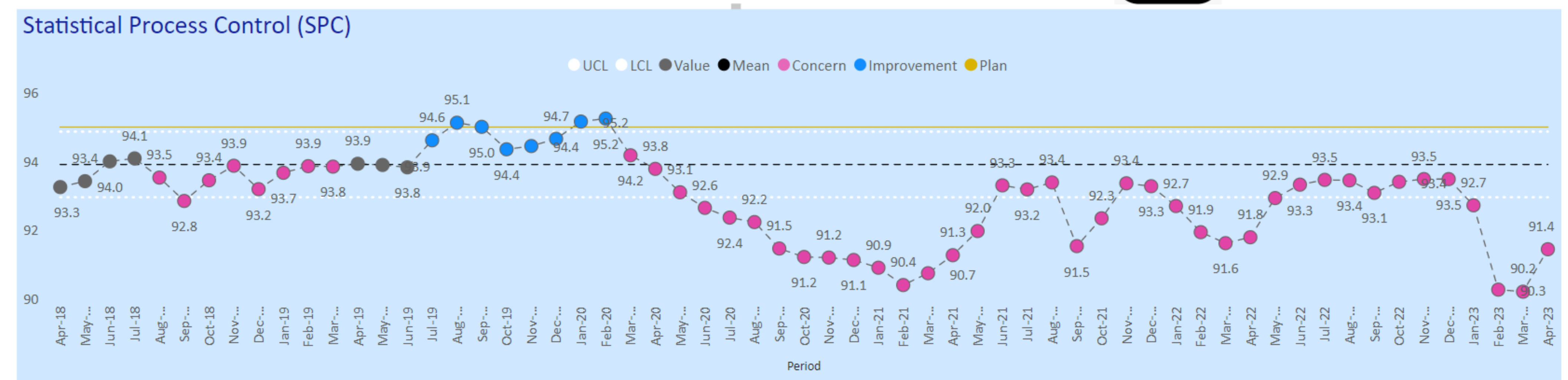
Staff Appraisals

April 2023

Question	Answers
E: What do we expect to happen?	Due to the reliance on historical, system driven processes there will be continued difficulties in trying to report accurately on 1-2-1 and Appraisal data. The Appraisal compliance figure will continue to fluctuate due to the impact of the change in system/process, however we expect to see some recovery by the end of Q1 of the new Appraisal process.
F: How will we know when we have addressed issues?	The overall aim will be aligned to the new appraisal process in achieving an improvement in the quality of values-based appraisal conversations, enabling the development of an inclusive, compassionate culture.

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	93.5%	93.5%	92.7%	90.3%	90.2%	91.4%
B: Acute and Urgent Care	92.1%	92.3%	90.6%	89.2%	89.4%	89.4%
C: ICCR	94.1%	94.1%	93.9%	91.6%	91.4%	91.9%
D: Secure Serv & Offender Health	94.6%	94.5%	93.2%	91.9%	91.8%	92.0%
E: Specialties	94.4%	94.0%	93.7%	91.9%	91.5%	92.7%
F: Corporate	93.8%	94.4%	93.8%	92.5%	93.8%	91.1%

Commentary

Substantive staff (Trust Target 95%, Commissioners Target 90%))
Overall, Trust's Fundamental Training compliance figure slightly increased from 90.5% in March to 91.4% in April 2023.
FT breakdown by division:

- • Chief Executive Locality – 77.7%,
- Exec Director - Medical Locality – 95.9%,
- Exec Director - Nursing Locality – 92.5%,
- Exec Director – Operations
  - o Acute and Urgent Care – 89.5%,
  - o ICCR – 91.7%,
  - o Secure Services and Offender Health – 92.1%
  - o Specialties – 92.7%
- Exec Director - Resources Locality – 96.3%,

TRAINING

Detailed Commentary

Fundamental Training

April 2023

Question	Answers
A: What has happened?	Substantive staff (Trust Target 95%, Commissioners Target 90%)) Overall, Trust's Fundamental Training compliance figure slightly increased from 90.5% in March to 91.4% in April 2023. FT breakdown by division: • • Chief Executive Locality – 77.7%, • Exec Director - Medical Locality – 95.9%, • Exec Director - Nursing Locality – 92.5%, • Exec Director – Operations o Acute and Urgent Care – 89.5%, o ICCR – 91.7%, o Secure Services and Offender Health – 92.1% o Specialties – 92.7% • Exec Director - Resources Locality – 96.3%, • Exec Director - Strategy People and Partnerships Locality – 75.3%, TSS Bank Workers (Trust Target 75%) Bank FT compliance has increased from 85.36% to 85.4 % at the end of April 2023. However, still over the commissioner's target.
B: Why has it happened?	Substantive staff FT compliance: • All areas remain slightly below ideal Trust target 95% except for Exec Director – Medical and Exec Director - Resources. We have achieved the commissioner's expectation of 90% in nearly all areas except CEO, New Care Models, Acute and Urgent Care and Strategy People and Partnerships. • Withdrawals have decreased; however, the volume of DNA's remain unsustainable & coupled with the increase in new starters compromises the agreed 12% buffer.
C: What are the implications and consequences?	Business, Administration and Financial Risks: • Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. • Finance: Procuring external training for AVERTS and Resus (ELS & ILS) has extra cost implications.

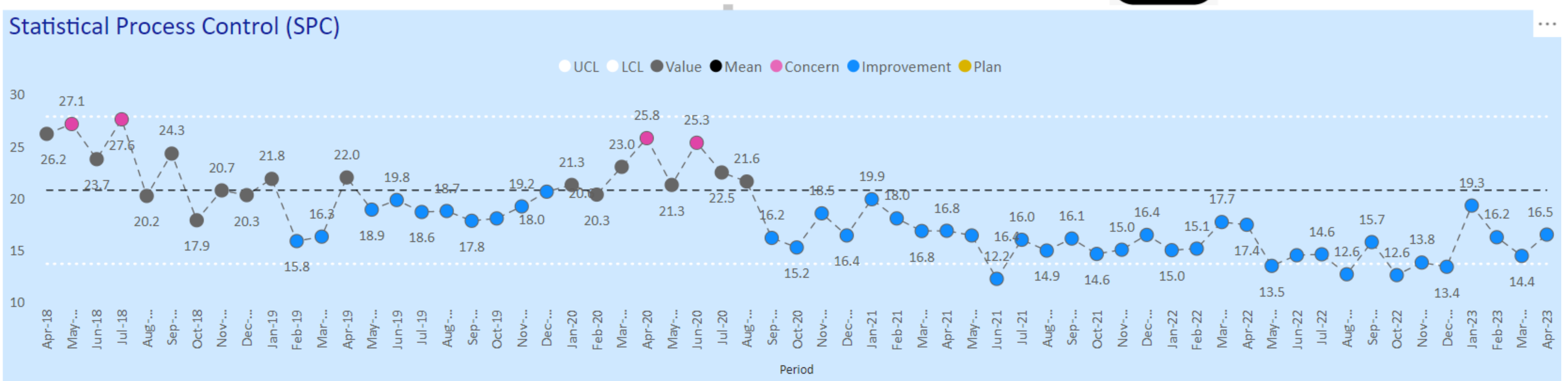
Detailed Commentary

Fundamental Training

April 2023

D: What are we doing about it?	• Training places adequate to reach target by the end of Q2 for ELS and ILS as Trust have been procured from external providers. • Continue to chase up staff who are due for AVERTS 1 day Update training to reduce the number of staff to attend AVERTS 5-days. • Training to provide more spaces to new starters and bank staff. We are now sending extra reminders around upcoming training. • Businesses as usual process, to keep the compliance at the required percentages, L&D constantly chasing staff to fill the spaces. This is ongoing process that L&D team does. • Additional training provision is available for TSS staff to increase capacity so TSS workforce can have the skills to practice safely in clinical environment.
E: What do we expect to happen?	Calculated trajectories have shown that FT recovery for substantive staff will be achieved in all subjects in Q2, as long as the DNA rate and staff turnover does not exceed the Trust agreed 12%.
F: How will we know when we have addressed issues?	With uptake of training offers and when the trajectories offered to the executive team and commissioners are achieved on the cited date. When expected compliance rates will reflect on insight reporting system.

Incidents resulting in harm (patients)



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	13.8%	13.4%	19.3%	16.2%	14.4%	16.5%
B: Acute and Urgent Care	10.5%	10.5%	21.9%	16.8%	12.5%	16.5%
C: ICCR	16.7%	13.6%	18.8%	19.8%	21.5%	23.3%
D: Secure Serv & Offender Health	15.9%	14.4%	17.5%	18.7%	14.3%	17.5%
E: Specialties	18.2%	17.7%	22.6%	12.6%	21.6%	14.0%

Commentary

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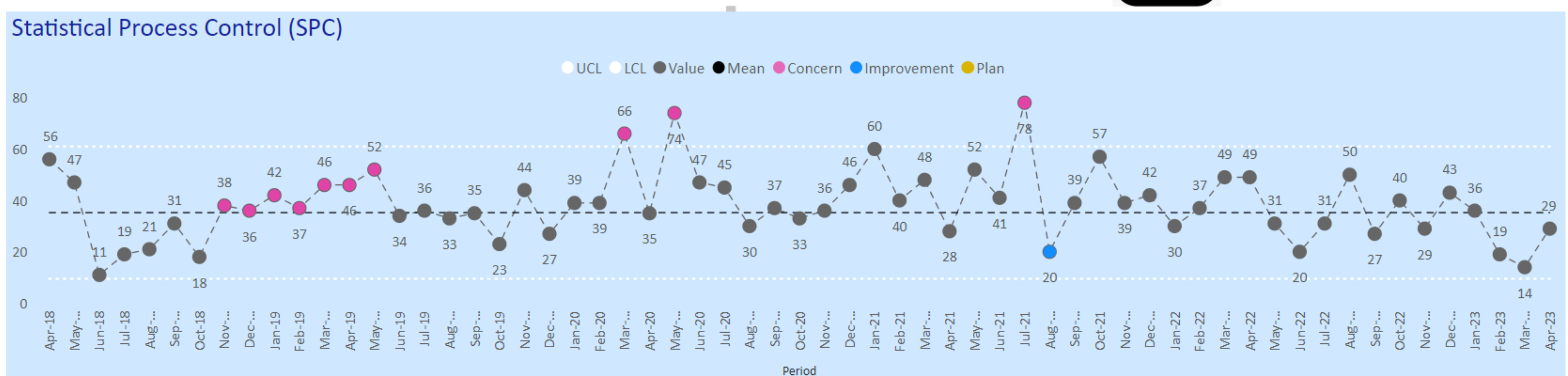
Birmingham and Solihull Mental Health NHS Foundation Trust

Ligature no anchor point



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

Division	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
A: All	29	43	36	19	14	29
B: Acute and Urgent Care	8	10	7	6	8	11
C: ICCR	0	0	0	0	0	0
D: Secure Serv & Offender Health	21	32	29	12	6	18
E: Specialties	0	1	0	1	0	0

Commentary

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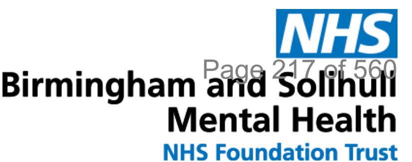


FPPC 17th May 2023

Performance metric trajectory updates

inclusive

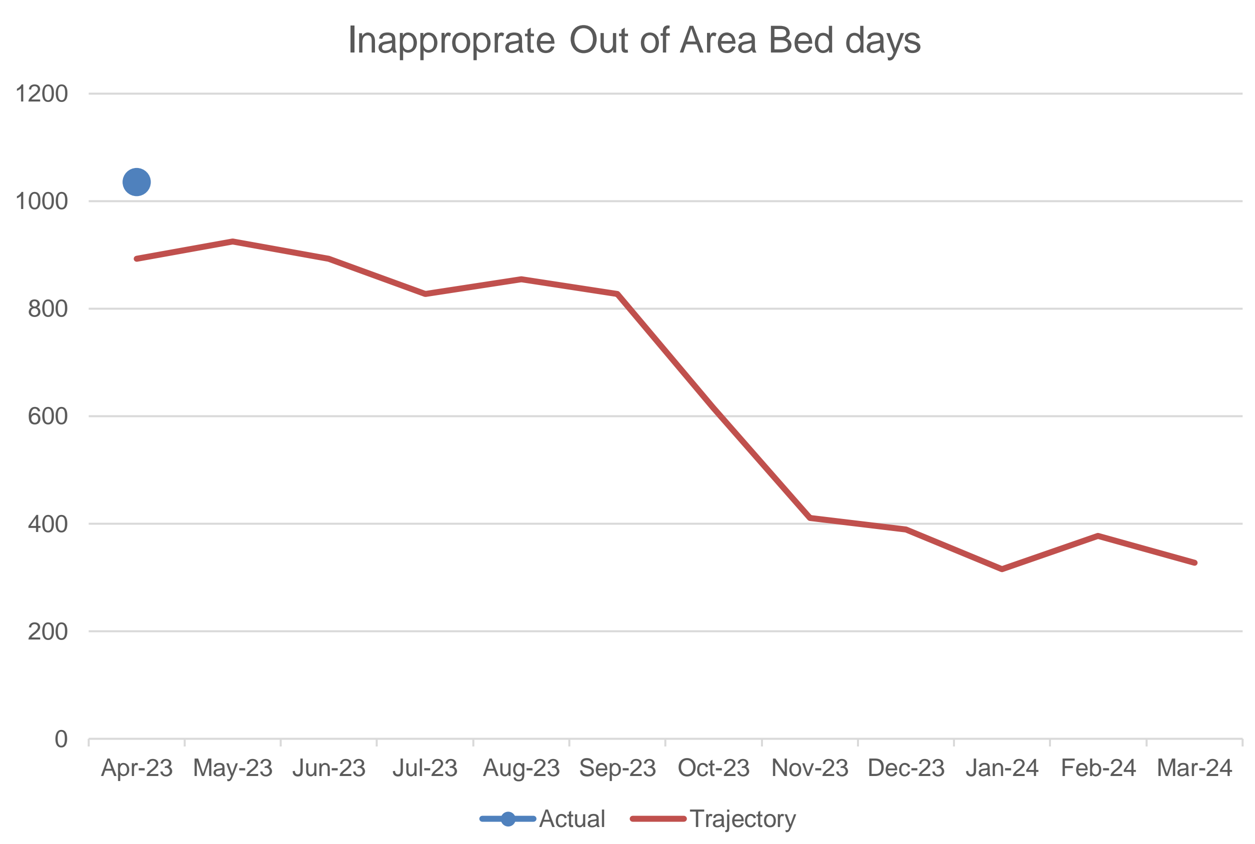
Trust Performance Metrics

At the February 2023 FPPC meeting, members requested an update on the performance for the following metrics in line with the plans and trajectories already provided:

Performance Metrics	People Metrics
• Inappropriate Out of Area bed days	• Vacancies
• IAPT waiting times 6 and 18 weeks	• Sickness
• New Referrals not seen within 3 months	• Appraisals
• CPA 12 month Reviews	• Bank and Agency fill rate
• 7 Day follow up	

The above areas were discussed at the Performance Delivery Group on the 4th May and relevant leads have provided an update on each area – see below.
A monthly update will be provided on progress with trajectories where this is in place.

Inappropriate Out of Area bed days

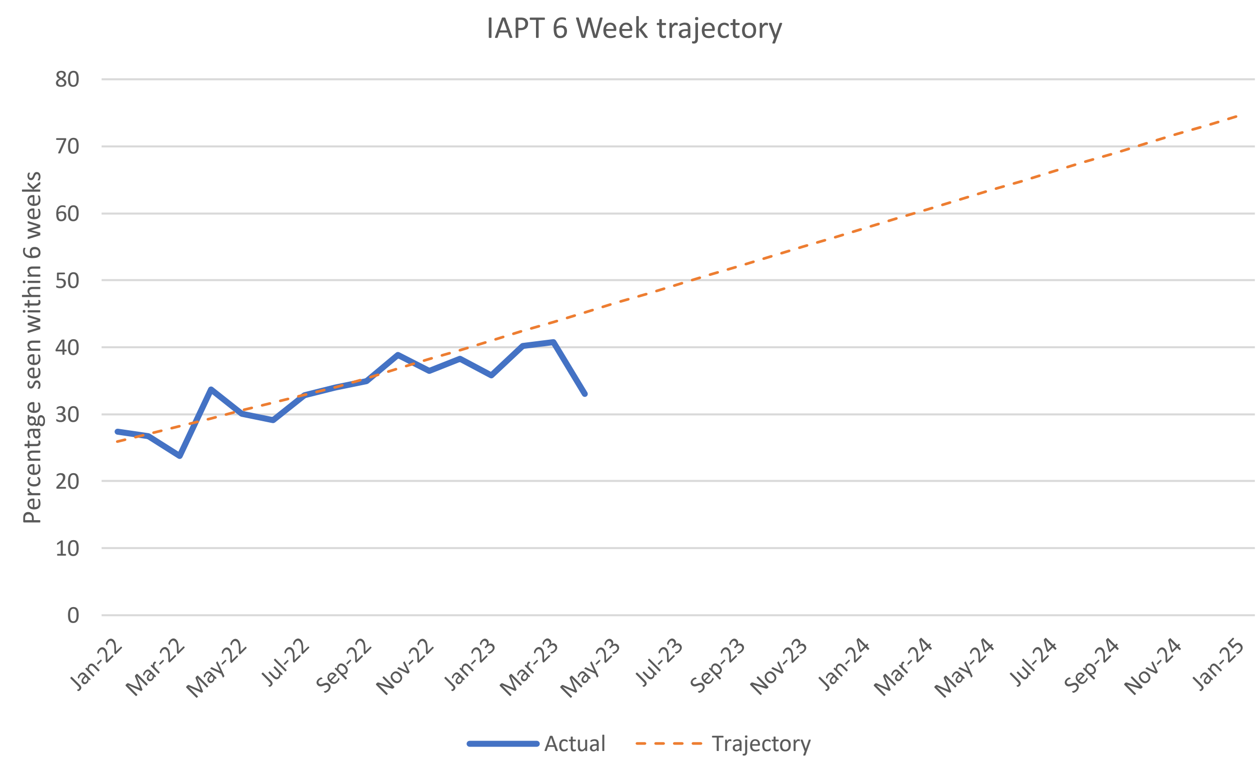


Inappropriate Out of Area trajectories have been agreed as part of the national planning round for 2023/24. The aim is to reach 328 beds in March 2024. The Number of OOA bed days in April is 1034 days.

Additional capacity has been sourced from the active care group in Kings Norton for acute beds which will now be classified as ‘appropriate’. The data here takes into account this change. Other internal reporting will be updated next month and back dated.

The additional capacity has allowed for repatriation of a number of patients so they are closer to home. The trajectories should be read in conjunction with the action plan update provided to February FPPC meeting

IAPT waiting times 6 weeks



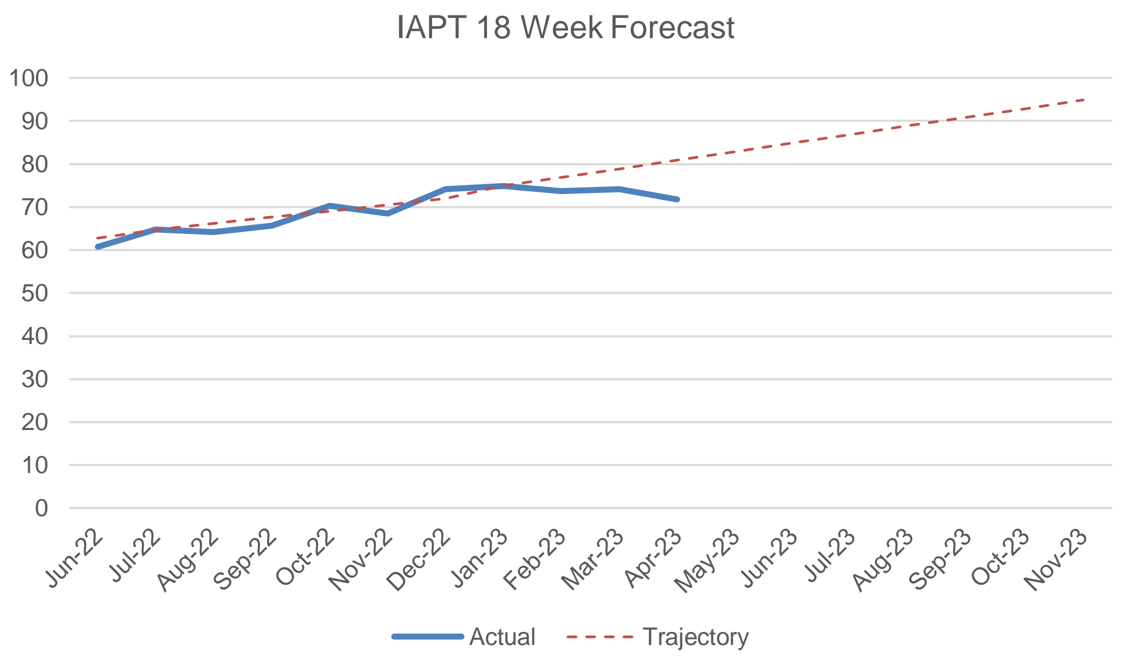
Trajectory provided by Associate Director for Specialties

The aim is to reach the 75% target by January 2025
April 2023 performance at 33%, below trajectory.

April has been affected by staff leaving in March along with sickness and annual leave.
The trajectory is based on the current staffing available and planned but will need to be adjusted in year to reflect success with staffing levels recruited recognising the challenging context of national shortages of this staffing group. The trajectory is dependent largely on staff recruitment. In order to be able to see more patients and thus reduce waiting times.

The Specialties deep dive meeting on the 4th May discussed the challenges the IAPT service are currently facing and the service agreed to review their action plan to see if there are additional actions that can be put in place. The trajectories should be read in conjunction with the action plan update provided to February FPPC meeting.

IAPT waiting times 18 weeks



Note - Trajectory provided by Associate Director for Specialties

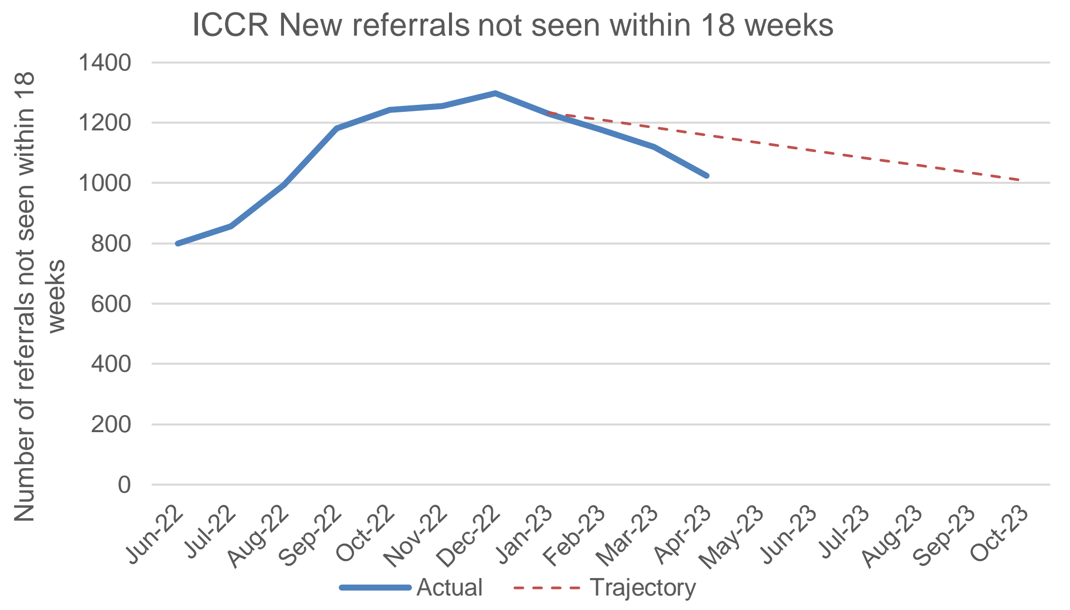
The aim is to reach the 95% target by November 2023. April 2023 Performance at 74.15% below trajectory. April has been affected by staff leaving in March along with sickness and annual leave.

The trajectory is based on the current staffing available and planned but will need to be adjusted in year to reflect success with staffing levels recruited recognising the challenging context of national shortages of this staffing group. The trajectory is dependent largely on staff recruitment. In order to be able to see more patients and thus reduce waiting times.

The Specialties deep dive meeting on the 4th May discussed the challenges the IAPT service are currently facing and the service agreed to review their action plan to see if there are additional actions that can be put in place. The trajectories should be read in conjunction with the action plan update provided to February FPPC meeting.

New Referrals not seen within 3 months

Birmingham and Solihull Mental Health NHS Foundation Trust



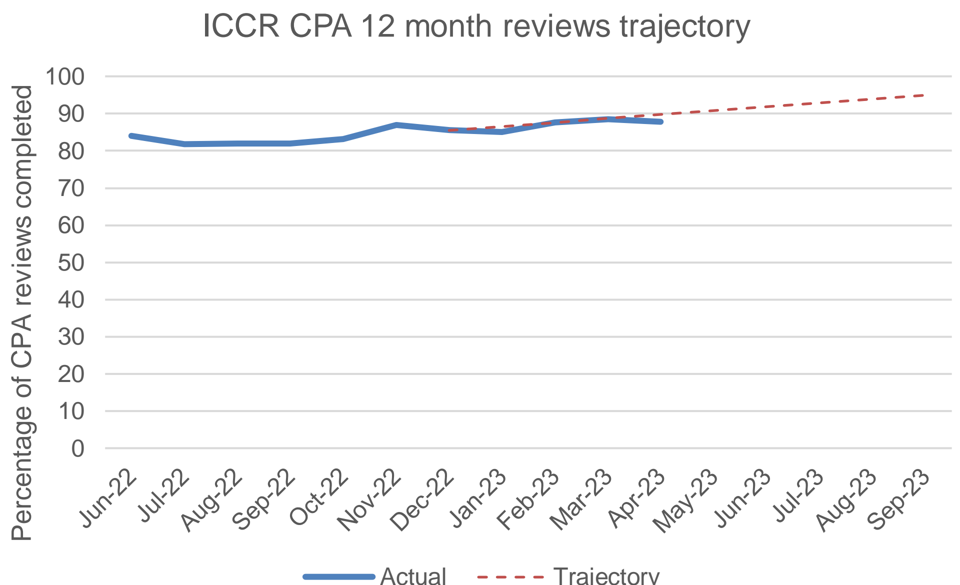
ICCR Due to the high number of patients waiting to be seen for a first appointment, the initial focus for the ICCR CMHTs will be to reduce the long waits focusing on service users waiting over 18 weeks. The trajectory is based on achieving a 20% reduction in the 18 week plus cohort by the end of October 2023. April 2023 at 1025.

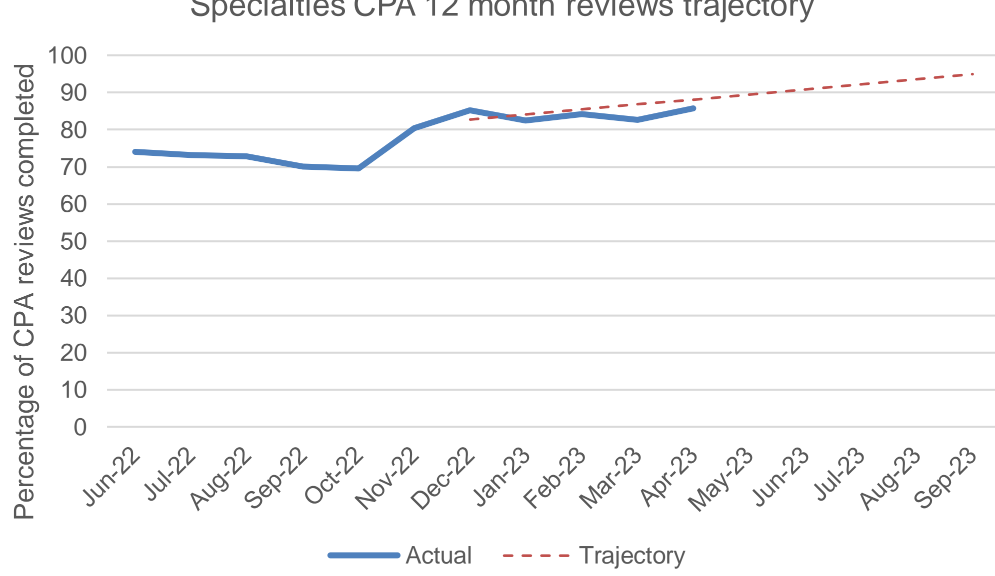
Note: This is different to the figure for new referrals not seen within 3 months.

Older adults CMHTs – In line with the report submitted to February FPPC and discussed in detail at the Specialties Deep Dive meeting on 4th May, the service is facing significant challenges including high caseload management and long term consultant and qualified nurse vacancies impacting on the ability to see new service user referrals within 3 months. It was agreed at the Deep Dive meeting that the immediate focus of the service plan is to focus on core services and review of staffing levels to ensure safe provision across teams including implementation of recruitment and retention plans. It should be noted therefore that an improvement trajectory would not be possible due to the above.

Note - ICCR Trajectory provided by Associate Director for ICCR. Older Adult CMHT position confirmed by Associate Director for Specialities.

CPA 12 month reviews





ICCR performance for April at 87.8% and Specialties at 85.7%

ICCR and older adults CMHTs – Improvement trajectory to achieve 95% by the end of September 2023. However it should be noted that the significant staffing challenges described in the previous slide will make this target challenging for Older adult CMHTs.

Note - Trajectory position provided by Associate Directors for Specialties and ICCR

7 Day follow up post discharge

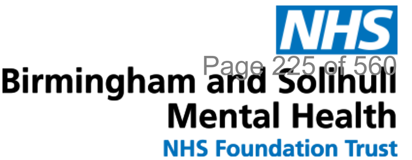
Maintaining a 95% standard on this qualitative metric is impacted on a combination of two key factors:

- To reduce the burden on services during Covid, we ceased the practise of confirming with other Trusts whether follow up had taken place for service users discharged to their services/area. This practise currently remains in place. Although the number of service users is small, the impact in percentage terms is high.
- Late data entry by staff on RIO is also a consistent theme, and although small in numbers, the impact in percentage terms is high. This area of data quality improvement is routinely discussed with ward managers to minimise occurrence.

As the above factors will vary month on month and ability to control both factors can be limited, it is not possible to establish an improvement trajectory.

Performance for April 2023 at 87.9% - 10/15 were discharged to other trusts (including FTB) and 1 follow up has been completed but awaiting data entry

Note – Commentary above provided by the AD for performance & Information

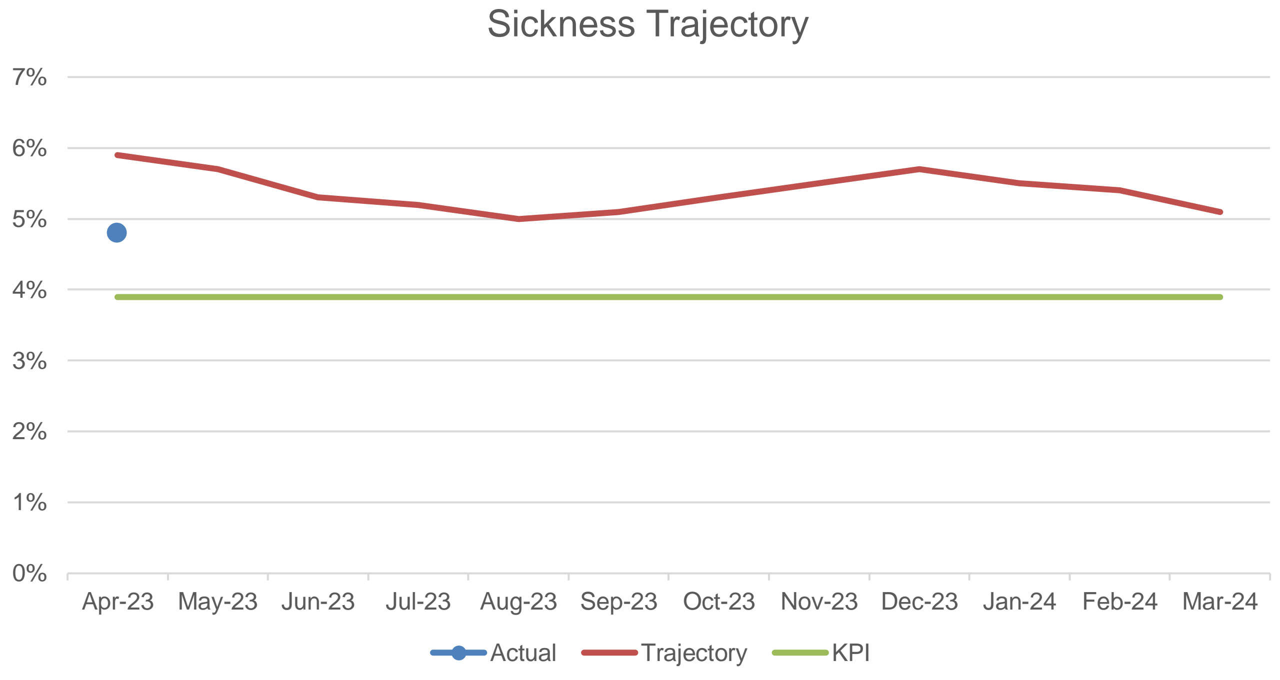


Workforce trajectories

The workforce trajectories commenced in April 2023

compassionate

Sickness Absence



- Sickness for April reduced to 4.8% below the trajectory of 5.9%. There have been reduction in both long term and short term sickness.
- The trajectory has incorporated seasonal impact variations to reflect previous summer and winter trends.
- The Trajectory has also been informed by NHS Digital data for NHS Mental Health Trusts in terms of long term and short-term trends.
- The people team are working with managers to support the management of long term sickness cases through a wide range of actions.

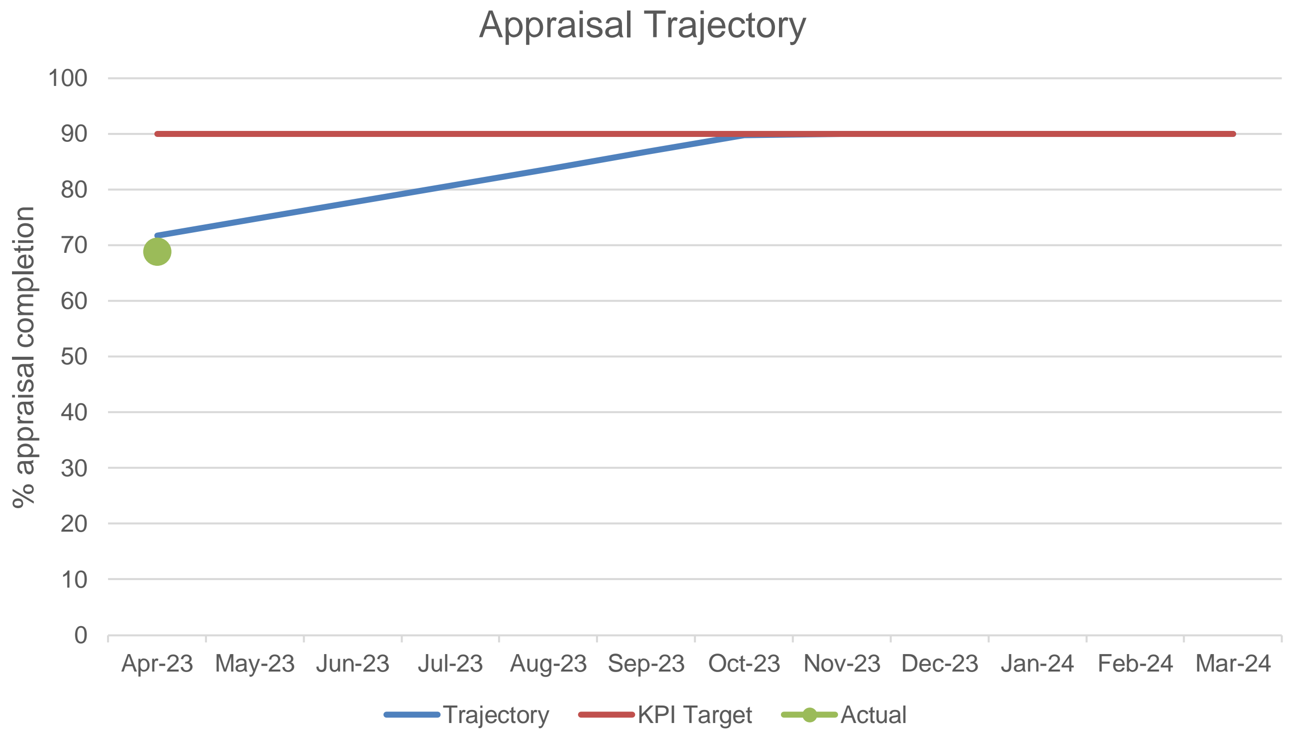
Note - Trajectory provided by People team

Vacancies

The HR lead has confirmed that the target for 2023/24 has been agreed for a 3% reduction in vacancies over the year. The vacancy figures are not currently available for April and an update will be provided to June FPP.

compassionate

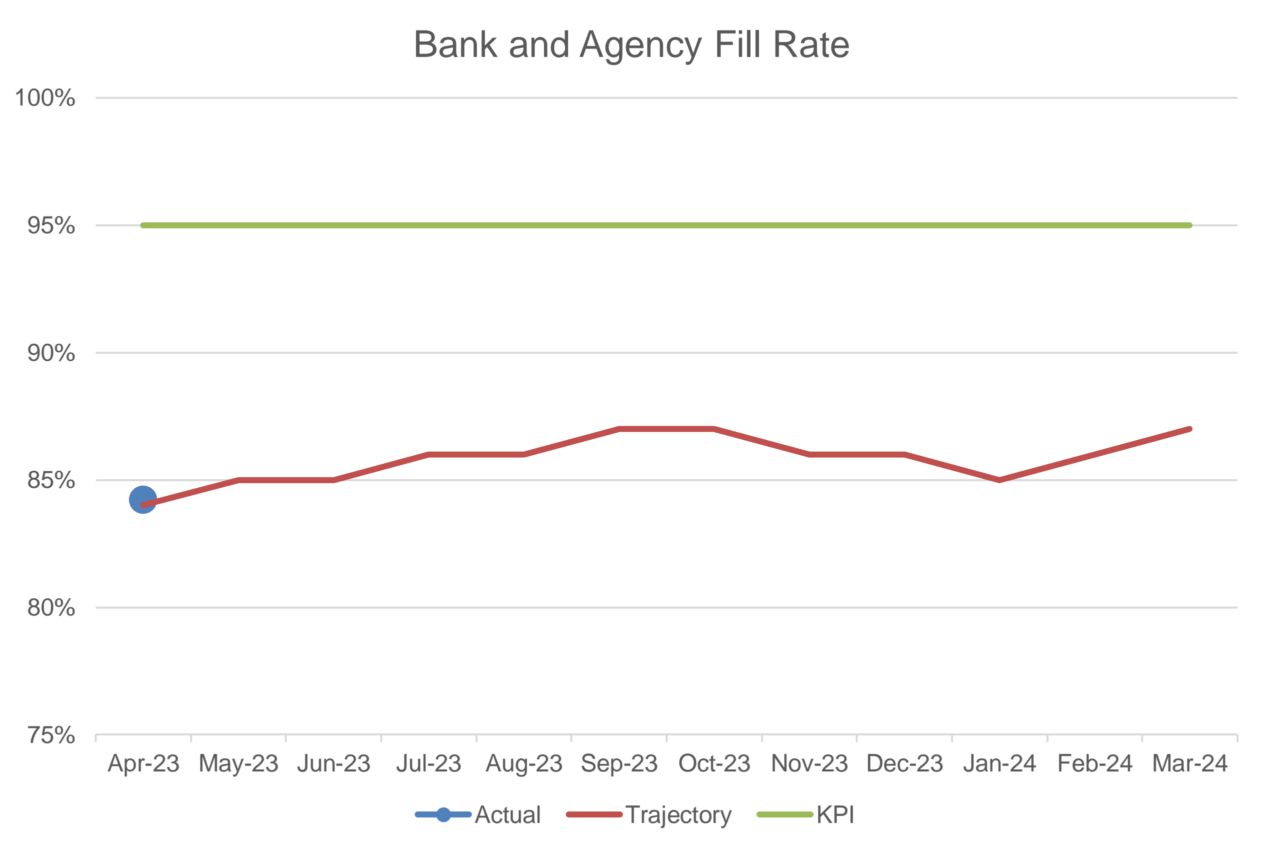
Appraisals



- Appraisals at 68.7% below the trajectory of 71.7% for April 2023
- A new appraisal system has been recently introduced which has had an impact on performance. This also means that appraisals during this year will be recorded in 2 different systems which makes monitoring challenging.
- A recovery plan has been developed which will include further targeted work, webinars and support to operational staff in navigating the new process on ESR. The webinars are available until June.
- It has also been noted that there are a number of appraisals which have been created but not finalised. L&D staff will be reviewing these to assess levels of completion.

Note - Trajectory provided by People team

Bank and Agency fill rate



Note - Trajectory provided by People team

Bank an agency fill rate at 84.1% in line with the trajectory of 84% for April 2023.

There will be little change with the current bank and agency fill rates unless there is a significant decrease in the number of bank shifts being requested.

Action to improve recruitment and retention to employ new staff in line with the workforce plan as well as filling existing vacancies will support improvement on this metric.

Demand on bank shifts continues to be high with on average, nearly 18,000 shifts being requested each month.

10. GOVERNANCE & RISK

10.1. Updates on any Action Plans arising from (Good Governance Reviews, External Visits, CQC, Coroner etc)

10.2. Updates on any Externally Commissioned Reports and Investigations

10.3. Freedom To Speak Up Annual Report

Meeting	BOARD OF DIRECTORS	
Agenda item	Item 10.3	
Paper title	Freedom to Speak Up Annual Report	
Date	7 June 2023	
Author (s)	Emma Randle, Lead Freedom to Speak Up Guardian	
Executive sponsor	Steve Forsyth, Sarah Bloomfield, Director of Quality and Safety	
Executive sign-off	☐ Yes	☒ No
This paper is for (tick as appropriate):		
☐ Decision	☒ Discussion	☒ Assurance

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

Executive summary & Recommendations:

This report provides an update on activity by, and recommendations from, the Lead Freedom to Speak Up Guardian (FTSUG) covering the period from the last full Board report in 2022. Reporting is now aligned with the Board Forward Planner, with the next report due in January 2024.

The Board are invited to:

Ensure all Associate Directors and their direct reports complete all three modules *Speak Up*, *Listen Up* and *Follow Up* by December 2023 to ensure a full understanding of the speaking up process and their role as senior leaders in setting the cultural tone of the organisation.

The Board are asked to monitor progress against this development objective which has been identified in the NHSE Improvement tool NHS England » The guide for the NHS on freedom to speak up

(Further reading is available in the Board of Directors Reading room).

Access to this training is through the Trust's Learning Zone

What is the ask? *(Please state specifically what you like the meeting, committee or Board to do).*

The Board is requested to:

GAIN RESONABLE ASSURANCE that the Guardians are taking action to continuously improve and develop the Trusts speaking up arrangements ensuring that barriers to speaking up are identified and tackled. That senior leaders effectively role model speaking up and FTSU is consistent throughout the health and care system, and ever improving

Confirm level of assurance demonstrated and evidenced in the report (tick as appropriate):

☐ Substantial Assurance

☒ Reasonable Assurance

☐ Limited Assurance

☐ No Assurance

Previous consideration of report by: (If applicable)

Regular reporting on Freedom to Speak Up is reported through to the People Committee

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)*

Not applicable

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

Not applicable

Equality impact assessments:

Equality groups are consistently monitored and reported on, barriers to speaking up identified and removed and access to FTSU made more assessable.

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

The FTSU Guardians are engaging with staff throughout the Trust

Acronyms *(List out any acronyms used in the report)*

FTSU- Freedom to Speak Up	WTE- Whole Time Equivalent
TNA- Trainee Nurse Associate	PSIRF- Patient Safety Incident Response Framework

Defining levels of assurance:

Level of assurance	Definition
Substantial Assurance	The evidence provided demonstrates there is a sound system of governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.
Reasonable Assurance	The evidence provided demonstrates there is generally a sound system of governance, risk management and controls in place. However, there are some issues e.g. with quality, non-compliance and performance that have been identified which may put at risk the achievement of objectives in the Division or Department, hence there is scope for improvement.
Limited Assurance	The evidence provided demonstrates there are significant gaps, weaknesses or non-compliance that have been identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the Division/Department.
No Assurance	There is absolutely no evidence to demonstrate, hence immediate action is required to address the fundamental gaps, weaknesses or non-compliance that have been identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the Division or Department.
Assurance (System/process-based assurance & outcome-based assurance)	Provides certainty through the evidence you may triangulate in demonstrating confidence that systems and processes are working properly and what needs to happen is happening (i.e. system/process-based assurance). However, this may not imply that expected outcomes will be achieved as planned (outcome-based assurance). It is often useful to stop and ask: • Do we really know what we think we know? • Where does the assurance come from? • How reliable is this assurance? • What is this assurance telling us?
Reassurance	This is the feeling of being assured and may be based on good performance, the lack of contradictory evidence or perhaps because someone with a professional background or expertise or management, tells you that something is so, and so it must be true.

Assurance is defined as - "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization." (HM Treasury – 2012).

FREEDOM TO SPEAK UP GUARDIAN

1. INTRODUCTION AND BACKGROUND

1.1. This report provides an update on activity by, and recommendations from, the Lead Guardian covering the period from the last Board report in July 2022. In the interim, quarterly reports have been submitted to the People Committee in November 2022 and April 2023.

1.2. Freedom to Speak Up Guardians are responsible for taking action to promote the following:

- Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up
- Speaking up policies and processes are effective and constantly improved
- Senior leaders role model effective speaking up
- All colleagues are encouraged to speak up
- Individuals are supported when they speak up
- Barriers to speaking up are identified and tackled
- Information provided by speaking up is used to learn and improve
- Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

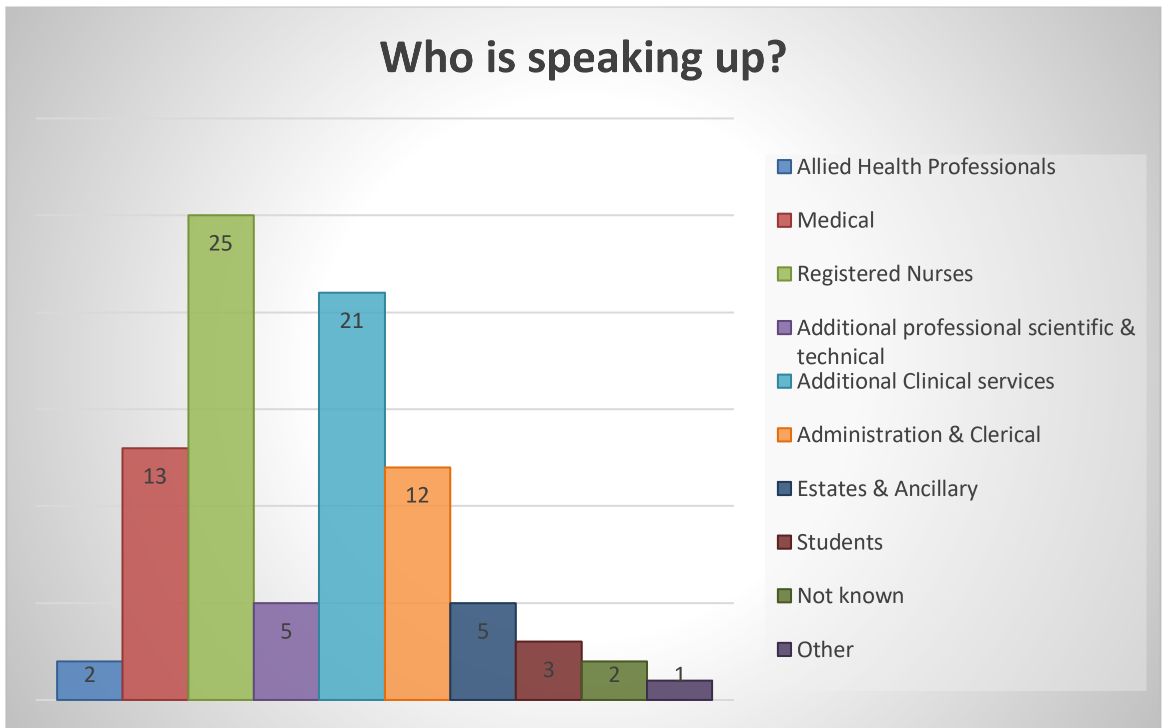
2. FREEDOM TO SPEAK UP ACTIVITY in Quarter 4

2.1 The Freedom to Speak up Guardians have received **89** speaking up concerns between January 2023 and March 2023. This is slightly less than the last quarter but still a three- fold increase in activity compared to the same period last year.

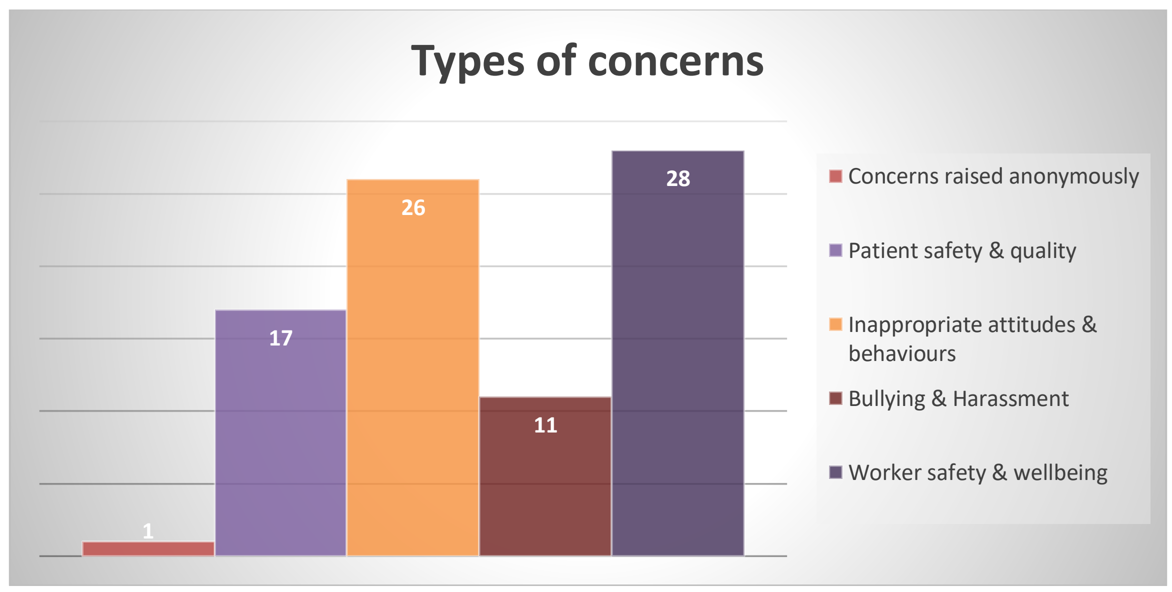
2.2 We are pleased that enquiries continue to increase significantly suggesting an increased awareness and confidence in the Guardians as an alternative route.

2.3 We have **33** ongoing enquiries that have resulted in formal processes with one dating back to April 2022 (Q1) still open.

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



Workers from a range of professional backgrounds have raised concerns but our Nurses continue to account for the biggest portion accounting for 28% of the overall number



This quarter, concerns which have an element of worker safety or wellbeing make up the highest proportion of enquiries

3. ANALYSIS OF OUR TRUST WITH NATIONAL COMPARATORS

3.1 We saw a decrease in concerns that had an element of patient safety and quality compared to last quarter (22% versus 19%) which is now in line with the national picture of 19.1% [1]

3.2 Like last quarter, we continue to see a reduction in the number of cases with an element of bullying and harassment

3.3 The category of inappropriate attitudes and behaviours was recently introduced. This quarter concerns of this nature have also reduced significantly (56% versus 29%).

3.4 Cases with an element of worker safety and wellbeing have remained the same since the last quarter (31%). This still remains significantly higher than the national figure of 13.7% but, is nevertheless encouraging as it suggests that our staff are willing to speak up in confidence and or openly

3.5 Few colleagues raise concerns anonymously amongst the cases we handle. This is to be celebrated with only 1% of cases raised like this. Our data shows we are continually below the national figure of 10.4%. Most colleagues raise concerns confidentially with us suggesting we are seen as a trusted and independent route

3.6 Although we have low levels of actual or perceived detriment for speaking up compared to the national picture, we must still guard against this.

4. TYPES OF ISSUES RAISED

4.1 Colleagues continue to raise issues about the quality of leadership in divisions previously reported on. Other themes include:

- On -going staffing challenges (secure care) to include TNAs feeling “unsafe” with an over reliance on agency staff to fill rota gaps; a disproportionate amount of staff injuries affecting one ward and a lack of protected time for TNAs to complete university work
- Allegations of bullying and harassment (to include racism)
- Bedroom seclusion
- Difficulty arranging flexible and hybrid working
- TNAs undertaking Level 3 Observations contrary to placement advice
- Fitness to practice
- Wage enquiries
- Recruitment practice

[1] Speaking Up Data - National Guardian's Office

4.2 Some of these concerns are being addressed through formal routes, on-going cultural deep dives, policy review, 1-1 coaching to improve professional competency and changes to the choice of recruitment platforms.

4.3 Where concerns have been prevalent in one service area, we have responded by offering out of hours drop- in surgeries to support colleagues on lates and night shifts

5. IMPROVING OUR SPEAK UP CULTURE AND ARRANGEMENTS

5.1 Capacity increased from April 2023 as Emma Randle commenced full time hours.

5.2 Work continues on the Reflection and Planning exercise, a gap analysis tool enabling us to identify our strengths and areas for development with clear time frames

5.3 Executives approved the FTSU business case in February 2023 by supporting the recruitment of x1 WTE FTSU Assistant (band 5) and x1 .6 Speaking Up Administrator (band 3).

5.4 The team expansion will enable us to systematically analyse and triangulate speaking up intelligence, data and other metrics, identify themes and trends, formulate heat maps identifying areas requiring bespoke training and specialist interventions at team level. We will also be able to work closely with local leaders on speaking up improvement plans

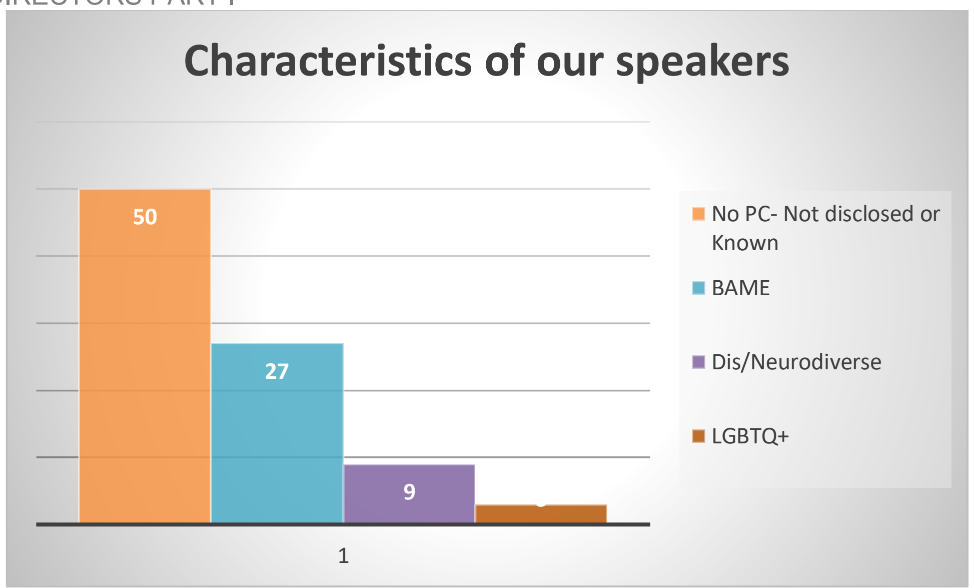
5.5 Adopting a quality improvement approach we will work with the OD team in the production and roll out of a *Speak Up Follow Up Listen Up* managers toolkit for both clinical and non-clinical settings

5.6 We now have eight Champions who have successfully completed their national training and are operational within their local areas. Lucy Thomas is compiling expressions of interest for Cohort 2 which will incorporate Champions from our lower banded colleagues.

5.7 An update of the FTSU Champion Network was presented at the QPES committee in May highlighting how it actively contributes to patient safety /quality and strengthens governance

6. SUPPORTING AN INCLUSIVE SPEAK UP CULTURE

6.1 We continue to monitor the protected characteristics of our speakers. Below is a breakdown of this data for Quarter 4:



6.2 Our data shows very little change in the representation of our equality groups when compared to Quarter 3. We can see a slight increase in speakers who identify as belonging to the LGBTQ+ community.

6.3 We have finished recording our FTSU Inclusion video *"Speaking up is for everyone"* and will showcase this at the AGM and during Speak Up month in October.

6.4 In March 2023, The Chair asked us to review the "Pull Up a Chair" initiative. We will table this report at the People Committee update in September.

7. NATIONAL REQUIREMENTS AND UPDATES

7.1 We can provide assurance that we are on track to meet the NHSE requirements of all trust Boards to evidence by the end of January 2024:

- ✓ An update to our FTSU policy to reflect the new national policy template
- ✓ Results of our assessment of the FTSU arrangements against revised guidance
- ✓ Assurance that we're on track by the implementation of our improvement plan

7.2 The 2021-22 Annual Report of the National Guardian for the NHS was laid before Parliament in January 2023. This report highlights the work of the Freedom to Speak Up Guardians and the National Guardian's Office in making speaking up business as usual.

7.3 The National Guardians Office are working with the Care Quality Commission (CQC) on the inclusion of Freedom to Speak Up as a quality indicator in their new regulatory framework.

8. LEARNING AND IMPROVEMENTS

8.1 We will be supporting the People Team and other stakeholders in adopting a Quality Improvement (QI) approach to improving the colleague experience of formal processes (such as investigations and grievances) ensuring they are consistently responded to within policy time frames

8.2 Anonymised concerns raised about patient safety and quality will feed into and inform the newly adopted Safety Summit Approach Safety Summit Approach - promoting excellence in patient safety (sharepoint.com). This is a mechanism enabling local teams and service areas to use intelligence and data from a range of sources for multidisciplinary review, learning and improvement

8.3 In 2022, the previous Chair of the Board asked FTSU to become rooted in the PSIRF. We are stakeholders in the implementation group, ensuring that the principles of speaking up are embedded into compassionate managers sign off to incidents.

8.4 The latest CQC Inspection report in April 2023 reflected the improvements in the organisations speaking up culture and noted in particular, that staff they spoke to in Older Adults, Crisis services and health-based places of safety, Forensic inpatient or secure wards felt able to speak up and raise concerns safely

8.5 The inspectors also reported that staff they spoke to on the acute wards for adults of working age and Psychiatric intensive care units and Long stay/ rehabilitation wards felt less able to raise concerns safely and did not always feel listened to

8.6 We continue therefore to offer drop- in surgeries, increasing our visibility, and improving accessibility to our colleagues working in these priority areas

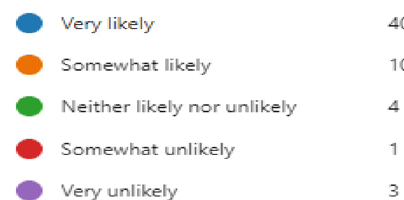
8.7 We will be working with the Associate Director of Governance to include speaking up in the Trust's action plan in response to the 2022 Ockenden Review.

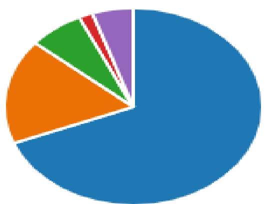
8.8 This quarter there is evidence of learning and improvement: For example, a further review of the therapeutic observation policy; resolution of a patient safety concern with the speakers observing positive change, improved communication and feedback between managers and staff in two areas; a planned business case to improve staffing levels in another and inclusive changes to the range of recruitment platforms

9. WHAT OUR COLLEAGUES SAY ABOUT SPEAKING UP

9.1 Feedback is an important part of the speaking up process and is sought from colleagues three months after their initial contact asking about their speaking up experience. Feedback is anonymous and is used for continuous learning and improvement:

5. Given your experience are you likely to speak up again?

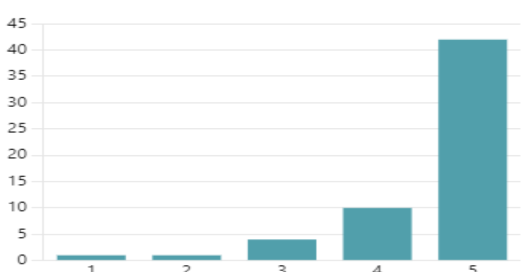




8. How likely are you to recommend the Guardians to your colleagues ?

More Details

4.57
Average Rating



9.2 Most of our testimonials are encouraging but some require us to pause and reflect:

55	anonymous	In the end the Trust didn't appropriately respond. At least FTSU gave them a chance to do that I suppose.
56	anonymous	I felt heard and relief. They helped me with different alternatives. Most importantly I felt I wasn't alone.
57	anonymous	Caring, considerate, understood our concerns & gave positive advice moving forward
58	anonymous	just someone to listen to me but didn't really get the support i needed in all honesty. It's good to guide people on what and where they can go, but that's it really i found. I had higher expectations from this service but didn't meet my expectations

10. RECCOMENDATIONS

The Board is invited to:

10.1 Ensure all Associate Directors and their direct reports complete all three modules, *Speak Up*, *Listen Up* and *Follow Up.* This will ensure a full understanding of the speaking up process and reinforce the importance that leaders have in role modelling a healthy FTSU culture. Access to this training is through the Trust's learning zone

10.2 The Guardians warmly invite feedback on this report and are happy to discuss it's content

Emma Randle, Lead Guardian, May 31st 2023

10.4. Quarterly Guardian of Safe Working Report

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	10.4		
Paper title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2022-23 Q4)		
Date	7 June 2023		
Author (s)	Dr Shay-Anne Pantall, Guardian of Safe Working & Consultant Psychiatrist		
Executive sponsor	Dr Fabida Aria, Executive Medical Director		
Executive sign-off	☒ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

Quarterly reports to the Trust Board are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

- Dr Shay-Anne Pantall commenced in post as the Guardian of Safe Working Hours in January 2023.
- No immediate safety concerns were raised during this quarter.
- 21 exception reports were raised during this quarter. 2 reports were duplicates. This is a significant increase (almost 10x) compared to the previous quarter. One exception report was raised relating to issues with education and training.
- Only 2 (10.5%) exception reports raised during this quarter were closed within 7 days. Delays in the process were due to the need to clarify the on call working pattern for Higher Trainees with Medical Workforce, disagreement with the initial outcomes and outcomes not being accepted promptly by the junior doctor.
- 7 exception reports are awaiting work schedule review, 3 for Level 2 review and 4 for Level 1 review.
- 10 fines were levied against the Trust for breaches in safe working hours. In response to this, a change to on call working patterns is actively being discussed with Higher Trainees.
- Rota monitoring took place for ST rotas in January and February 2023; response rates were poor.
- The number of vacant shifts continues to be high, with a 33% increase in shift vacancies compared to Q3 (508 compared to 382). The majority of gaps were due to post vacancies. 17 shifts required cover due to Industrial Action by junior doctors in March 2023. All on call locum vacancies during this period were filled.

- Work continues to help facilitate cultural change to support our doctors in training in raising issues.

What is the ask? ***(Please state specifically what you like the meeting, committee or Board to do).***

The Board is requested to note this report and the progress that has been made in encouraging postgraduate doctors in training to raise concerns. This report is for assurance to the Board that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions are being taken in response to concerns raised.

Confirm level of assurance demonstrated and evidenced in the report (tick as appropriate):

☐ Substantial Assurance
☒ Reasonable Assurance
☐ Limited Assurance
☐ No Assurance

Previous consideration of report by: (If applicable)

N/A

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

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

Financial Implications *(detail any financial implications)*

Fines have been levied by the Guardian of Safe Working due to breaches of the core rest requirements for non-resident on call working on 10 occasions in this period, covering 24.75 hours payment at enhanced rates.

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

No new risks identified.

Equality impact assessments:

No concerns

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

- Exception reports and themes are discussed in the Junior Doctors Forum on a regular basis. The meeting scheduled for February 2023 was unfortunately cancelled due to Guardian of Safe Working illness
- Individual letters are written to new doctors starting in our trust encouraging them to use the exception reporting system
- Doctors in training have bimonthly trainee council meetings. The meeting is open to all doctors in training in our Trust
- The Guardian of Safe Working Hours is invited to regular stakeholder meetings for the Trainee Raising Concerns QIP
- Collaboration with the trainee-led Exception Reporting Working Group
- I have met with postgraduate doctors in Higher Training in Forensic Psychiatry in their peer group meeting and trainees on an individual basis where this has been necessary.

The following are planned to improve engagement:

- Refresher training for Educational Supervisors and ST tutor regarding rota rules and exception reporting
- Attendance at PGME meetings to raise awareness of change to Guardian of Safe Working and share information about exception reporting rules
- Updates to information held on Connect regarding the Guardian of Safe Working and Exception Reporting
- Regular attendance at trainee meetings including: ST Forum, Trainee Council
- Drop-in clinics for postgraduate doctors in training, to be offered weekly in person at the Uffculme Centre or via MS Teams

Acronyms *(List out any acronyms used in the report)*

GoSW – Guardian of Safe Working
FY – Foundation Year
GPVTS – General Practice Vocational Training Scheme
CT – Core Trainee
ST – Speciality Trainee
JDC – Junior Doctor Contract
JDF – Junior Doctor Forum
QIP – Quality Improvement Project
PA – programmed activity

Defining levels of assurance:

Level of assurance	Definition
Substantial Assurance	The evidence provided demonstrates there is a sound system of governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.
Reasonable Assurance	The evidence provided demonstrates there is generally a sound system of governance, risk management and controls in place. However, there are some issues e.g. with quality, non-compliance and performance that have been identified which may put at risk the achievement of objectives in the Division or Department, hence there is scope for improvement.
Limited Assurance	The evidence provided demonstrates there are significant gaps, weaknesses or non-compliance that have been identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the Division/Department.
No Assurance	There is absolutely no evidence to demonstrate, hence immediate action is required to address the fundamental gaps, weaknesses or non-compliance that have been identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the Division or Department.
Assurance (System/process-based assurance & outcome-based assurance)	Provides certainty through the evidence you may triangulate in demonstrating confidence that systems and processes are working properly and what needs to happen is happening (i.e. system/process-based assurance). However, this may not imply that expected outcomes will be achieved as planned (outcome-based assurance). It is often useful to stop and ask: • Do we really know what we think we know? • Where does the assurance come from? • How reliable is this assurance? • What is this assurance telling us?

Reassurance	This is the feeling of being assured and may be based on good performance, the lack of contradictory evidence or perhaps because someone with a professional background or expertise or management, tells you that something is so, and so it must be true.
Assurance is defined as - "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization." (HM Treasury – 2012).	

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

January – March 2023

High level data

Number of doctors / dentists in training (total): 103

Number of doctors / dentists in training on 2016 TCS (total): 103

Amount of time available in job plan for guardian to do the role: 1 PA per week

Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports

2 exception reports submitted were duplicates and therefore have been excluded from the data.

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	4	1	1	4
ST 3-6	4	18	6	16
GPVTS	0	0	0	0
Total	8	19	7	20

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	4	1	1	4
ST North	1	3	1	3
ST South	0	13	2	11
ST Solihull/East	0	1	1	0
ST Forensic	3	2	3	2
Total	8	19	7	20

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	1	0	4
ST3-6	0	1	4	16
GPVTS	0	0	0	0
Total	0	2	4	20

b) Type of exceptions in the quarter:

18 related to working hours and one related to educational opportunities.

c) Work Schedule Reviews

Status (7 exception reports - figures include 4 exceptions carried forward);

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	4 (1 L1, 3 L2)
ST3-6	3 (3 L1)
GPVTS	0
Total	0

7 reviews are pending; four relate to the same postgraduate doctor in training and are carried forward from previous quarters. 3 exception reports have been escalated for L2 review (all carried forward) as of 21 December 2022 and 4 for L1 review (1 carried forward).

I met with the individual trainee awaiting 1 Level 1 review and 3 Level 2 reviews on 1 March 2023 to explore these exception reports and their experience of work schedule reviews. Further clarification of contemporaneous actions taken is required before the reviews can be completed.

Of the work schedule reviews, 3 are unresolved, 1 is pending, 2 are waiting for doctor agreement and 1 is completed.

d) Locum bookings and vacancies

Locum bookings JANUARY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	17	17	168.50	168.50
Rota 2	15	15	151.00	151.00
Rota 3	24	24	244.50	244.50
Rota 4	11	11	94.50	94.50
Rota 5	20	20	196.00	196.00
Rota 6	26	26	245.50	245.50
ST4-6 North	16	16	232.50	232.50
ST4-6 Rea/Tam	8	8	144.00	144.00
ST4-6 Sol/East	21	21	400.00	400.00
ST4-6 South	13	13	193.00	193.00

Total	171	171	2069.50	2069.50

Locum bookings FEBRUARY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	11	11	109.50	109.50
Rota 2	18	18	171.50	171.50
Rota 3	26	26	254.00	254.00
Rota 4	7	7	54.00	54.00
Rota 5	13	13	134.50	134.50
Rota 6	20	20	180.00	180.00
ST4-6 North	15	15	212.00	212.00
ST4-6 Rea/Tam	8	8	152.00	152.00
ST4-6 Sol/East	16	16	288.00	288.00
ST4-6 South	3	3	41.00	41.00
Total	137	137	1596.50	1596.50

Locum bookings MARCH 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	15	15	114.00	114.00
Rota 2	22	22	198.50	198.50
Rota 3	35	35	331.00	331.00
Rota 4	25	25	233.50	233.50
Rota 5	21	21	175.50	175.50
Rota 6	29	29	253.50	253.50
ST4-6 North	15	15	228.00	228.00
ST4-6 Rea/Tam	9	9	152.00	152.00
ST4-6 Sol/East	23	23	424.00	424.00
ST4-6 South	7	7	104.00	104.00
Total	200	200	2202.00	2202.00

Locum bookings JANUARY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	113	113	1100.00	1100.00
ST4-6	58	58	969.50	969.50
Total	171	171	2069.50	2069.50

Locum bookings FEBRUARY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	95	95	903.50	903.50
ST4-6	42	42	693.00	693.00
Total	137	137	1596.50	1596.50

Locum bookings MARCH 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	146	146	1294.00	1294.00
ST4-6	54	54	908.00	908.00
Total	200	200	2202.00	2202.00

Locum bookings JANUARY 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	125	125	1498.00	1498.00
Sickness	17	17	193.00	193.00
Paternity Leave	1	1	16.00	16.00
Off Rota	25	25	326.50	326.50
Comp Leave	3	3	36.00	36.00
Total	171	171	2069.50	2069.50

Locum bookings FEBRUARY 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	120	120	1416.00	1416.00
Sickness	2	2	32.00	32.00
COVID 19	1	1	4.50	4.50
Off Rota	7	7	90.00	90.00
Maternity Leave	7	7	54.00	54.00
Acting Up Consultant	0	0	0	0
Total	137	137	1596.50	1596.50

Locum bookings MARCH 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Comp Leave	2	2	40.00	40.00
STRIKE	17	17	160.00	160.00
Vacancy	146	146	1633.50	1633.50
Sickness	8	8	67.00	67.00
COVID 19	3	3	40.00	40.00
Off Rota	7	7	108.00	108.00
Maternity Leave	17	17	153.50	153.50
Total	200	200	2202.00	2202.00

Fines levied

Rota	No. of fines levied: Feb 2023	No. of fines pending: March 2023	Value of fines levied
ST North	2	1	£982.41
ST South	3	3	£831.27
ST Solihull	1	0	£780.02

6 fines have been levied for exception reports submitted in February 2023, totalling 16.5 hours at enhanced rates. 4 fines have been levied for exception reports submitted in March 2023, totalling 8.25 hours at enhanced rates.

All 10 fines were related to breaches of core rest requirements for overnight working for doctors working non-resident on calls (not achieving a minimum of 5 hours consecutive rest between 22:00 and 07:00).

A ledger code for fine monies is being established. As of 9 May 2023, the manual record of fines levied notes a total sum of £2322.37 (March fines pending). Ideas for disbursement will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The number of exception reports raised within this period was significantly higher than in the previous quarter. This may reflect change in workload for Higher Trainees on the ST rotas or an improvement in exception reporting culture amongst junior doctors in response to active change ideas as part of an ongoing trainee-led QIP. The majority (67%) of exception reports related to breaches of core requirements overnight during non-resident on calls.

There were 20 outstanding exceptions by the end of Quarter 4, including 3 outstanding Level 2 work schedule reviews and 4 outstanding Level 1 work schedule reviews. The delays in closing exception reports in a timely manner is of concern. Reminders are sent by Medical Staffing to the supervisors and doctors involved with open exceptions.

The main source of delay in resolution of exception reports was due to a need to seek clarification of the work schedules sent to higher trainees on North and South ST rotas. These rotas are non-resident on call at night including at weekends but were understood by Medical Workforce to be a ‘full shift’ pattern for weekend nights. Whilst this issue was investigated, Exception Reports were not able to be accurately resolved by the ST Tutor responsible for reviewing reports. This issue was resolved at the Medical Workforce and Education Meeting on 29 March 2023 and I subsequently met separately with Angela West, Senior People Partner, in April 2023 to agree outcomes of submitted exception reports. I also met with Dr Swarup, ST Tutor, on 6 April 2023 to offer guidance on closure of exception reports relating to on call working. At the time of writing, 12 of the outstanding exceptions have since been closed – further detail will be included in the 2023-4 Q1 report.

Rota monitoring took place in January – March 2023 for all ST rotas as follows:

- Forensic rota – 09/01/23 – 05/02/23
  This was in response to a number of exception reports that are being raised when StRs are working more than the estimated average of 5 hours during an on call working pattern. Only 2 of 8 (25%) doctors that worked on calls in this time period responded. Returned data covers 7 on calls of the 28 (25%) in the time period. All record rest compliant with the rules and that 5 hours continuous rest was achieved in all on call duties reported.

- North rota – 01/02/23 – 05/03/23
  We received a response from only 3 of 13 (23%) doctors that worked out of hours in this time period. Returned data covers 11 of 43 (26%) out of hours duties in this time period. 5 hours continuous rest was achieved on 2 of 6 (33%) on calls.

- South rota – 01/02/23 – 05/03/23
  We have received a response from only 4 of 12 (33%) doctors that worked out of hours in this time period. Returned data covers 18 of 43 (42%) out of hours duties in this time period. 5 hours continuous rest was achieved on 4 of 9 (45%) on calls.

- Solihull & East rota – 01/02/23 – 05/03/23
  We have received a response from only 2 of 12 (17%) doctors that worked on call in this time period. Returned data covers 8 of 33 (24%) on calls in this time period. 5 hours continuous rest was achieved on all on call duties reported.

Although response rates were less than 75% meaning no valid conclusions can be firmly drawn, the monitoring exercises replicate the findings from exception reports for breaches of continuous

rest overnight on both North and South ST rotas.

All of the 10 fines levied during this quarter relate to breach of overnight rest requirements for non-resident on call working; 3 Level 1 work schedule reviews have been triggered relating to this issue. I attended the ST Forum in May 2023 to meet with affected trainees. Higher trainees were encouraged to continue to submit Exception Reports against their existing work schedules pending further discussion between ST doctors, the Deputy Medical Director and Medical Workforce. This meeting took place on 16 May 2023. In response to the exceptions raised relating to breaches of rest requirements, a new rota pattern has been proposed by Medical Workforce and shared with ST reps for wider consultation.

There continues to be a high number of shift vacancies, with an increase in March compared to previous months. The largest proportion of the vacant shifts have been due to post vacancies. Industrial Action by junior doctors took place in March 2023; 17 shifts required cover as during the strike period. The shifts were primarily filled by internal locums.

Work is ongoing to encourage postgraduate doctors in training to raise concerns with regards to their working hours and training experience. Following my appointment, I have continued to work with trainees involved with the QIP addressing Trainees Raising Concerns to ensure a collaborative approach to improving exception reporting and confidence in the reporting system within the Trust. Several change ideas have been identified including provision of additional training for trainees and supervisors, an Exception Reporting relaunch event, updates to the information available on Connect and coproduction of exception reporting example vignettes between junior doctors, Medical Staffing and the BMA. A specific email address for the Guardian of Safe Working is planned following the upcoming email migration.

Actions taken to resolve issues
See above.

Summary

The post of Guardian of Safe Working Hours was re-appointed in December 2022. Dr Shay-Anne Pantall commenced in post in January 2023, succeeding Dr Sajid Muzaffar.

No immediate safety concerns were raised during this quarter. 19 unique exception reports were raised during this quarter, a significant increase compared to the previous quarter. One exception report was raised relating to issues with education and training.

10 fines were levied against the Trust for breaches in safe working hours. In response to this, a change to on call working patterns is actively being discussed with Higher Trainees.

Only 2 (10.5%) exception reports raised during this quarter were closed within 7 days. Delays in the process were due to the need to clarify the on call working pattern for Higher Trainees with Medical Workforce, disagreement with the initial outcomes and outcomes not being accepted promptly by the junior doctor.

7 exception reports are awaiting work schedule review, 3 for Level 2 review and 4 for Level 1 review.

Rota monitoring took place for ST rotas in January and February 2023; response rates were poor.

The number of vacant shifts continues to be high, with a 33% increase in shift vacancies compared to Q3 (508 compared to 382). The majority of gaps were due to post vacancies. 17 shifts required cover due to Industrial Action by junior doctors in March 2023. All on call locum

vacancies during this period were filled.

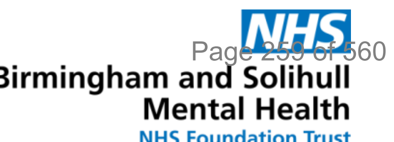
Work is ongoing to help facilitate cultural change to support our doctors in training in raising issues.

Questions for consideration:
Support from senior leaders in encouraging culture change in relation to raising concerns through use of exception reporting system would be beneficial. A joint communication to postgraduate doctors in training from senior leaders within the Medical Directorate may be helpful.

10.5. Questions from Governors and Public

10.6. Any Other Business (at the discretion of the Chair)

10.6.1. 10.6a. Health inequalities (including PCREF, Blaichir & Internal work)



MEETING	BOARD OF DIRECTORS
AGENDA ITEM	10.6a
PAPER TITLE	Health inequalities (including PCREF, Blaichir & Internal work)
DATE	7th June
AUTHOR	Jas Kaur, Associate Director of Equality, Diversity, Inclusion and Organisational Development
EXECUTIVE SPONSOR	Fabida Aria, Executive Medical Director

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

Equality & Diversity *(all boxes MUST be completed)*	
Does this report reduce inequalities for our service users, staff and carers?	Yes
What data has been considered to understand the impact?	Bsol health profiles Business intelligence service user demographic profiles National ethnicity profiles

Executive summary & Recommendations:

This presentation presents an overview of the approach towards tackling health inequalities here at BSMHFT. Going forward Health inequality updates will be provided at 6-month intervals to the Trust Board
Overviews of the activity being delivered across the Patient Carer Race Equality Framework (PCREF), and the approach to addressing the recommendations of the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) will be provided.
Details of the key work programs currently being delivered in the hope of addressing long standing health inequalities will outline key activity with identified year one outcomes across;

- Data availability & Usage
- SMI Physical Health
- Ethnic Disparities in Mental Health Act detention
- Adapting Psychological Service Provision
- Reducing Inequalities-Secure Care
- PPAC Inequalities Group
- Community Transformation
- Solar & CYP
- Reducing Restrictive Practice

The presentation will conclude by highlighting overarching themes of advocacy, co-production and accountability. Finally ending with the *Big-Ticket* items of overarching focus for the remainder of 2023 being:

- Determining Committee oversight
  - Governance sustainability
  - Board visibility
- Integrated strategic Data Dashboard
- Organisational roll out of PCREF
- Developing further representation across community collaborative
- Local service reducing health inequalities plans.

Reason for consideration:

Health Inequalities is a key building block of the 5 year Trust strategy.

Previous consideration of report by:

First Board update of the *Value Me* approach towards tackling Inequality

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

Links across People, Quality and Clinical Services priorities

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

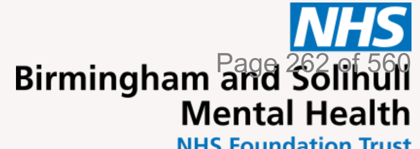
Financial implications based on building trust and confidence with service users, cares and communities in providing the right care at the right time,

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

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

Health Inequalities working group.
PCREF working group.

Value Me to Reduce Inequality June 2023



Inclusive culture

which is…

Anti racist

and

Anti discriminatory

for **all**

to

Improve

access,

experience

and

outcomes

for

our people

A picture of our population in 2021

Total population (2021)

1,361,158 living in 513,000 households

96,800 Students (2021 Census)

Sexual orientation

2.8% of our population identify as lesbian, gay, bisexual, another non-heterosexual identity.

Under 18yrs conception rate (2020)

Population

Birmingham 1,144,917

Solihull 216,241

Disability (2011 Census)

Disabled under the **Equality Act**

Disabled under the **Equality Act: Day-to-day activities limited a lot**

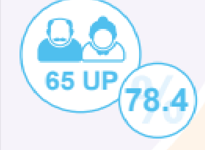
Disabled under the **Equality Act: Day-to-day activities limited a little**

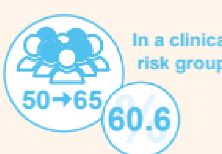
Economic activity status

Economically active (excluding full-time students):
9% Unemployed in total

Economically active (excluding full-time students):
91.7% in employment in total

Flu 2021/22 - vaccine uptake





Cancer

Birmingham and Solihull ICB had 6,384 emergency admissions with cancer, with a rate of 406 admissions per 100,000 population compared to 514 Nationally.

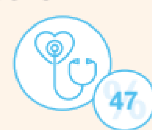
There were over 5,317 new cases of cancer diagnosed across Birmingham & Solihull. This is a rate of 344 per 100,000 patients compared to a National rate of 456.

Diabetes

Birmingham and Solihull patients are recorded as having diabetes

Number of patients with diabetes who had a foot examination.

Physical health checks



Percentage of patients in Birmingham and Solihull on SMI registers were in receipt of all six elements of the health checks in the 12 months to the end of December 2022.

Ethnicity (2019 ONS estimates)

Total 100 All usual residents

	Birmingham	Solihull
① Asian, Asian British or Asian Welsh	31.0%	11.0%
② Black, Black British, Black Welsh, Caribbean or African	11.0%	1.8%
③ Mixed or Multiple ethnic groups	4.8%	3.5%
④ White	48.6%	82.2%
⑤ Other ethnic group	4.5%	1.5%

3.9% of people cannot speak English well or at all, this is just under 48,000 people

Faith and religion

Christian	36.7%
Muslim	26.0%
No religion	25.5%
Not answered	6.0%
Sikh	2.8%
Hindu	2.1%
Other religion	0.5%
Buddhist	0.4%
Jewish	0.1%

A picture of our population in 2021

Age (2021 ONS population estimates)

Poverty £

People in Birmingham earn £49 a week less than the national average in full-time employment whereas in Solihull they earn on average £80.4 a week more. In both areas, there are significant disparities between those on the highest and lowest income.

Unemployment

70,900 workless households across Birmingham and Solihull.

5.3% of people with health conditions or illness >12 months are unemployed in Birmingham and Solihull compared to 2.8% nationally, and 49.7% are economically inactive. (Apr 21-Mar 22)

Children in relative low income families (under 16yrs)

97,119 children

Infant Mortality Rate

(2018-2020)

Child development

Percentage of children with a good level of development – Early years foundation stage (2021/22)

Percentage of children achieving a good level of development at the end of reception (2018/19)

Young people aged 16-17yrs not in education, employment or training

(NEET) (2020)

2,820 young people

6.5 | 4.4

Patients with known coronary heart disease immunised against flu

(2020/21)

7 GP practices achieved more than 90% coverage and 15 GP practices achieved less than 60% coverage

Women aged 25-49yrs who have had a cervical cancer screen in the last 3.5 years (2020/21)

22 GP practices have over 75% and 11 practices have less than 50%

3.5 years

Patients with severe mental health issues having a comprehensive care plan (2020/21)

25 GP practices had a care plan in place for over 90% of patients whilst 74 GP practices had it in place for less than 50% of patients with severe mental health issues

Hospital admissions caused by injuries in children 0-14yrs

(intentional & unintentional) (2020/21)

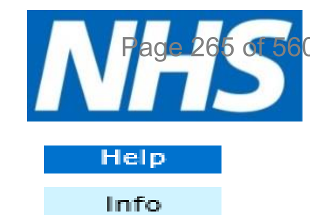
76.1 | 88.5

Population vaccination coverage

MMR one dose by 2yrs old (2021/22)

82.5 | 90.3

Mental Health Act data



Demographics of people detained under the Act

People subject to the Mental Health Act (MHA)

Version: 1.0.0

Help
Info

Geography type: England | Geography: England | Grouping: Ethnicity | Group: (All)

Legend: Asian, Black, Other, Mixed, White British, White Other, Missing/Invalid

People under active episodes - Ethnicity - 12 months to September 2021 - Section groupings

Section	Asian	Black	Mixed	Other	White British	White Other	Missing/Invalid
All Sections	6.5%	10.1%	3.4%	3.2%	57.6%	6.5%	12.6%
Section 2	7.0%	10.1%	3.3%	3.7%	56.7%	7.5%	11.7%
Section 3	7.3%	11.9%	3.6%	3.2%	59.6%	6.4%	8.0%
Section 135	6.9%	18.7%	5.4%		51.7%	7.5%	6.9%
Section 136	5.0%	6.7%	3.2%		58.0%	6.2%	17.9%
Other Short Term Orders	5.6%	7.0%	2.9%		67.7%	5.8%	8.5%
All Part 3 - via the criminal justice system	7.0%	16.9%	5.2%		53.6%	5.8%	8.8%
Community Treatment Order	9.0%	21.5%	5.0%	4.3%	50.0%	7.6%	
Conditional Discharge	9.1%	22.2%	6.4%		52.3%	5.2%	

Data consistently highlights that people from ethnic minority backgrounds (especially Black backgrounds) are:

- More likely to be detained under the Act
- More likely to enter the system through a criminal justice route
- More likely to be detained in hospital for longer
- More likely to be subject to ongoing conditions under the Act following discharge from hospital
- The key action being taken to address these issues is the development of the Patient and Carers Race Equity Framework (PCREF), a recommendation of the Independent Review of the Mental Health Act, which NHSE&I agreed to take forward.

Ethnicity

NHS

Birmingham and Solihull

The ethnicity of a PERSON, as specified by the PERSON.

BSMHFT

Coverage	Validity	Accuracy
100%	100%	91%

The ethnicity of a PERSON, as specified by the PERSON.

MIDLANDS COMMISSIONING

Coverage	Validity	Accuracy
98%	98%	81%

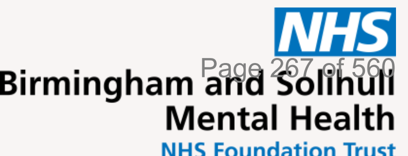
Number of individual providers scoring at least 95% on each of the DQ measures

The ethnicity of a PERSON, as specified by the PERSON.

ALL REGIONS

Coverage	Validity	Accuracy
97%	97%	79%

Number of individual providers scoring at least 95% on each of the DQ measures



Insight

Demographics: Main Characteristics - 1 Year Caseload

SERVICE / TEAM FILTER

Services/Teams Selected:
All Services and Teams

1 YEAR | CURRENT | NEW

SUs last 12 months	Current SUs	SUs New to the Trust
109,548	55,662	60,686

Service Users - Ethnicity

White 58.27%; Asian / Asia... 17.27%; No... 7.69...; Black / Blac... 6.98%; No...; Mixed; Ot...

Service Users - Age

85 plus 5.1%; 75-84 6.5%; 65-74 6.1%; 55-64; 45-54; 35-44; 25-34; 16-24 10.9%; <16 3.0%

Service Users - Gender

50%; 0%; Female; Male; Non bi...; Non-bi...; Not cla...; Not kn...; Other

Service Users - Disability

Yes 4.4%; No/Not Kn... 95.6%

Service Users - 2019 Index of Multiple Deprivation (Decile1 = most deprived)

50%; 0%; 1 2 3 4 5 6 7 8 9 10

2011 CENSUS DATA

Source: Office for National Statistics

BSol Population - Ethnicity

White 62.97%; Asian / Asian Bri... 23.38%; Black / ... 7.78%; Mixed 4.06%

BSol Population - Age

85 Plus 1.9%; 75-84 4.9%; 65-74 7.1%; 55-64 9.6%; 45-54; 35-44; 25-34; 16-24; <16

BSol Population - Gender

60%; 40%; 20%; 0%; Female; Male

BSol Population - LTI / Disability

18.3%

2011 Census BSol Population by 2010 Index of Multiple Deprivation (Decile1 = most deprived)

50%; 0%; 1 2 3 4 5 6 7 8 10

Contact Us

User: j-kaur5@bsmht.nhs.uk

Last Refreshed on: 23/05/2023 08:30

Report ID: 173

inclusive

Birmingham and Solihull
Mental Health
NHS Foundation Trust

Birmingham and Solihull
Mental Health
NHS Foundation Trust

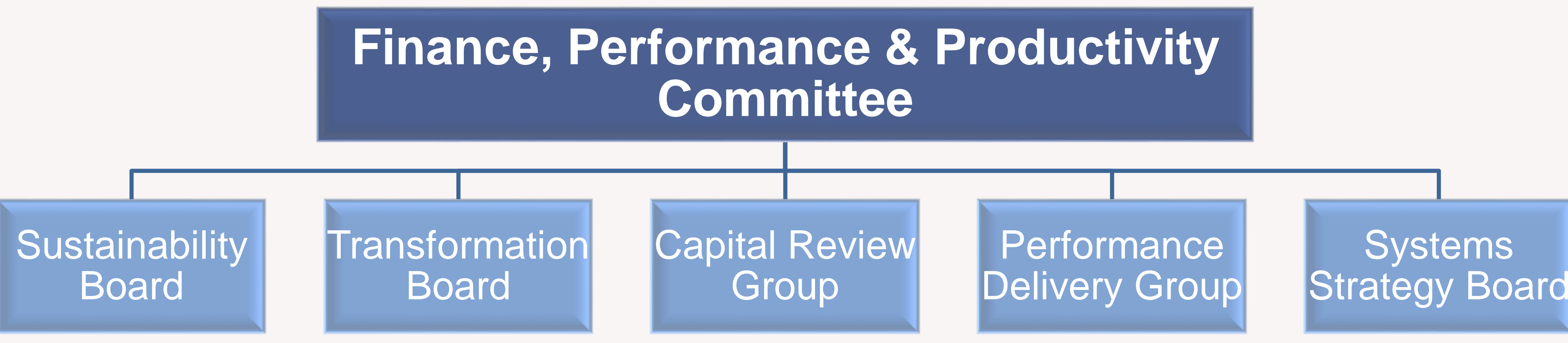
Board of Directors

Council of Governors

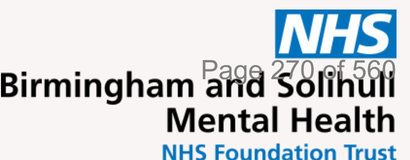
Nomination & Remuneration Committee

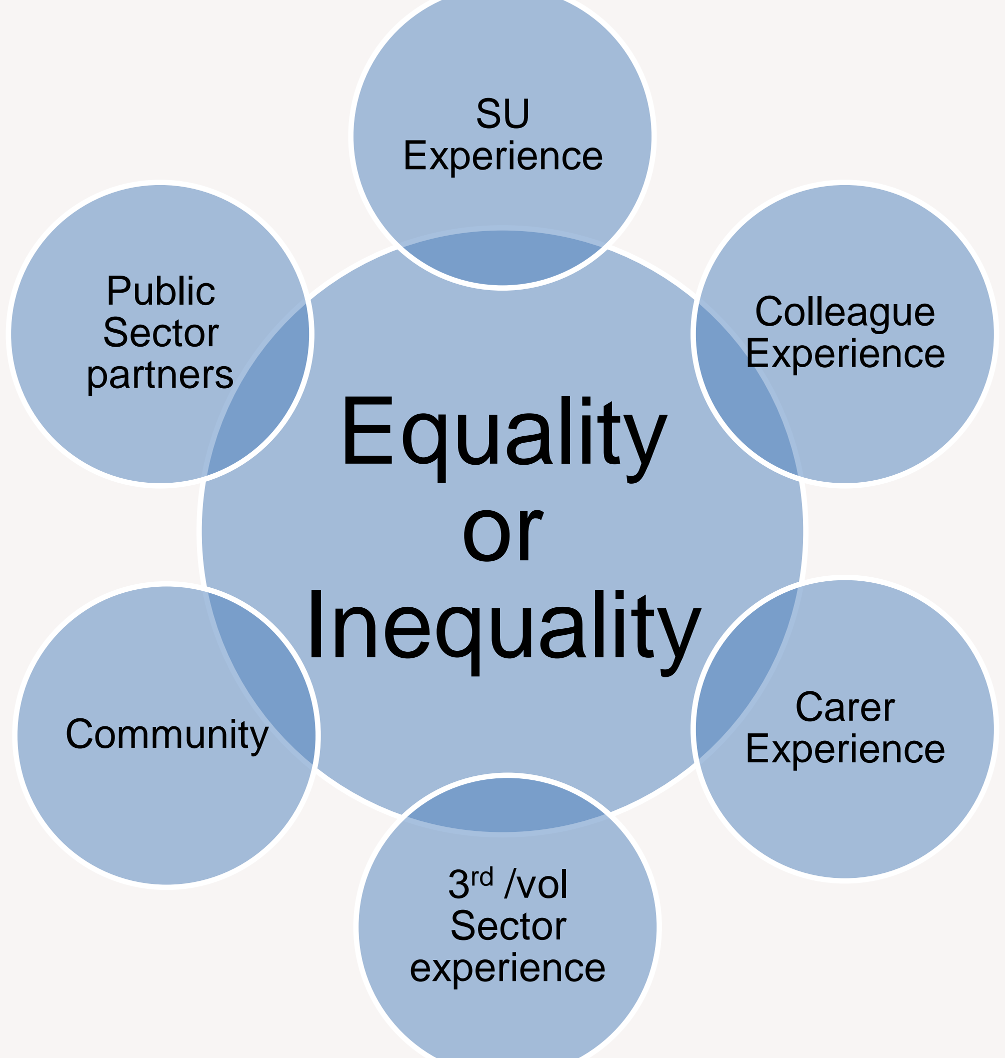
- Audit Committee
- People committee
  - Shaping the Future Workforce Sub Committee
  - Transforming our Culture & Saft Experience Sub Committee
  - Safer Staffing Sub Committee
- Charitable Funds Committee
- Nomination Committee
- Quality, Patient Experience & Safety Committee
  - *See next Slide for reporting Groups*
  - *Reach Out Commissioning Sub Committee*
- Finance, Performance & Productivity Committee
  - *See next Slide for reporting Groups*

Birmingham and Solihull
Mental Health
NHS Foundation Trust

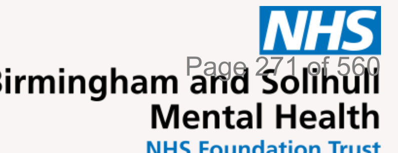


Together thinking about….





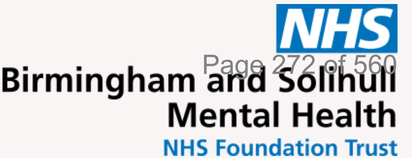
compassionate



Workforce

Equity Panel & Recruitment guidance QI	Staff Networks	Buddy Pool	Cultural Ambassador
Training & development: Mandatory, EQIA. Translation, LGBTQ+	Listening spaces	Integration of EDI & OD	Reporting; PSED, GPG WRES, WDES
Mental Health & LD Recruitment Programme	Active Bystander	No hate zone	Anti Discrimination, Anti Racist Policy & Framework

Priority Streams



Patient Carer & Race Equality Framework

Birmingham & Lewisham African and Caribbean Health Inequalities Review

inclusive

Overarching workstreams

PCREF

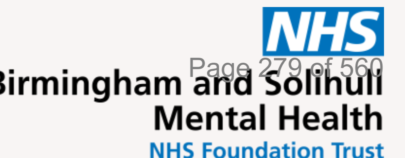
	Progress	2023/4 outcome
Leadership & Governance	• Anti Racist & Anti Discriminatory BSMHFT Pledge 2000/800+ takeup • Anti Racist Policy, Guidance and Framework • Reinforced support and development relating to Due Regard • Data with Dignity (WRES/Model Employer/EDS) • Active Bystander training 300+ colleagues trained • BLACHIR (Birmingham and Lewisham African & Caribbean Health Inequalities Review) • Robust Health Inequalities Governance	Monitor & sustain
Organisational Competency	• Co-produced scenarios-Service User & Community led • Learning products-QI approach • Local Induction Materials • Reducing Restrictive Practice-QI • Accessible language • Anti Racist Research	Test & Develop
Outcomes	• DIALOG+ Eurocentric Vs global • Reducing Restrictive Practices Data • Accessible Data • Community Collaborative • Increased transparency Complaints & process	Improve data collection and feed improvements (QI)

HI Area	BLACHIR Recommendation
Solar	Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
PCREF	Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
PCREF	Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
PCREF	Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users
PCREF	Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
PCREF	Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
PCREF	Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy.

HI Area	BLACHIR Recommendation
PCREF	Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
PCREF	Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
PCREF	Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
PCREF	Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black Community networks are established and engaged with Transformation work to ensure co-production and representation.
PCREF	Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black Mixed ethnic minority groups.
PCREF	Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
PCREF	Take action to address employment inequalities and issues around racism and discrimination in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations
PCREF	Provide targeted and culturally appropriate screening services for Black African and Black Caribbean older adults.
PCREF	Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.

HI Area	BLACHIR Recommendation
Community Transformation	Work with Black African and Black Caribbean communities and organisations to cocreate and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Community Transformation	Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Community Transformation	Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black Community networks are established and engaged with Transformation work to ensure co-production and representation.
Community Transformation	Ensure that the engagement of Black African and Black Caribbean communities is across all Black African and Black Caribbean . Data will be reviewed routinely and broken down via protected characteristics.

HI Area	BLACHIR Recommendation
Adapting psychological services provision	Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people
Adapting psychological services provision	Coproduce awareness campaigns for Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Adapting psychological services provision	Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
Adapting psychological services provision	Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Adapting psychological services provision	Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.
Adapting psychological services provision	Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.



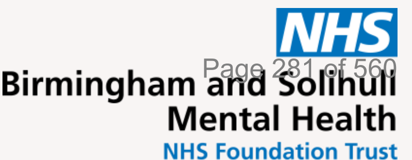
Specific workstreams

Birmingham and Solihull Mental Health NHS Foundation Trust

Work stream	Key Actions	Year 1 outcomes
Data availability & Usage Make access, experience and outcomes data available and accessible	• Develop dashboard o access, experience and outcomes	BI Data Dashboard available-workforce & SU
SMI Physical Health Ensure that all SMI SU have cultural appropriate health checks	• To understand demographic disparities in SMI checks taking place • To map all demographic specific interventions taking place and identify gaps	Data informed gap analysis Action plan
Ethnic Disparities in Mental Health Act detention Identify and reduce Ethnic disparities in Mental Health Act Detention	• Complete the CTO service evaluation and identify the recommendations to focus our next workstream	QI programme to address the outcomes and recommendations of service evaluation
Adapting Psychological Service Provision Adapt Psychological services in line with Cultural Humility and Cultural Safety	• to deliver the CaFI research (Culturally Adapted Family Intervention) • to implement the Tree of Life programme across the trust • To train practitioners in the trust in the use of community psychology approaches to reduce the impact of inequalities	Tree of Life Delivery team expansion with training delivered Co-designed and administered survey of service design
Reducing Inequalities-Secure Care	• Carry out the Reach Out Inequalities Service Evaluation Co-production • Carry out the PCREF competencies co-production • Co-Identify and co-celebrate culture and identity events	Set of learning materials that will address the competency requirements of PCREF
PPAC Inequalities Group	• Map all inequalities work happening across Psychology • Explore Data with Dignity for Psychological professional group and service user profile • Identify areas of focus and key priorities	Celebration of good practice Data with Dignity informed action plan
Community Transformation Service users are able to access the right services at the right time ensuring parity of services	• With a focus on low served communities: • Peer Support Training, • Mental Health 1st Aid • Managing Risk Training	Pop up mental health clinics – Mental Health First Aid Community integrated mental health support Accessible Communications
Solar & CYP	• Scoping the health inequalities for Children and Young People in Solihull. Current areas specifically to scope are around Unaccompanied Asylum Seeking Children	Have identified up to 3 priority areas with plans in place of how to support
Reducing Restrictive Practice	• To monitor ethnicity data as part of RRP • To develop an inclusive development programme that raises the feature of bias and discrimination in RRP	Demographic data embedded within Patient Safety Framework

compassionate inclusive committed

Priority Themes

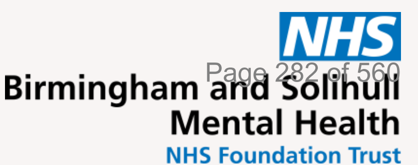


Advocacy

Co-Design
Co-Production

Accountability

DISRUPTION=SUSTAINABILITY of CHANGE =EQUALITY



2023/4 Big ticket items

- Determining Committee oversight
  - Governance sustainability
  - Board visibility
- Integrated strategic Data Dashboard
- Organisational roll out of PCREF
- Developing further representation across community collaborative
- Local service reducing health inequalities plans

10.6.2. 10.6b. To schedule an extraordinary Board Meeting on 21st June 2023 from 14:00 – 14:35 to ratify the Annual Report & Accounts for 2022/23

10.6.3. 10.6c. Ratification of Trust Constitution and associated documents

Birmingham and Solihull Mental Health NHS Foundation Trust

CONSTITUTION
Election Rules
Standing Orders - Board of Directors
Standing Orders – Commissioning Committee
Standing Orders - Council of Governors

V3.3 Revision May 2023

Constitution

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1. Name

The name of the foundation trust is The Birmingham and Solihull Mental Health NHS Foundation Trust (the trust).

2. Principal purpose

2.1 *The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England. The trust undertakes both provision and commissioning functions, as the Lead Provider for the West Midlands Reach Out Provider Collaborative, incorporating adult secure care and LDA secure care services, and with delegated authority for individual placements.*

2.2 The trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The trust may provide goods and services for any purposes related to:

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis, or treatment of illness, and

2.3.2 the promotion and protection of public health.

2.4 The trust may also carry-on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3. Powers

3.1 The powers of the trust are set out in the 2006, 2012 and 2022 Acts, subject to any restrictions in the terms of authorisation.

3.2 The powers of the trust shall be exercised by the Board of Directors and Commissioning Committee ("Board in Committee") on behalf of the trust. Standing Orders for the Board of Directors and Commissioning Committee are provided as Annexes 8 and 9 respectively.

3.3 The Board has a delegated responsibility from NHS England for the commissioning, contractual and quality and safety oversight of the entirety of the contracts awarded to the Trust as the Lead Provider of the West Midlands Reach Out Provider Collaborative. These roles and responsibilities are set out in the Lead Provider contract. In terms of financial risk exposure, this is mitigated by the formal risk and gain share agreement that is in place between the Provider Collaborative

partners. These responsibilities are discharged through the Commissioning Committee, which is the Board in Committee.

3.4 Any of these powers may be delegated to a committee of directors or to an executive director or (if in accordance with and for the purpose of provisions made by or under the Mental Health Act 1983) otherwise as resolved by the Board of Directors or by the Commissioning Committee for commissioning responsibilities.

4. Membership and constituencies

Further provisions related to the Council of Governors are set out in Annex 6 – Additional Provisions – and Annex 7 – Standing Orders, Council of Governors.

The trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1 a public constituency;

4.2 the staff constituency; or

4.3 the service users' and carers' constituency

5. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

6. Public Constituency

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7. Staff Constituency

7.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

7.1.1 they are employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 they have been continuously employed by the trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

7.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.4 The Staff Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.6 An individual who is:

7.6.1 eligible to become a member of the Staff Constituency, and

7.6.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made unless they inform the trust that they do not wish to do so.

8. Service Users' and Carers' Constituency

8.1 An individual who has, within the period specified below, attended any of the trust's hospitals as either a patient or as the carer of a patient may become or continue as a member of the trust.

8.2 The period referred to above shall be the period from 5 July 1948 to the date of an application by the patient or carer to become a member of the trust.

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Service Users' and Carers' Constituency.

8.4 The Service Users' and Carers' Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Service Users' and Carers' Constituency, each description of individuals being specified within Annex 3 and being referred to as a class within the Service Users' and Carers' Constituency.

8.5 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Service Users' and Carers' Constituency

8.6 The minimum number of members in each class of the Service Users' and Carers' Constituency is specified in Annex 3.

Automatic membership by default - patients

8.7 An individual who is:

8.7.1 eligible to become a member of the Service Users' and Carers' Constituency (otherwise than as a carer of a patient), and

8.7.2 invited by the trust to become a member of a specified constituency and a member of a specified class within that specified constituency,

shall become a member of the trust as a member of that specified constituency and specified class without an application being made, unless they inform the trust that they do not wish to do so.

8.8 The constituency and, where applicable, the class to be specified:

8.8.1 if they are eligible to be a member of any public constituency, is that constituency,

8.8.2 otherwise, is the Service Users' and Carers' Constituency and, where applicable, the class of which they are eligible to become a member.

9. Restriction on membership

9.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

9.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 10 – Further Provisions.

10. Council of Governors – composition

10.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

10.2 The composition of the Council of Governors is specified in Annex 4.

10.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The maximum number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

11.2 The Model Rules for Elections, as may be varied from time to time, form part of this constitution and are attached at Annex 5.

11.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the trust cannot amend the Model Rules.

11.4 An election, if contested, shall be by secret ballot.

11.5 A vacant Governor post may be filled without an election where permitted by the Model Rules as they apply to the trust or by paragraph 7 of Annex 10.

11.6 The provisions in this constitution take priority over the Election Rules in the event of conflict.

12. Council of Governors - tenure

12.1 An elected governor shall hold office for an initial term of 3 years and shall be eligible for re-election for two subsequent terms of not more than 3 years, subject to paragraph 12.3.

12.2 An elected governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

12.3 An elected governor shall be eligible for re-election at the end of their term, subject to a maximum period of office of 6 years.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 If a governor fails to attend three successive meetings of the Council of Governors, their tenure of office is to be immediately terminated unless the other governors are satisfied that:

13.3.1. the absence was due to a reasonable cause; and

13.3.2 they will be able to start attending meetings of the Council again within such a period as they consider reasonable.

13.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

13.5 Provision for the management of a complaint against a Governor, and the removal of Governors is set out in Annex 6.

14. Council of Governors – meetings of governors

14.1 The Chair of the trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 21.1 or paragraph 22.1 below) or, in his/her absence the Deputy Chair (appointed in accordance with the provisions of paragraph 23 below), shall preside at meetings of the Council of Governors.

14.2 Meetings of the Council of Governors shall normally be open to members of the public but they are not public meetings. Members of the public may be excluded from the whole or part of a meeting for special reasons either by resolution of the Council of Governors or at the discretion of the Chair of the meeting.

15. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 7.

16. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

17. Council of Governors – travel expenses

The trust may pay traveling and other expenses to members of the Council of Governors at rates determined by the trust.

18. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

19. Board of Directors – composition

19.1 The trust has a Board of Directors, which comprises both executive and non-executive directors.

19.2 The Board of Directors comprises:

19.2.1 a non-executive Chair

19.2.2 up to 6 other non-executive directors; and

19.2.3 up to 6 executive directors.

19.3 One of the executive directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accountable Officer.

19.5 One of the executive directors shall be the Director of Finance.

19.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

19.7 One of the executive directors is to be a registered nurse or a registered midwife.

19.8 The Board meets separately "in Committee" - and as the full unitary board - as the Commissioning Committee. The Commissioning Committee discharges the trust's accountability and responsibilities as lead provider for provider collaboratives.

20. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if –

20.1 they are a member of the Public Constituency.

20.2 (in a case falling under any of the preceding sub-paragraphs of this paragraph) they are not disqualified by virtue of paragraph 26 below.

21. Board of Directors – appointment and removal of the Chair and other non-executive directors

21.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the trust and the other non-executive directors.

21.2 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

22. Board of Directors – appointment of Deputy Chair

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as deputy chair.

23. Board of Directors - appointment and removal of the Chief Executive and other executive directors

23.1 The non-executive directors shall appoint or remove the Chief Executive.

23.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

23.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

24. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

24.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

24.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

24.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

25. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 8.

The standing orders for the practice and procedure of the Commissioning Committee (the Board in Committee), as may be varied from time to time, are attached at Annex 10.

26. Board of Directors - conflicts of interest of directors

If a director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the director shall disclose that interest to the members of the Board of Directors as soon as they become aware of it. The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

All Board members shall declare their interests as members of the Commissioning Committee, and vice versa. The Standing Orders for the Commissioning Committee shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

27. Board of Directors – remuneration and terms of office

27.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

27.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

28 Registers

The trust shall have:

28.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

28.2 a register of members of the Council of Governors;

28.3 a register of interests of governors. Where applicable, this should separate interests relevant to the Trust's provider role from those relevant to the Trust's commissioner role;

28.4 a register of directors; and

28.5 a register of interests of the directors. Where applicable, this should separate interests relevant to the trust's provider role from those relevant to the trust's commissioner role.

29 Registers – inspection and copies

29.1 The trust shall make the registers specified in paragraph 30 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

29.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of –

29.2.1 any member of the Service Users' and Carers' Constituency; or

29.2.2 any other member of the trust, if they so request.

29.3 So far as the registers are required to be made available:

29.3.1 they are to be available for inspection free of charge at all reasonable times; and

29.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

29.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

30 Documents available for public inspection

30.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

30.1.1 a copy of the current constitution and its Annexes;

30.1.2 a copy of the current authorisation;

30.1.3 a copy of the latest annual accounts and of any report of the auditor on them;

30.1.4 a copy of the latest annual report;

30.1.5 a copy of the latest information as to its forward planning; and

30.1.6 a copy of any notice given under section 52 of the 2006 Act. (Including section 31 notifications from the CQC, any enforcement notices from the HSE and improvement notices from HM Coroner).

30.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

30.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

30.2.2 a copy of any report laid under section 65D (appointment of trust special administrator), of the 2006 Act.

30.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

30.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

30.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

30.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

30.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

30.2.8 a copy of any final report published under section 65I (administrator's final report),

30.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

30.2.10 a copy of any information published under section 65M

(replacement of trust special administrator) of the 2006 Act.

30.2.11 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

30.2.12 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

31 Auditor

31.1 The trust shall have an auditor.

31.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

32 Audit committee

The trust shall establish a committee of non-executive directors as an audit committee, to perform such monitoring, reviewing and other functions as are appropriate. The Audit Committee will oversee both areas of trust responsibility (provider and commissioner).

33 Accounts

33.1 The trust must keep proper accounts and proper records in relation to the accounts. NHS Impact may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

33.2 The accounts are to be audited by the trust's auditor.

33.3 The trust shall prepare in respect of each financial year annual accounts in such form as NHSI may with the approval of the Secretary of State direct.

33.4 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

33.5 There shall be one set of consolidated Accounts that incorporates SSL Ltd (the trust's trading company), the trust's provider responsibilities and the trust's commissioning responsibilities.

34 Annual report and forward plans and non-NHS work

34.1 The trust shall prepare an Annual Report and send it to NHS England/Impact

34.2 The trust shall give information as to its forward planning in respect of each financial year to NHS England/Impact

34.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

34.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

34.5 Each forward plan must include information about –

34.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

34.5.2 the income it expects to receive from doing so.

34.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 36.5.1 the Council of Governors must –

34.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and

34.6.2 notify the directors of the trust of its determination.

35 Significant Transactions

35.1 The Council of Governors has powers to approve a “Significant Transaction”. The Board of Directors may enter into a Significant Transaction only if more than half of the Governors present and voting at the relevant meeting, approve its implementation.

35.2 A Significant Transaction relates to merger, acquisition, separation, or dissolution. It is defined in the Trust’s Significant Transactions Policy (v3, March 2020). The Policy must be followed to ensure due process.

36. <u>Meeting of Council of Governors to consider annual accounts and reports</u>

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

36.1 The annual accounts

36.2 Any report of the auditor on them

36.3 The annual report.

36.4 The Annual Quality Account

36.5 The documents shall also be presented to the members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

36.6 The trust may combine a meeting of the Council of Governors with the Annual Members' Meeting.

37. Instruments

37.1 Trust shall have a seal.

37.2 The seal shall not be affixed except under the authority of the Board of Directors.

37.3 The trust shall have a register of sealings, which shall be maintained by the Company Secretary.

38. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

The 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

The 2022 Act is the Health and Social Care Act 2022.

Council of Governors is the name the Trust gives to its Board of Governors.

NHS England/Impact is the name of the Regulator.

Secretary is the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary**.**

Service Users' and Carers' Constituency is the name the Trust gives to its Patients' constituency.

Terms of authorisation are the terms of authorisation issued by Monitor under Section 35 of the 2006 Act.

Voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraphs 6.1 and 6.3)

Public Constituency	Minimum number of members
Birmingham	10
Solihull	10
Rest of England and Wales	10

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 6.4 and 6.5)

Class of Staff Constituency	Minimum number of members
Medical staff	10
Non-medical clinical staff	10
Non-clinical staff	10

ANNEX 3 – THE SERVICE USERS' AND CARERS' CONSTITUENCY

Class of Service Users' and Carers' Constituency	Minimum number of members
Birmingham Service Users*	10
Solihull Service User*	10
Rest of England and Wales Service User*	10
Carer	10

* refers to the area (defined as in Annex 1) in which the Service User is resident.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS (update)

(Paragraphs 9.2 and 9.3)

Elected Governors

Constituency	Governors
South Birmingham and Worcestershire	Public Governor x1 Service User Governor x1 Carer Governor x1
East and North Birmingham and Black Country boroughs	Public Governor x1 Service User Governor x1 Carer Governor x1
Central and West Birmingham and Staffordshire	Public Governor x1 Service User Governor x1 Carer Governor x1
Solihull: Solihull and Coventry and Warwickshire	Public Governor x1 Service User Governor x1 Carer Governor x1

Staff Elected Governors

Staff Group	
Non-medical clinical staff	1
Medical staff	1
Non – clinical staff	1
Total staff	3

Stakeholder Governors

Appointer	Number of governors
Birmingham City Council	1
Solihull Metropolitan Borough Council	1
Birmingham and Solihull Councils for Voluntary Services	1
University of Birmingham	1
Birmingham City University	1
West Midlands Police	1

ANNEX 5

MODEL ELECTION RULES 2014

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PART 1 - INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

“2006 Act” means the National Health Service Act 2006;

“Corporation” means the public benefit corporation subject to this constitution;

“Council of governors” means the council of governors of the corporation;

“Declaration of identity” has the meaning set out in rule 21.1;

“Election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“e-voting” means voting using either the internet, telephone or text message;

“e-voting information” has the meaning set out in rule 24.2;

“ID declaration form” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“Internet voting system” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“Lead governor” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“list of eligible voters” means the list referred to in rule 22.1, containing the information in rule 22.2;

“Method of polling” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“Numerical voting code” has the meaning set out in rule 64.2(b)

“Polling website” has the meaning set out in rule 26.1;

“Postal voting information” has the meaning set out in rule 24.1;

“Telephone short code” means a short telephone number used for the purposes of submitting a vote by text message;

“Telephone voting facility” has the meaning set out in rule 26.2;

“Telephone voting record” has the meaning set out in rule 26.5 (d);

"Text message voting facility" has the meaning set out in rule 26.3;

"Text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"Voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"Voting information" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 – TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 - RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) Any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) Such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 - STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) The constituency, or class within a constituency, for which the election is being held,

(b) The number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) The details of any nomination committee that has been established by the corporation,

(d) The address and times at which nomination forms may be obtained;

(e) The address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) The date and time by which any notice of withdrawal must be received by the returning officer

(g) The contact details of the returning officer

(h) The date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) Is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) Full name,

(b) Contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) Constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) Any financial interest that the candidate has in the corporation, and

(b) Whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 - CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held, ("declaration of identity") and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency, (d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;

(ii) the voter’s declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter’s voter ID number;

(ii) the voter’s declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter’s vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that office was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency).

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 - COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

“ballot document” means a ballot paper, internet voting record, telephone voting record or text voting record.

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2

Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7

Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10

The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule

STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 - FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10, available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8 - DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS Impact has declared that the vote was invalid.

DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order

of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10 - ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Impact under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility (“numerical voting code”), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11 - QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS Impact.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS Impact by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as NHS Impact may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If NHS Impact requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS Impact shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the

corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 NHS Impact may prescribe rules of procedure for the determination of an application including costs.

PART 12 MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 13.1)

Persons also may not become or continue as a Governor of the Trust if:

1. they are a Director of the Trust, or an employee of the Trust with the courtesy title “director”, or a Governor or Director of another NHS body, or an employee of another NHS body with the courtesy title “director”, or a director or senior employee of an independent/private sector health care provider that competes with the Trust. These restrictions do not apply to Appointed Governors;

2. being a member of a public constituency, they were (or were entitled to be) a member of one of the classes of the staff constituency at any point during the preceding two years;

3. they are on the register of sex offenders;

4. they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted and/or they are the subject of an alert letter;

5. they fail to, or indicate that they are unwilling to, act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life, set out in Part A of Annex 11 as amended from time to time;

6. they fail to agree (or, having agreed, fail) to abide by the values of the Trust Principles set out in Part B of Annex 11

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 14)

THE BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Standing Orders COUNCIL of Governors

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1. INTRODUCTION

Statutory Framework

The Birmingham and Solihull Mental Health NHS Foundation Trust (The Trust) is a statutory body which became a public benefit corporation on [insert date] following its approval as an NHS Foundation Trust by Monitor - the Independent Regulator of NHS Foundation Trusts (Independent Regulator) pursuant to the National Health Service Act 2006 (the 2006 Act).

The principal place of business of the Trust is:

The Uffculme Centre
52 Queensbridge Road
Moseley
Birmingham.
B13 8QY

The Trust operates across c90 sites in the Birmingham and Solihull area.

NHS Foundation Trusts are governed by Act of Parliament, mainly the 2006 Act, by their constitutions and by terms of their authorisations granted by the Independent Regulator (Regulatory Framework).

The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Secretary).

2.2 Any expression to which a meeting is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in the interpretation and in addition:

"**TRUST**" means The Birmingham and Solihull Mental Health NHS Foundation Trust.

"COUNCIL OF GOVERNORS" means the Council of Governors of the Trust as defined in the Constitution and "Board" means the Council of Governors, unless the context otherwise requires.

“BOARD OF DIRECTORS” means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body, meeting to lead the Trust’s provider arm.

“COMMISSIONING COMMITTEE” means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body, meeting to lead the Trust’s commissioning arm.

“CHAIR OF THE BOARD” or “Chair of the Trust” is the person appointed by the Board of Governors to lead the Board of Directors and the Board in Committee and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. Except where the context otherwise requires, the expressions “the Chair of the Board” and “the Chair of the Trust” shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

“CHIEF EXECUTIVE” means the chief executive officer of the Trust.

“COMMITTEE” means a committee of the Council of Governors

“CONSTITUTION” means the constitution of the Trust.

“COMMITTEE MEMBERS” means the Chair and the Governors or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

“DEPUTY CHAIR” means the Non-Executive Director appointed from amongst the Non-Executive Directors as Deputy Chair by the Council of Governors to take on the Chair’s duties in their capacity as chair of the Council of Governors if the Chair is absent for any reason.

“EXECUTIVE DIRECTOR” means a Member of the Board of Directors who holds an executive office of the Trust.

“GOVERNOR” means a Governor of the Trust. (Governor in relation to the Council of Governors does not include the Chair).

“NON-EXECUTIVE DIRECTOR” means a member of the Board of Directors who does not hold an executive office with the Trust.

“OFFICER” means employee of the Trust or any other person holding a paid appointment or office with the Trust.

“SOs” means these Standing Orders.

“SECRETARY TO THE TRUST” means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Board of Governors

3.1.1 The composition of the Council of Governors shall be in accordance with the Constitution of the Foundation Trust.

3.2 Role of the Chair

3.2.1 The Chair is not a Governor. However, under the Regulatory Framework, they preside at meetings of the Council of Governors and have a casting vote.

3.2.2 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resume their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The roles and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint and remove the Chair and other Non-Executive Directors of the Foundation Trust at a general meeting.
- To approve at a general meeting the appointment by the Non-Executive Directors of the Chief Executive.
- To appoint or remove the auditor at a general meeting.
- To approve any project brought forward by the Board of Directors under the Significant Transactions Policy (v3, March 2020).
- To be consulted by the Trust's Board of Directors on forward planning and to have the Board of Governors' views taken into account.
- To be presented with the Trust's Annual Report and Accounts and the report of the auditor on the Accounts at a meeting.

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Governors, are not empowered to speak on behalf of the Trust and must seek the advice and views of the Chair concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it. For the avoidance of doubt, in this context the Chair acts as Chair of the Trust not as chair of the Council of Governors and in their absence Governors should seek the advice and views of the Deputy Chair of the Trust.

4. MEETINGS OF THE BOARD

4.1 Admission of the Public

4.1.1. The public shall be afforded facilities to attend publicly notified formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Council may determine and there shall be not less than 3 nor more than 6 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chair of the Trust may call a meeting of the Council at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Members of the Council, has been presented to them, or if, without so refusing, the Chair does not call meeting within seven days after such requisition has been presented to them at Trust's Headquarters, such one third or more Members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to them at least three clear days before the meeting.

4.3.2 Want of service of the notice on any Governor shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by Members of the Council in default of the Chair, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's Headquarters at least three clear days before the meeting.

4.4 Setting the agenda

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.4 Petitions

4.5.1 Where a petition has been received by the Trust, the Chair of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.5 Chair of Meeting

4.6.1 At any meeting of the Council the Chair of the Trust, if present, shall preside unless they have a conflict of interest. If the Chair is absent from the meeting or has a conflict of interest the Deputy Chair, if they are present, shall preside unless they have a conflict of interest. If the Chair and Deputy Chair are absent or have a conflict of interest such Non-Executive Director as the

Members of the Council present shall choose shall preside unless they have a conflict of interest. Where the Chair of the Trust, Deputy Chair and other Non-Executive Directors are all absent or have a conflict of interest, the Council of Governors shall select one of their number to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.7 Notices of Motion

4.7.1 A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.9 Motion to Rescind a Resolution

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council, it shall not be competent for any member other that the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate.

4.10 Motions

4.10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceed to the next business (*)
- the appointment of an ad hoc committee to deal with a specific item of
- business
- that the motion be now put. (*)
- a motion resolving to exclude the public under SO 4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in debate and who is eligible to vote.

4.10.3 No amendment to the motion shall be admitted, if in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.11 Chair's Ruling

4.11.1 Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters shall be final.

4.12 Voting

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.12.2. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.12.4 If a Governor so requests, their vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.13 Minutes

4.13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.13.3 Minutes shall be circulated in accordance with the members' wishes.

4.14 Suspension of Standing Orders

4.14.1 Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including two public governors, and that a majority of those present vote in favour of suspension.

4.14.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Members of the Council.

4.14.4 No formal business may be transacted while Standing Orders are suspended.

4.15 Variation and Amendment of Standing Orders

4. 15.1 These Standing Orders shall be amended only if:

- a notice of a motion under Standing Order 4.7 has been given; and
- no fewer than half the total of the Trust's Governors vote in favour of amendment; and
- at least two-thirds of the Council Members are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Independent Regulator.

4.16 Record of Attendance

4.16.1 The names of the Chair and Members of the Council present at the meeting shall be recorded in the minutes.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting unless at least one third of the Governors appointed are present, of which there must be at least two groups of governors represented. The groups are: staff, service user, public, stakeholder and carer governors.

4.17.2 If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6, 7 or 8) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. COMMITTEES

5.1 Subject to the Regulatory Framework and such guidance as may be issued by the Independent Regulator, the Council may, and if so required by the Independent Regulator, shall, appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chair and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to such guidance as may be given by the Independent Regulator or restriction imposed by the

Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term “Chair” is to be read as a reference to the Chair of the Committee as the context permits, and the term “Governor” is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Board in discharging its responsibilities.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.12 Interests which should be regarded as “relevant and material” are defined in the Trust’s Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors

6.1.3 At the time Board members’ interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council members’ directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust’s Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.5 During the course of a Council Meeting, if a conflict of interest is established, the Council Members concerned shall withdraw from the meeting and play no part in the relevant discussion or decision.

6.1.6 There is no requirement for the interests of Council members' spouses or partners to be declared. However, Standing Order 7, which is based on the regulations, requires that the interests of Governors' spouses or common-law partners, if living together, in contracts should be declared. Therefore, the interests of Council Members' spouses and cohabiting partners should also be regarded as relevant.

6.2 Register of Interests

6.2.1 The Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. The Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.2.3 The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating, and publicising the Register, the Trust shall comply with all guidance issued from time to time by the Regulator.

7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or another Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chair (or Governor) from a meeting of the Council while any contract, proposed contract or other matter in which they have pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chair or Governor shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is

proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

Or

(b) they are a partner of or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 The Chair or a Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

(b) of an interest in a company, body or person with which they are connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Governor:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Governor of any such committee or sub-committee as it applies to a Governor.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Governors should comply with the Trust Constitution, the “Code of governance for NHS provider trusts”, published by NHS England (came into

effect on 1 April 2023), the requirements of the Regulatory Framework, and any guidance and directions issued by the Independent Regulator.

8.2 Interest of Governors in Contracts

8.2.1 If it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Secretary of the Trust of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Governor should also declare to the Secretary of the Trust any other employment or business or other relationship of theirs, or of cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Trust.

8.3 Canvassing of and recommendations by Governors in Relation to Appointments

8.3.1 Canvassing of Governors of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.3.2 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability, experience, or character for submission to the Trust.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4 Relatives of Governors or Officers

8.4.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

The Chair and every Governor and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate whose candidature that Governor or Officer is aware.

8.4.3 On appointment, Governors (and prior to acceptance of an appointment in the case of officer members) should disclose to the Board whether they are related to any other Governor or holder of any office in the Trust.

8.4.4 Where the relationship to a Governor of the Trust is disclosed, the Standing Order headed Disability of Chair and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. SENIOR INDEPENDENT DIRECTOR

9.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.

9.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Profile", as amended from time to time.

9.3 Arrangements for the appointment and removal of the Senior Independent Director are described in Annex 8 – Board of Directors, Standing Orders.

10. APPOINTMENT OF A LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

10.1 Since 2010 Monitor, now NHS Impact (NHSI), has required all NHS Foundation Trusts to have a lead governor to facilitate direct communication in the limited circumstances where it may not be appropriate to communicate through the normal channels.

10.2 The criteria, eligibility and process for the selection of a lead governor and deputy lead governor within the Trust ((BSMHFT) are outlined in this document.

10.3 Primary Role and Accountability

Lead governor

10.3.1 The primary purpose of the lead governor is to facilitate direct communication between the Regulator (NHSI) and the governors. NHSI does not envisaged regular direct communication with governors save where there may be a real risk of the Trust significantly breaching its licence or constitution and where concerns cannot be satisfactorily resolved via the normal channels.

10.3.2 Once there is a risk that this may be the case, and the likely issue is one of board leadership, NHSI may wish to make contact with the governors at speed, through one established point of contact – the lead governor. This will enable governors to understand the Regulator's concerns and in understanding the views of governors as to the capacity and capability of individuals to lead the Trust and to rectify, successfully, any issues.

10.3.3 The Trust should support the lead governor in understanding NHSI's role, particularly the basis on which NHSI may take regulatory action, to ensure the lead governor is able to correctly communicate more widely with other governors.

10.3.4 The lead governor is accountable to the Council of Governors as a collective and the Trust Chair. Other than the specified additional responsibilities, the role does not hold any additional responsibility or powers beyond those of an individual governor.

10.3.5 Similarly, but not exclusively, where individual governors may wish to contact NHSI, this would be expected to be through the lead governor.

Deputy Lead governor

10.3.6 The primary role of the deputy lead governor is to deputise for the lead governor and to provide the Trust with a point of contact for the Council of Governors in the event that the lead governor is unavailable for a period of time or has a conflict of interest.

10.3.7 The deputy lead governor is accountable to the Council of Governors as a collective and the Trust Chair. Other than the specified additional responsibilities, the role does not hold any additional responsibility or powers beyond those of an individual governor.

10.4 Criteria and eligibility

10.4.1 The Council of Governors will select a governor to undertake the role of lead governor and deputy lead governor of BSMHFT.

10.4.2 Governors wishing to undertake the role of lead governor or deputy lead governor must:

a) have served as a governor for at least one year.
b) be able to commit time to undertake the role.
c) be prepared to acquire knowledge and understanding of the arrangements/requirements of the role and the responsibilities attaching.
d) understand NHSI's role as an external regulator and the requirements of the Trust constitution.
e) uphold the values of the Trust, understanding and championing the Trust's values.
f) be committed to the success of the Trust.

10.4.3 Desirable personal qualities for a lead governor include:

- excellent interpersonal and communication skills.
- the ability to deal with potential conflicts.
- the ability to command the respect, confidence and support of their governor colleagues.
- the ability to represent the views of their governor colleagues.

10.5 Process

10.5.1 The lead governor and deputy lead governor will be selected by the Council of Governors.

10.5.2 The process for the selection and appointment of the lead governor and deputy lead governor is as follows:

10.5.2.1 Upon a vacancy arising, the Chair will inform the Council of Governors of the vacancy and invite governors to express interest in the role.

10.5.2.2 Where more than one nomination is received, a confidential ballot of all governors will be held. Nominees will provide a short nomination statement describing their reasons for standing and a ballot paper showing all the candidates and their nomination statements will be distributed to all governors. Votes will be counted on a ‘first past the post’ basis. The Company Secretary will act as returning officer and at the deadline for receipt of votes will provide the outcome of the ballot to the Chair for announcement of the result to the Council of Governors. Ballot papers will be kept for six months and made available for scrutiny if required.

10.5.2.3 Where only one nomination is received, the Council of Governors will be asked to ratify the appointment at the next Council of Governors meeting.

10.6 Term of Office and Re-Election

10.6.1 The term of office of the lead governor and deputy lead governor will be for a period of their remaining term as a Governor or:

10.6.1.1 until they resign the position by giving notice to the Chair; or
10.6.1.2 until they are removed from the position by a resolution passed at a general meeting of the Council of Governors.

10.6.2 At the end of their term of office an individual may stand for re-election to the role. Governors serving as lead governor are eligible to nominate themselves for the role of deputy lead governor and visa versa.

10.6.3 The Governance & Membership Manager will notify NHSI of any change of lead governor.

11. PROCESS RELATING TO ALLEGED BREACH OF CODE OF CONDUCT AND TERMINATIONS OF A GOVERNOR`S MANDATE

11.1 Informal Resolution

11.1.1 Upon receiving information or a concern about the conduct of a governor, the Chair will take fair and reasonable steps over a period of up to 14 days to resolve the matter informally if appropriate.

11.1.2 Where during the informal discussions the governor admits to a breach of the Code of Conduct, the need to proceed to a panel hearing may be avoided with the agreement of the governor. Any admission of a breach of the Code of Conduct must be confirmed in writing by the governor. Following discussion, if the Chair agrees not to proceed to a hearing, the Chair is able to decide on an appropriate resolution in agreement with the governor concerned. The governor has the right to proceed to a formal panel process if informal resolution is not agreed.

11.2 Establishing the Panel

11.2.1 If the matter cannot be resolved informally as at paragraph 11.1 it shall be open to a panel consisting of the Senior Independent Director of the Board of Directors (who will chair the panel) and 4 (four) governors to consider the allegations and what (if any) action should be taken. Where there is a need to form a panel, members will be selected by the Senior Independent Director in consultation with the Lead Governor. If the Lead Governor has been involved as per paragraph 11.1, the Deputy Lead Governor with support the Senior Independent Director.

11.2.2 The panel should conduct a fair investigation which may include the need to commission an investigatory report. The panel should, in the first instance, seek one or more individuals with relevant experience to conduct an investigation, either from within or outside the Council of Governors. For example, the Trust's HR department has considerable experience in advising

on such issues and the panel may commission a senior member of the HR team to be a member of the investigation team. Any governor who is a member of the panel should not be part of the investigation team. The Company Secretary will support the panel with the administration processes of commissioning and investigator.

11.2.3 The panel will be quorate if the Senior Independent Director and 3 governors are present. If in this scenario members of the panel are required to vote and a majority cannot be reached, the chair of the panel will have the casting vote.

11.3 Suspension

11.3.1 The panel may on a majority vote of its members suspend a governor who is the subject of allegations that the panel is investigating.

11.3.2 This suspension will not be communicated to the wider Council of Governors or Trust employees.

11.4 Investigation process

11.4.1 The governor will be informed that an investigation will be undertaken. Where possible this should be face to face but if this is not practicable then it is appropriate for this information to be provided over the telephone and confirmed in writing at the earliest opportunity. This communication should include a copy of this Annex of the Trust's Constitution.

11.4.2 The investigating officer(s) may request written statements from parties involved or witnesses to the incident(s) being investigated ahead of an investigation meeting. All parties must be advised that during the investigation the issue must remain confidential.

11.4.3 The investigating officer(s) will arrange a meeting with the governor concerned. They will also arrange a meeting with any other witnesses as deemed necessary.

11.4.4 Where the governor who is the subject of the investigation is invited to the meeting, they will be advised of their right to be accompanied by a companion (not acting in a legal capacity). Reasonable notification will be given of the meeting. The governor will inform the investigating officer of the name of the companion they wish to accompany them in advance of such a meeting.

11.4.5 The investigating officer(s) will reasonably gather other documentation relevant to the investigation.

11.4.6 If the investigating officer(s) feels that they need to obtain further information from a witness it is appropriate for a further statement to be requested or another interview arranged in accordance with the above process.

11.4.7 It is important that all investigations are carried out thoroughly and should be undertaken normally within 20 working days. The governor who is the subject

of the investigation should be informed in writing by the investigating officer(s) if this timescale is not likely to be met and given a revised timescale for completion, outlining any reasons for the delays.

11.4.8 Upon completion of the investigation an investigation report will be submitted to the panel members and the governor concerned. The panel will consider the report.

11.4.9 If necessary, a panel hearing will be called as soon is reasonably practical to consider the allegations and if applicable any potential sanctions.

11.5 The Panel Hearing Process

11.5.1 The governor concerned is permitted to make written and/or oral representations to the panel for consideration in the panel hearing irrespective of whether the governor has been interviewed as part of an investigation.

11.5.2 The governor has the right to be accompanied at the panel hearing by a companion (i.e., an advocate). The companion can speak on the governor's behalf, with permission from the governor.

11.5.3 The investigating officer(s) will present their case to the panel members. Once the presentation is completed, the panel members may question the investigating officer(s). The governor will then present their case and panel members may question the governor.

11.5.4 After questions from the panel, the investigating officer(s) and the governor will have the opportunity to sum up.

11.5.5 There will be an adjournment for the panel members to consider the cases presented and reach a conclusion. The panel will reach its conclusions based on a majority vote of its members. This may include a recommendation to the Council of Governors to consider terminating the tenure of the governor in question. By way of example, lesser sanctions may include but are not limited to one or more of:

a) Requirement that the governor signs the Code of Conduct;

b) Requirement that the governor attends specified training;

c) Requirement that the governor desists from specified conduct.

11.5.6 If possible, the meeting will reconvene the same day and the chair of the panel will issue their decision and the reasoning that directed their conclusion. The decision will be confirmed in writing to the governor within 5 working days. If it is not possible to reconvene the same day, the panel should meet within 10 working days and issue their decision in writing to the governor within 5 working days of this meeting.

11.6 Panel Decision not Comprising a Recommendation to Terminate Tenure

11.6.1 Any decision made by the panel may be appealed in writing by the governor concerned within 28 days of the date upon which notice in writing of the panel's decision is communicated to the governor concerned (time of the essence).

11.6.2 The appeal will be heard by the Council of Governors in private session within 14 days of the date upon which the notice of the appeal is received by the Trust.

11.6.3 If it is not possible to hear an appeal within the 14 days' time limit, then the Council of Governors shall be asked to agree either to hold an exceptional meeting for an appeal hearing within the 14 days' time limit or to extend the time limit to the date of the next meeting of the Council of Governors after expiry of the time limit.

11.6.4 The governor has the right to have the appeal against the panel's decision heard by the full Council of Governors, however, the governor may request that a subgroup of the Council of Governors, comprising Governors who have not already been involved in the process, hear the appeal instead. This request will need to be agreed by the Council of Governors.

11.6.5 If the Council of Governors agrees to the above the subgroup will consist of four (4) governors and the Chair who will act as chair of the subgroup.

11.7 Appeal Process to Council of Governors of a Decision not Comprising a Recommendation to Terminate Tenure

11.7.1 The Chair or (if the Chair is disqualified) the Deputy Chair shall act as the chair of the appeal. If both the Chair and Deputy Chair are disqualified, then the Chief Executive in consultation with the lead governor shall nominate another Non-Executive Director of the Trust to act as the chair of the appeal. At the start of an appeal hearing, the Council of Governors must approve the appointment of the chair of the appeal if they are not the Chair or Deputy Chair.

11.7.2 The Council of Governors will receive the original investigation report and outcome letter and the written grounds for appeal.

11.7.3 At the decision appeal hearing:

11.7.3.1. The chair of the panel will present their reasons for the conclusions reached and decision taken.

11.7.3.2. Governors may ask the chair of the panel clarification questions about their decision.

11.7.3.3. The appellant may address the Council of Governors outlining their grounds of appeal. The representation may be time limited at the absolute discretion of the chair of the appeal.

11.7.3.4. The appellant has the right to be accompanied at the hearing by a companion (i.e., an advocate). The companion can speak on the appellant's behalf, with permission from the appellant.

11.7.3.5. Governors may ask the appellant clarification questions about their comments, response, and representations.

11.7.3.6. The appellant and the chair of the panel may make final summary representations to the Council of Governors which may be time limited at the absolute discretion of the chair of the appeal.

11.7.3.7. The chair of the appeal may make such recommendations as they consider appropriate to the Council of Governors.

11.7.3.8. The chair of the appeal may exclude the appellant and the chair of the panel from the meeting so that the Council of Governors may discuss the chair of the appeal's recommendation in their absence. The chair of the appeal shall invite the appellant and the chair of the panel to return to the meeting on the conclusion of such discussion.

11.7.4 The Council of Governors shall decide whether to uphold the panel's decision or to apply any other sanction by a majority vote of all governors present and voting. The members of the panel who are present will count towards the quorum but will be omitted from the vote. The Council of Governors' decision will be communicated in writing to the appellant within 5 working days of the date of the Council of Governors' meeting.

11.7.5 The chair of the appeal may at their absolute discretion at any time adjourn the appeal hearing to a date and time to be fixed.

11.7.6 The chair of the appeal may at any time before or during an appeal hearing take such advice as they consider to be appropriate from the Trust's officers and/or advisers and if necessary, may adjourn an appeal hearing to do so in private.

11.8 Appeal Process to a Subgroup of a Decision not Comprising a Recommendation to Terminate Tenure

11.8.1 The Chair or (if the Chair is disqualified) the Deputy Chair shall act as chair of the appeal. If both the Chair and Deputy Chair are disqualified, then the Chief Executive in consultation with the Lead Governor shall nominate another Non-Executive Director of the Trust to act as chair of the appeal. At the start of an appeal hearing, the Council of Governors must approve the appointment of the chair of the appeal if they are not the Chair or Deputy Chair.

11.8.2 At the subgroup decision appeal hearing:

11.8.2.1 The chair of the panel will present their reasons for the conclusions reached and decision taken.

11.8.2.2 The subgroup except the appellant may ask the chair of the panel clarification questions about their decision.

11.8.2.3 The appellant may address the subgroup outlining their grounds of appeal. The representation may be time limited at the absolute discretion of the chair of the appeal.

11.8.2.4 The appellant has the right to be accompanied at the hearing by a companion (i.e., an advocate). The companion can speak on the appellant’s behalf, with permission from the appellant.

11.8.2.5 The subgroup may ask the appellant clarification questions about their comments, response and representations.

11.8.2.6 The appellant and the chair of the panel may make final summary representations to the subgroup which may be time limited at the absolute discretion of the chair of the appeal.

11.8.2.7 The chair of the appeal may make such recommendations as they consider appropriate to the subgroup.

11.8.2.8 The chair of the appeal may exclude the appellant and the chair of the panel from the meeting so that the subgroup may discuss the chair of the appeal’s recommendation in their absence. The chair of the appeal shall invite the appellant and chair of the panel to return to the meeting on the conclusion of such discussion.

11.8.3 The chair of the appeal may at their absolute discretion at any time adjourn the appeal hearing to a date and time to be fixed.

11.8.4 The chair of the appeal may at any time before or during an appeal hearing take such advice as they consider to be appropriate from the Trust’s officers and/or advisers and if necessary, may adjourn an appeal hearing to do so in private.

11.8.5 The subgroup shall decide whether to uphold the panel’s decision or to apply any other sanction by a majority vote of subgroup members present and voting.

11.8.6 The subgroup decision will be presented to the full Council of Governors for ratification.

11.9 Panel Decision Comprising a Recommendation to Terminate the Tenure of a Governor

11.9.1 Following a panel hearing the panel may recommend to the Council of Governors the termination of a governor's tenure. The chair of the panel will set out the reasons for the recommendation of termination of tenure.

11.9.2. At the termination hearing:

11.9.2.1 The chair of the panel will present their reasons for the recommendation to terminate the governor's tenure.

11.9.2.2 The Council of Governors, except the governor concerned, may ask the chair of the panel clarification questions about their recommendation.

11.9.2.3 The governor concerned has the right to be accompanied at the hearing by a companion (i.e., an advocate). The companion can speak on the governor's behalf, with permission from the governor.

11.9.2.4 The governor may address the Council outlining their case for non-termination.

11.9.2.5 The Council may ask the governor concerned clarification questions about their comments, response, and representations.

11.9.2.6. The governor concerned and the chair of the panel may make final summary representations to the Council of Governors which may be time limited at the absolute discretion of the Chair.

11.9.2.7 The Chair may make such recommendations as they consider appropriate to the Council of Governors.

11.9.2.8 The Chair may exclude the governor concerned and the chair of the panel from the meeting so that the Council of Governors may discuss the chair of the panel's recommendation in their absence. The Chair shall invite the governor concerned and the chair of the panel to return to the meeting on the conclusion of such discussion.

11.9.3 Termination of a governor's tenure of office requires the approval of two-thirds of the members of the Council of Governors present and voting providing the meeting is quorate in accordance with the Standing Orders for the Practice and Procedure of the Council of Governors. The members of the panel who are present will count towards the quorum and will be able to vote.

11.9.4 A governor whose tenure has been terminated by the Trust is not eligible to stand again for election as a governor of the Trust.

11.9.5 In the event of an appeal being referred to the Council of Governors if the governor concerned is aggrieved at the decision, they may apply in writing within 7 days to the Council of Governors for the decision to be referred to an independent assessor. The independent assessor will then consider the

evidence and conclude whether the proposed removal is reasonable or otherwise.

11.9.6 On receipt of an application the Chair and Lead Governor and the applicant governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on an independent assessor within 21 days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Centre for Effective Dispute Resolution to nominate the independent assessor. The independent assessor's decision will be binding and conclusive on the parties.

11.10 Timeline

11.10.1 All time limits specified in this section are for guidance only unless it is stated that time is of the essence. Breach of a time limit shall not invalidate any step taken or decision made unless time is of the essence.

12. MISCELLANEOUS

12.1 Standing Orders to be given to Governors

12.1.1 It is the duty of the Secretary to the Trust to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

12.2 Review of Standing Orders

12.2.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

APPENDIX A

GOVERNORS' CODE OF CONDUCT

This document sets out in very broad terms the role and responsibilities of all Governors of Birmingham & Solihull Mental Health NHS Foundation Trust and the standards of conduct expected of them.

GOVERNORS' ROLE

- To appoint the Chair and the Non-Executive Directors and, as appropriate, remove.
- To decide the remuneration and allowances and other terms and conditions of the Chair and other Non-Executive Directors.
- To approve the appointment of the Chief Executive.
- To appoint and, if appropriate, remove the auditors.
- To receive the annual accounts, any report of the auditors on them, and the annual report.
- In preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council. The Council (at least 50%) must approve an increase of 5% or more in non-NHS income in any one financial year.
- To approve amendments to the Trust's constitution.
- To approve an application by the Trust to enter into a merger, acquisition, separation or dissolution (a "Significant Transaction").
- To hold the Non-Executive Directors, individually and collectively to account, for the performance of the Board of Directors.
- To represent the interests of the members and of the public.

NOLAN PRINCIPLES

The Nolan Committee set out seven principles for all who serve the public in any way. Governors are holders of a public office and are therefore expected to adhere to the Nolan Principles.

These principles are listed below.

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for doing so.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

DECLARATION OF INTERESTS

Governors on election or appointment are required to list all relevant interests which may reasonably be thought – by any other person – to influence their actions in the performance of their duties as a governor of this Trust. These interests are to be reviewed on a regular basis.

It is the responsibility of the governor to inform the Company Secretary immediately in writing of any changes to their interests and these should be recorded in the minutes of the Council.

VALUES

Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners. Our values describe our core ethics and principles. They help guide our culture by inspiring people's best efforts and constraining unwanted actions that do not align with our values. These are:

- Compassionate
- Inclusive
- Committed

BEHAVIOURS

Our everyday and detailed behaviours describe what our values look like in practice. They give us a shared language to help bridge the wide range of specialties and roles in our Trust. Governors will be expected to adhere to our Every Day Behaviours Guide.

CODE OF CONDUCT
I will:

- support the Trust, its Constitution, and the NHS Constitution.
- respect the whole Trust Team (Governors, Board, Staff and Members) and recognise and support the common purpose in achieving the Trust's Vision, Values and Behaviours.
- be a good Ambassador for the Trust and always work in the best interests of the Trust, its Patients and Members.
- always observe confidentiality on matters relating to the work of the Trust, its Patients and Staff .
- attend meetings of the Governor's Council and related Sub Committees during which I will observe good meeting practices.
- respect and accept the majority decisions of the whole Governors Council, understanding that this is the sole decision-making body for the Governors. Committees and working parties will advise the Council of their work for agreement and ratification by the full Governors Council.
- understand that I should never approach the media except through the Communications Office and wherever possible passing media approaches to that office.
- oppose any discrimination and claim no privileges in my role as Governor.
- undertake all appropriate training provided to enable me to fulfill my role as Governor.
- act responsibly, whilst contributing to the work of the Governors Council, bringing my strengths to bear, whilst respecting the strengths of the other Governors.
- represent and be accountable to the Membership of the Trust and the wider public.
- abide by the Polices and Procedures of the Trust, including the Whistleblowing policy and guidance.
- participate in public contacts, including visits to Trust sites after agreement and sanctioning by the Trust. I will act as an observer and not adopt a management role.
- make effective use the resources available to me.

Code of Conduct Acceptance

I, (name) representing (public constituency/staff constituency/partner organisation

……………………………………………………………………………………………………..
confirm that I have read and agree to abide by the Code of Conduct for the Council of Governors of Birmingham & Solihull Mental Health NHS Foundation Trust

Date …………………………………………………………………………………………….

Signature ……………………………………………………………………………………...

Delete as appropriate
Copies of the signed declaration will be kept by the Company Secretary

APPENDIX B

MEETING ETIQUETTE: GOOD GOVERNANCE ETIQUETTE OF THE COUNCIL OF GOVERNORS

We will:

- Respect one another as possessing individual and corporate skills, knowledge and responsibilities.
- Show determination, tolerance and sensitivity – rigorous and challenging questioning, tempered by respect.
- Show group support and loyalty towards each other.
- Listen carefully to all ideas and comments and be tolerant to other points of view – be sensitive to colleagues' needs for support when challenging or being challenged.
- Be honest, open and constructive.
- Be courteous and respect freedom to speak
- Regard challenge as a test of the robustness of arguments – ensure no one becomes isolated in expressing their view. Treat all ideas with respect.
- Read all papers before the meeting.
- Arrive on time and participate wholeheartedly.
- Focus discussion on material issues and on the resolution of issues.
- Make the most of time.
- Support the chair, colleagues and guests in maximising scope and variety of viewpoints heard.
- Ensure individual points are relevant and short.
- Take decisions and abide by these.
- Refer to past systems or mistakes as being responsible for today's situation.
- Act in a positive manner.
- Ensure Governor has the right to challenge/question another.
- Be ready to apologise if offence is taken.
- Stay open to discussion.
- Maintain a view of the strategic picture.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 25)

Birmingham and Solihull Mental Health NHS Foundation Trust

Standing Orders for the Practice and Procedure of The Board of Directors

FOREWORD

The Trust Board holds the responsibility to agree the Standing Orders and the Reservation of Powers to the Board and Delegation of Powers.

Those documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfill the dual role of protecting the Trust's interests by ensuring, for example, all transactions maximize the benefit to the Trust and protecting staff from possible accusations that they have acted less than properly. This is provided, of course, staff have followed the correct procedures outlined in the relevant document.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All Board directors and all staff should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions to the extent required for the proper conduct of their duties.

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APPENDIX A **CODE OF BUSINESS CONDUCT**

INTRODUCTION

The principal place of business of the Trust is Uffculme Centre, 52 Queensbridge Rd, Birmingham. B13 8QY

NHS Foundation Trusts are governed by a Regulatory Framework that confers the functions of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 ("the 2006 Act"); their constitutions; the terms of their authorisations granted by the Independent Regulator of NHS Foundation Trusts ('the Independent Regulator'); and binding guidance issued by the Independent Regulator.

The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the practice and procedure of the Board of Directors.

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Trust's Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

1.2.1 **"Board of Directors"** means the Chair, executive and non-executive directors of the Trust collectively as a body as constituted in accordance with the constitution and the 2006 Act.

1.2.2 **"Chief Executive"** means the Chief Officer of the Trust.
1.2.3 **"Committee"** means a committee appointed by the Trust.
1.2.4 **"Committee members"** mean persons formally appointed to the Board of Directors to sit or to chair specific committees.
1.2.5 **"Director of Finance"** means the chief financial officer of the Trust.
1.2.6 **"Executive Director"** means a Director who is also an officer of the Trust.
1.2.7 **"Director"** means an executive (including the Chief Executive) or non-executive director (including the Chair) of the Board.
1.2.8 **"Nominated Officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
1.2.9 **"Non-executive Director"** means a director of the Trust who is not an officer of the Trust, except where the Director is a nominee of the university that provides the Trust's medical school.
1.2.10 **"Officer"** means employee of the Trust or any other person holding a paid appointment of office within the Trust.

2. THE TRUST

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Board of Directors as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi trustees. Accountability for charitable funds held on trust is to the Charity Commission.

2.4 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the document entitled 'Reservation of powers to the Board of Directors and Scheme of Delegation' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in that document also.

2.4 **Appointment and Powers of Deputy Chair** – For the purposes of allowing the proceedings of the Board of Directors to be conducted in the absence of the Chair for any reason and subject to Standing Order 2.6 below, the Council of Governors may appoint a non-executive director to be Deputy Chair, for such period, not exceeding the remainder of their term as a Director, as they may specify on appointment.

2.5 Any non-executive director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another non-executive director as Deputy Chair in accordance with the provisions of Standing Order 2.5.

2.6 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

2.7 Senior Independent Director

2.7.1 The Code of Governance for Foundation Trusts, states in paragraph A4.1

"In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson."

2.8 Appointment of the Senior Independent Director

2.8.1 Following the resignation of the current Senior Independent Director (SID) or the current SID is at the end of their Term of Office, the following appointment process will apply:

2.8.1.1 When a vacancy for a Senior Independent Director arises, the Trust Chair will seek expressions of interest from Non-Executive Director colleagues regarding standing for the role of Senior Independent Director.

2.8.1.2 If only one Non-Executive Director expresses an interest in the role, a report will be prepared for the Board of Directors in private session, proposing the Non-Executive Director as the new Senior Independent Director.

2.8.1.3 If approved, following the meeting of the Board of Directors, a report will be presented to the next Council of Governors meeting to request endorsement to the appointment of the Non-Executive Director as the new Senior Independent Director.

2.8.1.4 If more than one expression of interest is received, then the Non-Executive Directors will be asked to write a supporting statement to the Board of Directors, detailing why they wish to be considered for the role. This will include ensuring they can deliver on the areas detailed within the role profile.

2.8.1.5 The statement will be circulated to Board Members and a formal vote undertaken. All Board Members will have a vote on the process. The process will be conducted in a timely manner by the Associate Director of Corporate Governance.

2.8.1.6 Once the results are known, the recommended candidate from the Board of Directors for the appointment of Senior Independent Director, will be presented for formal endorsement to the Council of Governors.

2.8.1.7 The Associate Director of Corporate Governance will then formally write confirming the appointment to the Non-Executive Director as SID. This letter will be placed on their personal file in the central electronic filing system.

2.8.1.8 If the vote results in a tie, then the Chair will have a casting vote and a report will be prepared for the Council of Governors for formal endorsement.

2.9 Any Member of the Board of Directors so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon in consultation with the Council of Governors appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.8 above.

2.10 **Role of Directors –** The Board of Directors will function as a corporate decision-making body, Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Admission of the Public and the Press** - Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

3.2 The Chair (or Deputy Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete business without the presence of the public".

3.3 **Confidentiality.**

3.3.1 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board of Directors. Proceedings shall not be transmitted in any manner whatsoever without the prior agreement of the Board of Directors.

3.3.2 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board of Directors.

3.3.2 Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Board of Directors meeting, without the express permission of the Board of Directors. This prohibition shall apply equally to the content of any discussion during the Board of Directors' meeting which may take place on such reports or papers.

3.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5 The Chair of the Trust may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.6 **Notice of Meetings** - Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to them at least three clear days before the meeting.

3.7 Want of service of the notice on any Director shall not affect the validity of a meeting.

3.8 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice or emergency motions allowed under these Standing Orders. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.9 Agendas will wherever possible be sent to Directors at least five clear days before the meeting and supporting papers, whenever possible.

3.10 Before each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda, shall be shared on the Trust website at least three clear days before the meeting.

3.11 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

3.12 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.13 **Petitions** - Where a petition has been received by the Trust the Chair of the Board of Directors shall include the petition as an item for the agenda of the

next Board of Directors meeting subject to the powers granted to the Chair by these Standing Orders to regulate arrangements for Board of Directors' meetings.

3.14 **Chair of Meeting** - At any meeting of the Board of Directors, the Chair of the Board of Directors, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Vice -Chair are absent such Director (who is not also an officer of the Trust) as the Directors present shall choose shall preside.

3.15 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the Directors present shall choose shall preside. If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or to the interests of the non-executive Directors as a class, neither the Chair nor any of the other non-executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair or the other non-executive Directors) shall elect one of their number to preside during that period and that person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.16 **Annual Members' Meeting** – The Trust will publicise and hold an annual members' meeting.

3.17 **Notices of Motion** - A Director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda, subject to Standing Order 3.8.

3.18 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.19 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within 6 months; however the Chair may do so if they consider it appropriate.

3.20 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.21 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)
- A motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.22 **Chair's Ruling** - Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.23 **Voting** - Every question put to a vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.24 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.25 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.26 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.27 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.28 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be an executive director.

3.29 An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

3.30 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.31 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.32 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.33 **Suspension of Standing Orders** - Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.34 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.35 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

3.36 No formal business may be transacted while Standing Orders are suspended.

3.37 The Audit Committee shall review every decision to suspend Standing Orders.

3.37 **Waiver of Standing Orders** - Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.38 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.

3.39 The Audit Committee shall review every decision to waive Standing Orders.

3.40 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.17 has been given; and
- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Directors are present; and
- the variation proposed does not contravene any provision of the Regulatory Framework.

3.41 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

3.42 **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least one half of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present.

3.43 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

3.44 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) they shall no longer count towards the quorum. If a quorum is then not available for discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee). The above requirement for at least one non-executive Director to form part of the quorum shall not apply where the non-executive Directors are excluded from a meeting.

3.45 **Adjournment of Meetings -** The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

3.46 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

3.47 **Observers at Board of Directors meetings -** The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors meetings and may change, alter or vary these terms and conditions as it deems fit.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Regulatory Framework, the Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions subject to such restrictions and conditions as the Board of Directors thinks fit by:

a) committee or sub-committee appointed by virtue of Standing Order 5 or by a Director or an officer of the Trust; or
b) in the case of delegation for the purposes of a provision of, or made under, the Mental Health Act 1983, in such other manner as is permitted by the relevant provision in each case subject to contractual arrangements and such restrictions and conditions as the Board of Directors thinks fit to ensure appropriate oversight.

4.2 **Emergency Powers -** The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors for noting.

4.3 **Delegation to Committees -** The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees, or subcommittees, which it has formally constituted. The constitution and terms of reference of these committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 When the Directors are not meeting as the Board of Directors in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Board of Directors in public session.

4.4 **Delegation to Officers -** Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or otherwise for the purposes of and in accordance with the Mental Health Act 1983 shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive Director to provide information and advise the Board of Directors in accordance with the Constitution, Terms of Authorisation, any statutory requirements or provisions required by the Independent Regulator of NHS Foundation Trusts. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

4.7 The arrangements made by the Board of Directors as set out in the "Reservation of Powers to the Board of Directors and Delegation of Powers" document shall have effect as if incorporated in these Standing Orders.

4.8 **Overriding Standing Orders -** If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Subject to the Regulatory Framework, the Board of Directors may appoint committees of the Board of Directors. The Board of Directors shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees subject to contractual arrangements and such restrictions and conditions as the Board of Directors thinks fit to ensure appropriate oversight.

5.2 A committee appointed under this regulation may, subject to their terms of reference and the Regulatory Framework, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors. In which case the term "Chair" is to be read as a reference to the Chair of the committee as the context permits, and the term "Director" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Board of Directors in public.)

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.6 The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. The Chair of each Board of Directors committee shall be a non-executive Director.

5.7 The committees established by the Board of Directors shall include an Audit Committee and a Remuneration and Terms of Service Committee.

5.8 The Board of Directors may elect to change the committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders.

5.9 **Confidentiality -** A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests **-** The Constitution requires Directors to declare interests which are relevant and material to the Board of Directors. All existing Directors should declare such interests. Any Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are to be interpreted in accordance with guidance issued by the Independent Regulator of NHS Foundation Trusts and include:

a) Directorships, including non-executive directorships held in private companies or PLC's (with the exception of those of dormant companies).
b) Ownership or part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of trust in a charity or voluntary organisation in the field of health and social care.
e) Any connection with a voluntary or other organisation contracting for NHS services.
f) Research funding/grants that may be received by an individual or their department.
g) Interests in pooled funds that are under separate management.

h) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.
i) Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means.
j) Any other commercial interest in the decision before the meeting.
k) Membership of the Reach Out Commissioning Sub-Committee

6.1 At the time Directors’ interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next Board of Directors meeting following the change occurring. It is the obligation of the Director to inform the Secretary of the Trust in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the Register upon receipt within 5 working days.

6.2 Directors' directorships of companies in 6.2(a) above and Directors' directorships of companies likely or possibly seeking to do business with the NHS in 6.2(b) above should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Board of Directors meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement for the interests of Directors' family or close personal relationships to be declared. However, Standing Order 7 requires that the interest of Directors' family or close personal relationships, if living together, in contracts should be declared.

6.7 If Directors have any doubt about the relevance of an interest, this should be Discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests -** The details of Directors’ interests recorded in the Register will be kept up to date by means of a monthly review of the Register by the Secretary in which any changes to interests declared during the preceding month will be incorporated.

6.9 The Register will be available to the public and the Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

7. EXCLUSION OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order if the Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board of Directors may exclude the Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the Director shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order a Director shall be treated, subject to Standing Order 7.2 and Standing Order 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

Or

(b) they are a partner of, or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of family or close personal relationship, the interest of one party shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which they are connected as mentioned in Standing Order 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where a Director has:

(a) an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest. Shareholdings in excess of 3% and directorships in any publicly listed, private or not for profit company, business, partnership or consultancy which is doing or might reasonably be expected to do business with the NHS including pharmaceutical companies, should be declared.

7.8 Standing Order 7 applies to a committee or sub-committee as it applies to the Board of Directors and applies to a member of any such committee or sub-committee (whether or not he/she is also a Director) as it applies to a Director. Full details of the declaration requirements are available it in the Trust Declaration Policy.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 **Policy -** Staff must comply with the national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" (contained in Appendix B). This Section of Standing Orders should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a member of their family or of someone with whom they have a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared to be entered in a register of interests of staff.

8.4 **Canvassing of and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors or of any Committee of the Board directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience, or character for submission to the Trust.

8.4 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.8 Every Director and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9 On appointment, Directors (and prior to acceptance of an appointment in the case of executive Directors) should disclose to the Board of Directors whether they are related to any other Director or holder of any office in the Trust.

8.9 Where the relationship to a Director is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

8.10 No formal definition of relationship is made. In considering whether a disclosure is required the influence rather than immediacy of the relationship is more important. In case of doubt disclosure should be made.

9. TENDERING AND CONTRACT PROCEDURE

9.1 The procedure for making all contracts by or on behalf of the Trust shall comply with: the Regulatory Framework; these Standing Orders (except where Standing Order 3.33 or 3.37 is applied); and the Trust’s Standing Financial Instructions. Such contracts involving charitable funds shall comply with the requirements of the Charities Act and the trust deed.

10. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Chief Executive or their nominated officer in a secure place.

10.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers. The Board has resolved that the seal may be used between Board meetings, based on business need, at the discretion of the Chief Executive or Director of Finance. Two Executive Director signatories are required for use of the seal. The Seal shall be used whenever required by law, or on the advice of the Trust's solicitor. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Company Secretary or Trust Solicitor. A report on the use of the seal will be provided to the Board, after its use, at the next available opportunity.

10.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

10.4 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors and to the Audit Committee at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

11. SIGNATURE OF DOCUMENTS

11.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

11.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document, not required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee, sub-committee, or standing committee with delegated authority.

12. PROCESS FOR THE RECEIPT OF COMPLAINTS/BREACH OF CODE OF CONDUCT AGAINST CHAIR/NON-EXECUTIVE DIRECTOR

12.1 Introduction

12.1 Governors have a range of roles to fulfil incorporating legal, oversight and governance responsibilities. They have strategic stewardship responsibilities and are expected to act in the best interest of the NHS foundation trust. They represent the interests of NHS foundation trust members and hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, including ensuring the Licence is complied with. It is therefore essential that Governors are fully aware of the values, vision and behaviours the Trust seeks to promote to staff, members, patients and the wider public.

12.2 Purpose

12.2.1 The purpose of this procedure is to provide a robust process to follow in the event that a Non-Executive Director or the Chair is alleged to have breached the Board Code of Conduct in Appendix 1.

12.3 Definitions

12.3.1 The following definitions apply for terms used in this procedure:

Chair: the chair of the Trust.

NEDs : Non-Executive Directors of the Trust.

Council of Governors: the Council of Governors as constituted in the BSMHFT Constitution.

Associate Director of Corporate Governance: Trust Lead for Corporate Governance.

Governor: a member of the Council of Governors.

Member: a member of the BSMHFT Trust.

Complainant(s): the person(s) who is raising the complaint or concern.

A Complaint is any expression of dissatisfaction that requires a response.

Conflict of interest: a situation in which an individual has more than one interest which prevents the proper exercise of their duties and finds themselves unable to be impartial under this procedure. If Governors have

any doubt as to the relevance or materiality of an interest, this should be discussed with the Chair.

Investigator: the person requested to conduct a fair, prompt and proportionate investigation under this procedure

CoG Investigation Panel: (responsible for the investigation and takes the role of the “Commissioning Manager as detained in Trust Policies.

Lead Governor: A Governor elected by the Council of Governors to the role of Lead Governor.

Deputy Lead Governor: A Governor elected by the Council of Governors to the role of Deputy Lead Governor.

Terms of Reference: the framework used by the Investigator, setting out the issues to be investigated and matters to be considered as part of the investigation.

Supporter: to support a NED or Chair/Complainant during the process.

Suspension: the process of placing on a NED or the Chair so that they do not participate in the work of the Trust, while an investigation is undertaken into the allegations reported. Suspension is a neutral act; it is neither a disciplinary action nor an assumption of guilt. A suspended Chair or NED shall continue to be required to adhere to the Board Code of Conduct.

Present at a meeting: this can be virtually as well as face-to-face.

12.3.2 If any post holder is conflicted or otherwise unavailable to act, references in this procedure to that post holder shall be construed as references to a suitable deputy agreed by the Lead Governor. If the Lead Governor is conflicted, then the Deputy Lead Governor shall deputise.

12.4 Duties and Responsibilities

12.4.1 The Lead Governor is responsible for undertaking their role as per this procedure and for being able to take immediate action where necessary under 5.3 of this Procedure.

12.4.2 The Council of Governors is responsible for ensuring that in the event of the need to sanction or remove a NED or the Chair that the process is fair, rigorous, lawful and transparent.

12.4.3 The Associate Director of Corporate Governance is responsible for ensuring that the procedure is enacted and followed, and supporting the Lead

Governor, the Council, and the CoG Investigation Panel to discharge their duties, including receipt of external advice.

12.4.4 The NED's and the Chair are responsible for their own conduct and for demonstrating an appropriate standard of behaviour at all times in line with the Board Code of Conduct. The NED's and the Chair should be aware that complaints of inappropriate conduct or behaviour and/or breaches of the Board Code of Conduct may still be dealt with under this procedure, and could still therefore lead to their removal as a NED or the Chair, where the complaint in question relates to events occurring outside of their specific duties as NED or the Chair. This is because such behaviour and/or breaches of the Code of Conduct still have the potential to adversely impact on the Trust's reputation and/or may still be considered relevant to the question of whether they are fit to carry out their duties. The NED's or the Chair are responsible for engaging with any action taken in line with this procedure and for arranging their own support for formal meetings.

12.4.5 The CoG Investigation Panel is responsible for undertaking its role as per this procedure. The CoG will meet to identify and agree on 3 Governors to form the CoG Investigation Panel.

12.4.6 Supporters are responsible for recognising this is confidential business of the Trust.

12.5 Miscellaneous

12.5.1 Any written correspondence may be by electronic means (email). Any documents attached to emails should be protected by password.

12.5.2 It is anticipated that all timescales set out within this procedure will be met; however, the Lead Governor in consultation with the Company Secretary may extend any timescale given, if they have a clear reason to do so. Where a time limit imposed on is not met, or the Chair/NED indicate that they do not intend to engage with the procedure, the Lead Governor may continue to progress the procedure without further process or delay.

12.5.3 At any time, the Lead Governor is authorised to take such interim measures as may be immediately required, including the exclusion of the NED or the Chair concerned from a meeting or suspension from duties, on the basis that such measures are necessary to:

12.5.3.1 enable an effective investigation to be undertaken into any concern or complaint about a NED or the Chair;

12.5.3.2 address or prevent any significant disruption to the effective operation of any part of the Trust;

12.5.3.3 manage risk to the health or well-being of any NED or the Chair, Governor, employee, volunteer or patient of the Trust;

12.5.3.4 protect the reputation of the Trust.

Any suspension should be within the terms of the applied Policy. The suspension should be ratified and kept under review in line with the applied Policy.

12.5.4 During any period of suspension from duties, the NED or the Chair is not permitted to:

12.5.4.1 attend or enter the Trust's premises unless he or she is doing so as a patient of the Trust, as a carer or family member of a patient of the Trust or with the consent of the Lead Governor;

12.5.4.2 contact any of the Trust's NED's or the Chair, Governors, employees, suppliers, volunteers or patients without the express prior permission of the Lead Governor, other than in circumstances where any such contact is purely of a personal nature and unrelated to their position or duties as a Chair/NED or in relation to this process.

12.5.5 Any decision by the Lead Governor under paragraph 5.3 shall be communicated to the CoG Investigation Panel as soon as reasonably practicable and is effective when the NED or the Chair is notified either verbally or in writing. The NED or the Chair will be required to maintain confidentiality in regard to their suspension and the process being undertaken, save that they may disclose information about the process being followed to their Supporter required for the purposes of paragraphs 9 and 11 below.

12.5.6 The Lead Governor shall notify the Council of Governors that an interim measure has been imposed as soon as reasonably practicable.

12.5.7 In order to protect the legitimate interests of a NED or the Chair and any Complainant, the Council of Governors shall not be entitled to receive any further information regarding the use of this procedure in relation to any NED or the Chair until it is notified of any charge on which it is being asked to make a decision.

12.5.8 Notwithstanding the use of this procedure, a NED or the Chair is entitled to resign at any time. Where a NED or the Chair who is subject to this procedure resigns, the Lead Governor will provide an overview of the complaint to the Council where this would not unduly prejudice the interests of the NED or the Chair, and the complaint may still be investigated under this procedure if the Council of Governors considers necessary or appropriate to do so in the circumstances.

12.5.9 The CoG Investigation Panel or Council of Governors are authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The costs of such advice must be agreed with the Trust via the Chief Executive.

12.5.10 Any meeting or hearing under this Procedure may be conducted remotely, by telephone or video conference technology, if the Lead Governor, following consultation with the Associate Director of Corporate Governance, considers it possible and appropriate in the circumstances. If any meeting or hearing is conducted remotely in this way, instructions for how to attend the meeting or hearing will be sent (usually by email) to all parties who are invited to attend, prior to the start of the meeting or hearing itself. Specific rules for remote participation in the meeting or hearing may also be circulated to all attendees in advance, and any failure to adhere to these rules by any NED or the Chair attending the meeting or hearing may be treated as a breach of the Board Code of Conduct and dealt with accordingly.

12.5.11 Normally this Procedure will apply as set out; however, in some circumstances it may not meet the circumstances of a complaint and investigation, for example where multiple complaints and counter complaints arise. The aim should be to incorporate the essential elements of the Procedure and the final decision of the most appropriate process will remain with the Lead Governor, following consultation with the Associate Director of Corporate Governance.

12.6 Process on Initial Receipt of a Complaint or Allegation

12.6.1 This procedure shall apply where the Lead Governor identifies, or becomes aware of, a complaint about a NED or the Chair from any source (it may be necessary to consider section 12.5.3 at this stage).

12.6.2 The Lead Governor shall ensure that all complaints are documented before proceeding.

12.6.3 The Lead Governor, in consultation with the Associate Director of Corporate Governance, will determine whether and how to proceed with a complaint: either informally or formally. Consideration should be given to undertaking a without prejudice wellbeing check of the NED or the Chair against whom the complaint has been received and the Complainant(s). This check will be with the informed consent of the person being assessed.

12.6.4 If the Lead Governor decides a complaint shall be dealt with informally, the Lead Governor will discuss it with the NED or the Chair and if appropriate, offer advice or support to the NED or the Chair in an effort to avoid any further breaches of the Board Code of Conduct or the Trust Constitution. This will be documented in writing to the NED or the Chair and kept on file for a period of 12 months. The complaint shall not be taken further under this procedure,

unless the Lead Governor subsequently determines that the complaint is more serious than first thought and should be dealt with as in paragraph 12.7 below.

12.6.5 If the Lead Governor decides a complaint shall be dealt with formally, the provisions of paragraph 12.7 below will apply.

12.6.6 With the support of the Associate Director of Corporate Governance, the Lead Governor shall document:

12.6.6.1 their reasons for their decision under paragraph 12.6.4;

12.6.6.2 any advice or support offered to a NED or the Chair under paragraph 12.6.4; and
12.6.6.3 provide a copy to the Associate Director of Corporate Governance.

12.6.7 The Lead Governor shall report all complaints and any actions taken to the CoG Investigation Panel.

12.6.8 In the event that the NED or the Chair complained against raises a counter-complaint, the Lead Governor and the Associate Director of Corporate Governance shall decide how to proceed with that counter-complaint.

12.7 Initial Consideration by the CoG Investigation Panel

12.7.1 The Lead Governor shall provide written details of the complaint to the NED or the Chair and advise them that the matter will be referred to the CoG Investigation Panel. The Lead Governor will invite the NED or the Chair to provide a response to the complaint within 10 working days so that this can be considered by the Panel. If the NED or the Chair requests any further information in relation to the complaint than that which has already been provided, the Lead Governor, with support by the Associate Director of Corporate Governance, will determine whether it is appropriate or necessary to provide this information.

12.7.2If the NED or the Chair fails to provide a response to the complaint or fails to provide a response within 10 working days (without providing a good reason for the delay), this may be deemed a breach of the Code of Conduct, which requires a NED or the Chair to cooperate fully and in a timely manner with any authorised due process or investigation. This alleged breach may be added to the existing allegations made against the Chair/NED in the complaint, which will then be considered by the CoG Investigation Panel as detailed at paragraph 12.7.4 below.

12.7.3 The complaint and any response received from the NED or the Chair will be sent to the CoG Investigation Panel for discussion at the next meeting which should be convened at the earliest opportunity.

12.7.4 At the next meeting of the CoG Investigation Panel, the Panel shall be asked to determine by a majority of those present and voting whether the complaint requires further investigation. In the event the NED or the Chair has not provided a response to the complaint as envisaged in paragraph 12.7.1 (or has not provided a response within the required timeframe set out in paragraph 12.7.1), the CoG Investigation Panel will be entitled to consider and vote on whether the complaint requires further investigation solely based on the information available to it at that meeting.

12.7.5 If the majority required for the decision under is not achieved, no further action shall be taken against the Chair/NED under this procedure in relation to that complaint unless the Lead Governor receives new information or evidence and subsequently determines that the complaint is more serious than first thought and asks the CoG Investigation Panel to reconsider the matter or the NED or the Chair refuses to engage with the help and support offered as set out in paragraph 12.7.6 below. The NED or the Chair will be informed of the decision by the Lead Governor in writing within ten (10) working days and will be offered advice or support.

12.7.6 For the purposes of this procedure, advice and support may include:

12.7.6.1 Helping a NED or the Chair to understand their obligations under the Board Code of Conduct and the Trust's Constitution;
12.7.6.2 Offering an opportunity for a NED or the Chair to discuss their behaviour with the Lead Governor to help them to comply with their obligations under the Board Code of Conduct and the Trust's Constitution.
12.7.6.3 Offering mediation between a NED or the Chair and a Complainant.

12.8 Investigation

12.8.1 If the majority required for the decision is achieved, the Committee shall agree Terms of Reference (ToR) for an investigation into the complaint and instruct the Associate Director of Corporate Governance to initiate an investigation. The Associate Director of Corporate Governance may delegate responsibility for undertaking the investigation to an external third party with relevant experience.

12.8.2 The Terms of Reference will be documented.

12.8.3 The NED or the Chair shall cooperate with the investigation, and any failure to do so may be considered to be a breach of the Board Code of Conduct. Any such breach may be added to the existing allegations made against the NED or the Chair in the complaint and investigated accordingly in accordance with this paragraph 8.

12.8.4 The Committee shall also require the Complainant to cooperate with the investigation, in so far as it is possible for the Panel to do so.

12.8.5 An investigation should be completed as soon as practicable, and ideally within thirty (30) working days, subject always to paragraph 5.2 above. If a significantly longer period than 30 working days is required for the investigation to be completed, then this should be agreed by the CoG Investigation Panel. Under the terms of the relevant Policy, the "Commissioning Manager" will be the COG Investigation Panel.

12.8.6 Where further complaints about the NED or the Chair are identified in the course of an investigation, the Investigator may ask the CoG Investigation Panel to widen the ToR or decide whether a new investigation is required.

12.8.7 The Investigator shall produce a draft investigation outcome report setting out:

12.8.7.1 The Terms of Reference and the evidence obtained for each element of the ToR;
12.8.7.2 Any information obtained from the NED or the Chair,
12.8.7.3 Any other information that the Investigator deems appropriate.

12.8.8 The draft investigation outcome report shall then be sent to the Lead Governor and then to the NED or the Chair for them to provide any comments on factual accuracy, which must be provided within 10 working days of receipt of the report. If the NED or the Chair does not provide any comments within 10 working days, the NED or the Chair will be deemed not to have any comments to make in relation to the conclusions in the report, and this procedure will continue to be followed as set out below. Once any factual accuracy amendments have been made, the report will change from "draft" to "final" status.

12.8.9 The final investigation report, along with any comments from the NED or the Chair, shall be sent to the members of the CoG Investigation Panel by the Associate Director of Corporate Governance in good time to be read before the meeting at which it is to be discussed.

12.9 Consideration of the Final Investigation Report

12.9.1 The CoG Investigation Panel can decide to hold preliminary meetings in private to consider the Investigation Report to consider whether any further information is required before the Investigation is complete.

12.9.2 The CoG Investigation Panel shall hold a meeting in private to consider the investigation report.

12.9.3 The NED or the Chair shall be entitled to (but can choose not to) attend a CoG Investigation Panel meeting convened for the purposes of paragraph 9.2. They shall be entitled to make representations relevant to the contents of

the investigation report. They may attend the CoG Investigation Panel meeting with a supporter, but that supporter shall not be entitled to address the meeting. Where the NED or the Chair seeks to rely on information that they have not previously provided to the Investigator, they will only be allowed to do so where this is agreed by the Lead Governor. The NED or the Chair and Supporter shall be required to withdraw from the meeting after making representations and shall not be allowed to be present when the CoG Investigation Panel discusses the investigation report and vote on any matter.

12.9.4 A Complainant shall not be entitled to attend a CoG Investigation Panel meeting convened for the purposes of paragraph 12.9.2 without the permission of the Lead Governor. Where a Complainant is asked to attend a CoG Investigation Panel meeting, they may attend with a Supporter, but that Supporter shall not be entitled to address the meeting. The Complainant and Supporter shall not be allowed to be present when the panel discusses the investigation report and vote on any matter.

12.9.5 Having considered the investigation report and any submissions, the panel shall be asked to determine by a majority of those present and voting whether the complaint should be taken forward by means of the formal route set out at paragraph 10.

12.9.6 If the majority required for the decision under paragraph 12.9.5 is not achieved, the panel shall adopt the informal route set out at paragraph 12.6 above.

12.10 Formal Council of Governors Route

12.10.1 If the majority required in paragraph 12.9.5 is achieved, the panel shall instruct the Company Secretary to prepare a draft statement stating that the NED or the Chair has breached the Board Code of Conduct or the Trust's Constitution or both.

12.10.2 The panel shall consider the draft statement and the evidence of the breaches and make any amendments. A majority of those present and voting at a meeting of the panel shall be required to approve the terms of the statement and propose a sanction. Abstentions are not included in the voting total.

12.10.3 A confidential Extraordinary Council of Governors meeting shall be called. A copy of the statement, the evidence, the proposed sanction and the evidence relied upon by the panel in support of the statement, along with any information or representations that have been received from the NED or the Chair in the course of this procedure, shall be sent at least 7 days prior to the meeting to:

12.10.3.1The NED or the Chair who is subject to this process, with an invitation to attend the Extraordinary Council of Governors meeting to

make representations and then withdraw. The NED or the Chair shall be asked to respond in writing to the invitation at least five (5) working days before the meeting;

12.10.3.2 All members of the Council of Governors, with a request that they each confirm safe receipt of the information.

12.10.4 The Extraordinary Council of Governors meeting will take place and the Council will consider the issues as set out in paragraph 12.10.7 below regardless of whether the NED or the Chair who is subject to this process responds to the invitation as set out in paragraph 12.10.3.1 or attends the meeting itself.

12.10.5 If the NED or the Chair attends the meeting convened for the purposes of paragraph 12.10.3, they shall be entitled to make representations relevant to the contents of the charge statement. They may attend the Council meeting with a Supporter but that Supporter shall not be entitled to address the meeting. Where the NED or the Chair seeks to rely on information that they have not previously provided to the Investigator or the CoG Coordinating Committee, they will only be allowed to do so where this is agreed by the Lead Governor. The NED or the Chair (with their Supporter) shall be required to withdraw from the meeting after making their representations, and shall not be allowed to be present or to vote when the Council discusses the charge statement and votes.

12.10.6 In recognising this is confidential business of the Trust, where the Complainant is not a member of the CoG, a Complainant shall not be entitled to attend a Council meeting convened for the purposes of paragraph 12.10.3 without the permission of the Council. Where a Complainant is asked to attend a Council meeting, they may attend with a Supporter, but that Supporter shall not be entitled to address the Council. The Complainant (and Supporter) shall not be allowed to be present or to vote when the Council discusses the charge and votes.

12.10.7 If a quorum as laid down in the Constitution is not achieved for any reason, the meeting will be rescheduled for another date which will be as soon as practicably possible taking into account the notice requirements set out in Trust's Constitution. Any Governor who has any conflict of interest in the matter which is the subject of the complaint, shall disclose their conflict as soon as is practicable after the commencement of the meeting and will not take part in the consideration or discussion of the charge. The Lead Governor should consider whether to exclude that Governor from the meeting entirely.

12.10.8 At the meeting called under paragraph 12.10.3, the Council will review the available evidence, determine whether the allegations set out in the statement are proven and decide by way of a vote whether to impose a sanction.

12.10.9 Sanctions may include (but are not limited to):

12.10.9.1 A written warning. A time limit of up to 12 months will be applied to this sanction.
12.10.9.2 Removal from office as a NED or the Chair from the Trust.

12.10.10 The threshold of votes required in order to impose a sanction on a NED or the Chair is as follows:

12.10.10.1 in the case of the sanction of removal from their office as NED or the Chair, this shall only be imposed with the support of not less than two- thirds of the Governing body; or
12.10.10.2 in the case of any other sanction, this shall only be imposed with the support of a majority of those present and voting at the Council meeting where the statement is considered.

12.10.11 If the relevant threshold as set out in paragraph 10.10 is not reached for the purposes of imposing a sanction, no further action shall be taken against the NED or the Chair under this procedure in relation to that complaint.

12.10.12 The NED or the Chair shall be notified of the Council's decision by the Lead Governor in writing usually within ten (10) working days of the decision. Where a sanction is proposed, the NED or the Chair shall be asked to acknowledge in writing receipt of the sanction within ten (10) working days, although any failure to do so on the NED or the Chair part will not affect the imposition of the sanction, which will take effect regardless from the date of the letter confirming the Council's decision.

12.10.13 If the imposed sanction is removal from office, the NED or the Chair will be required to return all Trust property (ID badge, parking permit, papers etc.) to the Company Secretary immediately.

12.10.14 If the NED or the Chair was suspended at any time during the process under paragraph 5.3, then the suspension is concluded when the outcome and any sanction is communicated to the NED or the Chair under paragraph 12.10.13.

12.11 Appeal

12.11.1 The NED or the Chair has the right to appeal the decision reached by the CoG Investigation Panel, not the findings but the process taken to reach those findings. An appeal must be raised in writing.

12.11.2 An appeal must be lodged within ten (10) working days of receipt of the outcome letter. The NED or the Chair should state in full their grounds of appeal.

12.11.3 Appeals should be sent to the Associate Director of Corporate Governance and an independent external Lead Governor will be appointed.

12.11.4 Appeal hearings will normally be set up within 15 working days of receipt of the appeal letter.

12.11.5 It is the responsibility of the NED or the Chair to state their case for appeal. The Associate Director of Corporate Governance will have available to them the original hearing information and any further information submitted by the NED or the Chair in advance of the appeal hearing.

12.11.6 The decision may be given on the day or may be deferred for further consideration in which case the NED or the Chair will usually be written to within 7 working days of the hearing with the details of the decision reached. The outcome will also be presented to the Council of Governors, usually within 7 working days of the hearing.

12.11.7 The Complainant will be notified in writing of the completion of the process.

12.11.8 The outcome is final and there is no further right of appeal.

12.12 Communications

12.12.1 If a NED or the Chair is removed, a communications plan will be produced the Chief Executive/Associate Director of Corporate Governance.

12.13 Process for Monitoring Compliance with and Effectiveness of the Procedure

12.13.1 Frequency
Each time the Procedure is used, the internal auditors will audit compliance to ensure that this Procedure has been adhered to and a formal report will be written and presented to the Council of Governors.

12.13.2 Dissemination of Results
At the next Council of Governors meeting.

Appendix 1

CODE OF CONDUCT FOR BOARD OF DIRECTORS

INTRODUCTION

High standards of corporate and personal conduct are an essential component of public service. The purpose of this code is to provide clear guidance of the standards of conduct and behaviour expected of all directors.

This code of conduct applies to all voting members of the trust board, namely the chair, non-executive and executive directors and other directors who participate in Board meetings. These are all referred to as directors.

This code, together with the Trust constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the trust. The code is designed to operate in conjunction with the NHS Improvement code of governance, the trust's constitution and standing orders and other relevant codes of practice.

This code is complementary to the trust's values:

Our values are our guide to how we treat ourselves, one another, our service users, families and
carers, and our partners.

Our values were developed by listening to feedback about what people wanted to see
and experience when working for us, with us or accessing our services.

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

Our values will only make a difference when we each let them guide our own thoughts, feelings, decisions, attitudes and actions.

The more we demonstrate our values through our work, the more likely others are to experience our values when working with us.

Our everyday and detailed behaviours describe what our values look like in practice. They give us a shared language to help bridge the wide range of specialties and roles in our Trust.

Compassionate

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

Inclusive

● Treating people fairly, with dignity and respect.
● Challenging all forms of discrimination.
● Valuing all voices so we all feel we belong.

Committed

● Striving to deliver the best work and keeping service users at the heart.
● Taking responsibility for our work and doing what we say we will.
● Courage to question to help us learn, improve and grow together.

Directors are responsible for complying with the provisions of this code whenever they conduct business of the trust or act as its representative.

PRINCIPLES OF PUBLIC LIFE AND PUBLIC SERVICE VALUES

In 1995, the Committee on Standards in Public Life (the Nolan Committee) identified three public service values and seven principles of conduct underpinning public life “for the benefit of those who serve the public in any way”.

The Trust recognises the Seven Principles:

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for doing so.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

> Directors should promote and support these principles by leadership and example.

GENERAL PRINCIPLES

Public sector values matter in the trust and directors have a duty to conduct trust business with probity. They have a responsibility to respond to staff, patients and their families, and other stakeholders impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this code depends on a vigorous and visible example from the trust board and the consequential behaviour of all those who work within the organisation.
The Board therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct.

The Board will lead in ensuring that the provisions of the NHS constitution, the standing orders, financial standing instructions and accompanying scheme of delegation, conform to best practice and serve to enhance standards of conduct. The Board expects that this code will inform and govern the decisions and conduct of all directors.

The Board has confirmed its commitment to compliance with the Bribery Act and to ensure that all staff are aware of their responsibilities in relation to the prevention of bribery and corruption and that the risk of trust exposure to acts of bribery is mitigated. Directors must ensure that they are aware of the implications of the Bribery Act 2010, and of its underpinning principles, and will support related initiatives.

PUBLIC SERVICE VALUES IN MANAGEMENT

The Board will ensure that public service values guide the organisation in achieving its results. The Board has a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda for the Board.

Accounting, tendering and employment practices will reflect the highest professional standards. Public statements and reports by the trust board will be

clear, comprehensive, understandable and balanced, and fully represent the facts. Annual and other key reports will be issued in good time to all stakeholders in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

The Board will maintain a sound system of internal control and establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with all its stakeholders.

DECLARATION OF INTEREST AND CONFLICTS OF INTEREST

Directors will act impartially and will not be influenced by social, family or business relationships. They will not use their public position to further their private interest.

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity. Directors must make a declaration of interests in accordance with the trust's conflicts of interests policy on appointment, as changes arise and annually.
These will be formally recorded in the minutes of the trust board and entered into a register, which is published on the trust's website. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

If directors acquire any relevant interest subsequent to their appointment, they must declare this at the next board meeting so that it is formally recorded in the minutes, and entered into the register.

Declaration of interests is a standing item at the beginning of every meeting of the trust board or its committees, to ensure that any change in interests is declared and that board or committee members declare any interest they have that is relevant to a matter on the agenda. Their subsequent participation at the meeting will be at the chair's discretion.

HOSPITALITY AND OTHER EXPENDITURE

Directors will set an example to the trust in the use of public funds and the need for good value in incurring public expenditure. All expenditure on these items should be capable of justification as reasonable in the light of general practice in the public sector.

The Board is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the organisation in the eyes of the immediate community and its wider stakeholders.

The trust has adopted a conflict of interests policy, which covers gifts and hospitality, and which will be followed at all times by directors and all employees. Directors must not accept gifts or hospitality other than in compliance with this policy and must make disclosures in accordance it. Advice on the acceptance of gifts and hospitality should be sought from the Company Secretary

The Board should also take cognisance of the trust's Fraud, Corruption and Bribery Policy and is legally bound by the Bribery Act 2010, under which it is an offence for employees to pay or receive bribes.

RELATIONS WITH SUPPLIERS

The conflict of interests policy includes provisions relating to the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation must be carefully considered, and the decision recorded. The trust board should be aware of the risks of incurring obligations to suppliers at any stage of a contracting relationship. Suppliers will be selected on the basis of quality, suitability, reliability and value for money.

FIT AND PROPER PERSON

All directors are required to comply with Care Quality Commission Regulation 5: fit and proper persons: directors. Directors must certify on appointment, and each year within the appraisal process, that they are/remain a fit and proper person. If circumstances change so that a director can no longer be regarded as a fit and proper person or if it comes to light that a director is not a fit and proper person, they are suspended from being a director with immediate effect pending confirmation and any appeal. Where it is confirmed that a director is no longer a fit and proper person, their board membership is terminated.

PERSONAL CONDUCT

Directors must conduct themselves in a manner which maintains the integrity of the organisation and its standing in the NHS and the wider community.

Specifically directors must: act in the best interests of the trust and adhere to its values and this code of conduct;

- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the board in order for it to fulfil its role and functions;
- recognise that the board is collectively responsible for the exercise of its powers and the performance of the trust;
- raise concerns and provide appropriate challenge regarding the running of the trust or a proposed action where appropriate;
- recognise the differing roles of the chair, senior independent director, chief executive, executive directors and non-executive directors;

- make every effort to attend meetings where practicable;
- adhere to good practice in respect of the conduct of meetings and respect the views of others;
- take and consider advice on issues where appropriate;
- acknowledge the responsibility of the council of governors to hold the non-executive directors individually and collectively to account for the performance of the board;
- represent the interests of the trust's members, public and partner organisations in the governance and performance of the trust; and to have regard to the views of the council of governors;
- not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person; and
- accept responsibility for their performance, learning and development.

OPENNESS AND PUBLIC RESPONSIBILITIES

The Board will make its decisions in public unless there is a justifiable and properly documented reason for not doing so.

The needs of the population that the trust serves and the resulting provision of services are subject to constant change. The trust board will be open with the public, patients and staff as the need for change emerges. Major changes will be consulted upon before decisions are reached in accordance with statute, guidelines and best practice. Clear and understandable information supporting those decisions will be made available and positive responses will be given to reasonable requests for information.

The trust will act in a socially responsible and inclusive manner. The Board will forge an open relationship with the communities it serves. The Board will actively involve staff, the Council of Governors and other key stakeholders and partners in setting out a vision for the organisation, which demonstrates concern for the wider health of the population and best use of public resources allocated to the trust. The trust will work in partnership and co-operate with local and national bodies to support the delivery of safe, high quality care.

CONFIDENTIALITY AND ACCESS TO INFORMATION

Directors must comply with the trust's confidentiality policies and procedures.

Directors must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the trust board and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation, and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act (now replaced by the General Data Protection Regulation - GDPR), the Freedom of Information Act and other relevant legislation which will be followed at all times by the trust board.

Nothing said in this code precludes directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998.

RAISING MATTERS OF CONCERN – "SPEAKING UP" OR "WHISTLE-BLOWING"

The trust board acknowledges that directors and staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The trust board has adopted a policy (speaking up policy and procedure ((incorporating whistleblowing/raising concerns policy and procedure)) which should be followed at all times by directors and all staff.

Where a director believes that a board colleague is non-compliant with all or part of this code, they should raise the matter with the chair of the board. Where the chair is the person who is alleged to have contravened the code, the concerns should be raised with the senior independent director.

The trust board will seek to ensure that NHS resources are protected from fraud, corruption and bribery and that any incident of this kind is reported to the Local Counter Fraud Specialist in line with the counter fraud policy.

EXTERNAL COMMUNICATIONS

The trust has a guideline for communicating with the media. Directors will be familiar with, and abide by, this policy. All press enquiries must be referred to the communications team.

When speaking as a director of the board, whether in a public forum or in a private or informal discussion, directors should ensure that they reflect the current policies or view of the trust. They should do so only with the prior knowledge and approval of the Communications Team. Where this is not practicable, they should report their action to the communications team as soon as possible. Comments should be well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of the trust.

COMPLIANCE

Directors must satisfy themselves that the actions of the board and its members in conducting business fully reflect the values in this code and, as far as is reasonably practicable, that concerns expressed by staff and others are fully investigated and acted upon. All directors are required, on appointment, to subscribe to the code of conduct.

The chair and non-executive directors of the board are responsible for taking firm, prompt and fair disciplinary action against any executive or other director in breach of the code of conduct.

The corporate nature of the organisation will mean that, in most cases, if a decision is open to criticism individual directors will not be legally liable due to the specific statutory protections where they are acting in good faith. However directors who commit a criminal offence will carry personal responsibility for any liability.

Directors will be cognisant of their responsibilities and appropriate conduct relating to equality and human rights and the related legislation. Non-executive directors have a key role in applying proper scrutiny to equality and human rights in NHS organisations.

CODE OF CONDUCT TRUST BOARD MEMBERS DECLARATION

I (full name)…………………………………………………………………..have read, understood and agree to comply with BSMHFT code of conduct for trust board members.

Signature …………………………………………………….

Date …………………………………………………….

Please return this completed, signed form to:
Associate Director of Corporate Governance

ANNEX 9 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COMMISSIONING COMMITTEE

(Paragraph 25)

Birmingham and Solihull Mental Health NHS Foundation Trust

Standing Orders for the Practice and Procedure of
The Commissioning Committee

FOREWORD

Trust Boards have a responsibility to agree Standing Orders and Schedules of Reservation of Powers and Delegation of Powers to their boards.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfill the dual role of protecting the Trust's interests by ensuring, for example, all transactions maximize the benefit to the Trust and protecting staff from possible accusations that they have acted less than properly. This is provided that staff have followed the correct procedures outlined in the relevant document.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All Board directors and all staff should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions to the extent required for the proper conduct of their duties.

These Standing Orders relate to the business of the Commissioning Committee ("**CoCo**"), which is a new governance forum to enable discharge of the Trust's Lead Provider responsibilities.

The CoCo is a decision-taking forum. The CoCo is the 'Board in Committee', i.e., its membership comprises all Non-Executive and Executive Directors of the Foundation Trust. It is the controlling mind of the Trust's commissioning arm, i.e., those Provider Collaborative arrangements for which it is Lead Provider.

These Standing Orders should be read in conjunction with the Standing Orders for the Board of Directors, i.e., Annex 8 of the Trust's Constitution. As the Board in Committee, the Commissioning Committee is bound by many of same Standing Orders as are expressed in Annex 8.

These are not repeated in these Standing Orders, but still apply in full, to wit:

Standing Order 1	Interpretation
Standing Order 2	The Trust
Standing Order 6	Declarations of Interests and Register of Interests
Standing Order 7	Exclusion of Chair and Directors in Proceedings on Account of Pecuniary Interest
Standing Order 8	Standards of Business Conduct Policy
Standing Order 9	Tendering and Contract Procedure
Standing Order 10	Custody of Seal and Sealing of Documents
Standing Order 11	Signature of Documents
Standing Order 12	Process for the Receipt of Complaints/Breach of Code of Conduct against Chair/Non-Executive Director
Appendix 1	Code of Conduct for Board of Directors

1. MEETINGS OF THE COMMISSIONING COMMITTEE

1.1 Admission of the Public and the Press – The commercial and contractual nature of the proceedings of the CoCo dictate that all meetings of the CoCo are Part II, i.e., private discussions. This means that the public and press are excluded from all meetings.

Confidentiality

1.2 Matters to be dealt with by the CoCo shall be confidential to the members of the CoCo and to any other officer in attendance.

1.3 Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of any papers or discussion.

Calling Meetings

1.4 Ordinary meetings of the CoCo shall be held at such times and places as members of the CoCo may determine.

1.5 The Chair of the Trust may call a meeting of the CoCo at any time. If the Chair refuses to call a meeting after a requisition, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, such one third or more Directors may immediately call a meeting.

Notice of Meetings

1.6 Before each meeting of the CoCo, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every Director, at least three clear days before the meeting.

1.7 Want of service of the notice on any Director shall not affect the validity of a meeting.

1.8 In the case of a meeting called by Directors in default of the Chair, no business shall be transacted at the meeting other than that specified in the notice or emergency motions allowed under these Standing Orders. Failure to deliver such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

1.9 Agendas and supporting papers will wherever possible be sent to Directors at least five clear working days before the meeting.

Setting the Agenda

1.10 The CoCo may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or

following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

1.11 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 clear days before the meeting. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

Chair of Meeting

1.12 At any meeting of the CoCo, the Chair of the Board of Directors, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Deputy Chair are absent such Director (who is not also an officer of the Trust) as the Directors present shall choose shall preside.

1.13 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the Directors present shall choose shall preside. If any matter for consideration at a meeting of the CoCo relates to the interests of the Chair or to the interests of the non-executive Directors as a class, neither the Chair nor any of the other non-executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair or the other non-executive Directors) shall elect one of their number to preside during that period and that person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

Notices of Motion

1.14 A Director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations.

Withdrawal of Motion or Amendments

1.15 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

Motion to Rescind a Resolution

1.16 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the CoCo, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within 6 months; however, the Chair may do so if they consider it appropriate.

Motions

1.17 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

1.18 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)
- A motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

Chair's Ruling

1.19 Statements of Directors made at meetings of the CoCo shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters shall be final.

Voting

1.20 Every question put to a vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have the casting vote.

1.21 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

1.22 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

1.23 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

1.24 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

1.25 An officer who has been appointed formally by the Trust to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be an executive director.

1.26 An officer attending the CoCo to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

Minutes

1.27 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

1.28 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Suspension of Standing Orders

1.29 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

1.30 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

1.31 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

1.32 No formal business may be transacted while Standing Orders are suspended.

1.33 The Audit Committee shall review every decision to suspend Standing Orders.

Waiver of Standing Orders

1.34 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

1.35 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.

1.36 The Audit Committee shall review every decision to waive Standing Orders.

Approval, Variation, and Amendment of Standing Orders

1.37 These Standing Orders shall be approved and amended only if:

- a notice of motion has been given; and
- at least half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Directors are present; and
- the variation proposed does not contravene any provision of the Regulatory Framework.

Record of Attendance

1.38 The names of the Directors present at the meeting shall be recorded in the minutes.

Quorum

1.39 No business shall be transacted at a meeting of the CoCo unless at least one half of the whole number of the Directors appointed (including at least one non-executive director and one executive director) are present.

1.40 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

1.41 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee). The above requirement for at least one non-executive Director to form part of the quorum shall not apply where the non-executive Directors are excluded from a meeting.

Adjournment of Meetings

1.42 The CoCo may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included on the agenda of the meeting of which it is an adjournment.

1.43 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

Observers at CoCo meetings

1.44 The CoCo will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the CoCo meetings and may change, alter, or vary these terms and conditions as it deems fit.

2. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

2.1 Subject to the Regulatory Framework, the CoCo may make arrangements for the exercise, on behalf of the CoCo, of any of its functions subject to such restrictions and conditions as the CoCo thinks fit by a sub-committee appointed or by a Director or an officer of the Trust.

Emergency Powers

2.2 The powers which the CoCo has retained to itself within these Standing Orders and the Standing Orders for the Board of Directors, in so much as those may apply, may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the CoCo for the record.

Delegation to Sub-Committees

2.3 The CoCo shall agree from time to time to the delegation of executive powers to be exercised by sub-committees, which it has formally constituted. The constitution and terms of reference of these sub-committees and their specific decision-making and financial powers shall be approved by the CoCo.

2.4 Those functions of the Trust which have not been retained as reserved by the CoCo or delegated to a sub-committee or otherwise for the purposes of and in accordance with the Mental Health Act 1983 shall be exercised by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the CoCo.

2.5 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the CoCo and Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the CoCo and Board of Directors.

2.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the CoCo of the Director of Finance or other executive

Director to provide information and advise the CoCo in accordance with the Constitution, Terms of Authorisation, any statutory requirements or provisions required by NHSEI. Outside these statutory requirements the role of the Director of Finance shall be accountable to the Chief Executive for operational matters.

2.7 The arrangements made by the Board of Directors as set out in the Scheme of Delegation document shall have effect as if incorporated in these Standing Orders.

Overriding Standing Orders

2.8 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the CoCo for action or ratification. All Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3. SUB-COMMITTEES

3.1 The CoCo may appoint sub-committees. The CoCo shall determine the membership and terms of reference of sub-committees and shall if it requires to, receive and consider reports of such sub-committees subject to contractual arrangements and such restrictions and conditions as the CoCo thinks fit to ensure appropriate oversight.

3.2 A sub-committee appointed under this regulation may, subject to their terms of reference, appoint Task and Finish Groups consisting wholly of members of the sub-committee.

2.3 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any sub-committees established by the CoCo. In which case the term “Chair” is to be read as a reference to the Chair of the sub-committee as the context permits, and the term “Director” is to be read as a reference to a member of the sub-committee also as the context permits. There is no requirement to hold meetings of sub-committees, established by the CoCo in public.

3.4 Each such sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the CoCo) as the CoCo shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

3.5 Where sub-committees are authorised to establish Task and Finish Groups they may not delegate executive powers to those groups unless expressly authorised by the CoCo.

3.6 The CoCo shall approve the appointments to each of the sub-committees which it has formally constituted. The Chair of each CoCo sub-committee shall be an Executive Director.

3.7 The sub-committees established by the CoCo shall include a separate sub-committee for each Provider Collaborative for which the Trust holds Lead Provider responsibility.

3.8 The CoCo may elect to change or add to the sub-committees of the CoCo, as necessary, without requirement to amend these Standing Orders.

Confidentiality

3.9 A member of a sub- committee shall not disclose a matter dealt with by, or brought before, the sub-committee.

3.10 A member of a sub-committee shall not disclose any matter reported to the CoCo or otherwise dealt with by the sub-committee, notwithstanding that the matter has been reported or action has been concluded. All issues discussed by the CoCo and its sub-committees shall be deemed commercial in confidence.

ANNEX 10 – FURTHER PROVISIONS

1.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

1.1.1 acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

1.1.2 summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

1.1.3 keeping the register of members and other registers and books required by this constitution to be kept;

1.1.4 having charge of the Trust's seal;

1.1.5 publishing to members in an appropriate form information which they should have about the Trust's affairs;

1.1.6 preparing and sending to the Independent Regulator and any other statutory body all returns which are required to be made.

1.2 Minutes of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Secretary. Minutes of meetings will be read at the next meeting and signed by the Chair of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

1.3 The Company Secretary is to be appointed and removed by the Board as a body or the Chair acting on the recommendations of the Board. The Company Secretary will be accountable to the Chair and the Associate Director of Corporate Governance for professional development and supervision.

2. The Company Secretary (if any) and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, including (but not limited to) any liability arising by reason of the Trust acting as a Corporate Trustee, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks and may participate in risk pooling schemes, including (but not limited to) insurance and schemes operated by the NHS Resolution. Any costs arising in this way will be met by the Trust.

3. No proposal to the amendment of this Constitution will be reported to NHSEI unless it has been approved by the Board of Directors and a majority of those governors present and voting at a meeting of the Council of Governors

4. The validity of any act of the Trust is not affected by any vacancy among the directors or the governors or by any defect in the appointment of any director or governor.

4.1 If:

(a) an executive director is temporarily unable to perform his/her duties due to illness or some other reason (the "Absent Director"); and

(b) the board of directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and

(c) the board of directors agree that the duties of the Absent Director need to be carried out;

then the Chair (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

4.2 For the purposes of paragraph 4.1 of this Annex, the maximum number of directors that may be appointed under paragraph 19.2.3 of the Constitution shall be relaxed accordingly.

4.3 The acting director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint him under this paragraph notifies him that he/she is no longer to act as an acting director.

4.4 The acting director shall be an Executive Director for the purposes of the 2006 Act. He shall be responsible for his/her own acts and defaults and he/she shall not be deemed to be the agent of the Absent Director.

5 If:

(a) an executive director post is vacant ("Vacant Position"); and

(b) the board of directors agree that the Vacant Position needs to be filled by an interim postholder pending appointment of a permanent postholder, then the Chair (if the Vacant Position is the Chief Executive) or the Chief Executive (in any other case) may appoint a director as an interim director ("Interim Director") to fill the Vacant Position pending appointment of a permanent postholder.

5.1 The Interim Director will vacate office on the appointment of a permanent postholder or, if earlier, the date on which the persons entitled to appoint him under this paragraph notifies him that he/she is no longer to act as an Interim Director.

5.2 The Interim Director shall be an Executive Director for the purposes of the 2006 Act.

6. When a vacancy arises for one or more elected governors, the Council of Governors shall have the option to take from the list of members who stood for election at the most recent election of governors for the class or constituency in question whichever member who was not elected as a

governor at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the trust, shall be available to the Governors on 2 occasions within 12 months of the previous election. Governors appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of governors and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Governor whose cessation of office gave rise to the vacancy.

7. The Trust may confer on senior staff the title “Director” as an indication of their corporate responsibility within the Trust but such persons will not be Directors of the Trust for the purposes of the 2006 Act (“statutory directors”) unless their title includes the title “Chief”, “Executive” or “Non-Executive Director” or “Chairman” and will not have the voting rights of statutory directors or any power to bind the Trust.

8. Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer acting in good faith on the basis of such error.

9. Notwithstanding any provision of the Election Rules, the Trust and the Returning Officer shall:

9.1 not be obliged to send any information or photographs unless received by the Trust from the candidate;

9.2 not be in breach of any obligation to include in any communication, or otherwise provide, information which is equivalent in size and content for all candidates if the information provided by one or more of the candidates does not so allow;

9.3 have the right to edit or not publish any election statement if it exceeds the permitted number of words or because it contains statements which the Trust or the Returning Officer reasonably believes are factually inaccurate, offensive or libelous.

10. The minimum age for membership of the Trust is 12 years old.

11. Management of disputes between the Board and the Council of Governors

In terms of dealing with any disagreements, if at any point the Council of Governors has any concerns about engagement with the Board of Directors, they should raise these in the first instance with the Chair of the Trust. The Council of Governors may require any director to attend a Council of Governors meeting, although this would normally be discussed in the first instance with the Lead Governor, Senior Independent Director and Chair. In exceptional circumstances, NHS Impact has established a panel for the advising of governors. Questions raised to this panel by the governors will only be addressed if it relates to whether a Trust has failed or is failing to act in

accordance with its constitution or to act in accordance with Chapter 5 of the NHS Act 2006. Prior to referring a question to the panel more than half of the members of the Council of Governors voting must approve the referral and the panel will required evidence of this voting process prior to considering a question.

ANNEX 11 – NOLAN PRINCIPLES AND TRUST VALUES

PART A – NOLAN PRINCIPLES (ref Standards of Business Conduct Policy, NHS England, v4.1, 28 March 2019, p20)

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for doing so.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

PART B – TRUST VALUES

All members of the Trust must role model the Trust values:

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

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

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

Birmingham & Solihull Mental Health NHS Foundation Trust

Reservation of Powers to The Board and The Commissioning Committee and Delegation of Powers

Prepared: May 2023
Trust Board Approval: 3rd May 2023
Next Review: May 2024
Responsible Officer: Executive Director of Finance

Version Control

This document has been updated to reflect the Trust's responsibilities as a Lead Provider and Commissioner.

It is now in Three Parts.

Part 1: All Trust Activities

Section 2	Reservation of Powers to the Commissioning Committee – new Section
Section 3	Delegation of Powers to the Board - previously Section 2
Section 4	Delegation of Powers to the Commissioning Committee – new Section
Section 5	Scheme of Delegation – previously Section 3
Section 6	Scheme of Delegation Implied By: The Constitution - previously Section 4
Section 7	Part 1 - All Trust Activities – Scheme of Delegation Implied By: Standing Financial Instructions – previously Section 4

Part 2: As a Provider

Section 8	Part 2 – Providers – Scheme of Delegation Implied By: Standing Financial Instructions – previously within Section 4

Part 3: As a Commissioner

Section 9	Part 3 - Commissioner – Scheme of Delegation Implied By: Standing Financial Instructions – new Section

This is an entirely new section that incorporates documents generated from the ICB's SFIs.

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INTRODUCTION

The Constitution states that subject to such directions as may be given by the Secretary of State, the Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee or by the Chair or a director or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit. The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to provide a framework of how those powers may be reserved to the Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions even those delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Should any difficulties arise regarding the interpretation or application of the Scheme of Delegation then the advice of the Executive Director of Finance, MUST BE SOUGHT BEFORE ACTING.

A. Role of the Accountable Officer

All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Accountable Officer. The Accountable Officer shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally, and which functions have been delegated to other directors and officers.

B. Caution over the Use of Delegated Powers

Powers are delegated to individuals on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

D. Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a post holder to whom powers have been delegated those powers shall be exercised by the person nominated by the post holder to act in that capacity.

1. RESERVATION OF POWERS TO THE BOARD

1.1 Annex 8 of the Constitution provides the Standing Orders for the Practice and Procedure of the Board of Directors. The Constitution states that "*The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the document entitled 'Reservation of Powers to the Board of Directors and Scheme of Delegation' and shall have effect as if incorporated in the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in that document also".*

Section 4 of Annex 8 provides detail on areas of delegation. Section 4 of the 'Reservation of Powers' [this document], provides section references back to the constitution, this covers:

- Interpretation of Standing Orders
- Chairing and calling of meetings of the Board
- Register of Interests
- Management of contracts
- Keeping and use of the seal
- Approval and signature of legal documents and deeds
- Arrangements for making contracts
- Requirement for staff to be aware of their responsibilities in respect of SFIs and the Constitution
- Tendering and contract procedure

Those matters reserved to the Board are set out in paragraphs 1.2.1 to 1.2.9 below:

1.2 Matters reserved to the Board

1.2.1 Approval of The Constitution, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business and scheme of delegation of powers from the Board to officers and powers reserved for the Council of Governors (as laid out in Annex 7 of the Constitution).

1.2.2 Reference to arrangements for Chairing the Board in the absence of the Chair.

1.2.3 Appointment of the Senior Independent Director.

1.2.4 Role of the Directors in functioning as a corporate decision making body.

1.2.5 Arrangements for calling meetings, notice of meetings and arranging for holding private sessions of the Board.

1.2.6 Arrangements for suspending, waiving, varying or overriding standing orders.

1.2.7 Determining arrangements for the creation of Board Sub Committees and for any delegation, and creation and approval of their Terms of Reference

1.2.8 Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

1.2.9 Arrangements for the exclusion of Chair or Directors on account of pecuniary interests.

1.2.10 Arrangements for the custody and use of the seal and sealing of documents.

1.2.11 Reviewing arrangements for the Standing Orders, Standing Financial Instructions, and the Scheme of Delegation.

2. RESERVATION OF POWERS TO THE COMMISSIONING COMMITTEE

2.1 Annex X of the Constitution provides the Standing Orders for the Practice and Procedure of the Commissioning Committee. The Constitution states that "*The Commissioning Committee has resolved that certain powers and decisions may only be exercised by the Commissioning Committee in formal session. These powers and decisions are set out in the document entitled 'Reservation of Powers to the Board of Directors and Commissioning Committee Scheme of Delegation' and shall have effect as if incorporated in the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in that document also".*

2.2 **Matters reserved to the Commissioning Committee**

2.2.1 Approval of Commissioning Framework, Contracting Framework, Commissioning Budgets.

2.2.2 Reference to arrangements for Chairing the Commissioning Committee in the absence of the Chair.

2.2.3 Arrangements for calling meetings and notice of meetings of the Commissioning Committee.

2.2.4 Determining arrangements for the creation of Sub-Committees and for any delegation, and creation and approval of their Terms of Reference.

2.2.5 Arrangements for the exclusion of Chair or Directors on account of pecuniary interests.

3. DELEGATION OF POWERS TO THE BOARD

3.1 **Delegation to Committees**

The Board may determine that certain of its powers shall be exercised by Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account NHS Improvement requirements. The Board shall determine the reporting requirements in respect of these committees. Committees may not delegate to sub-committees unless expressly authorised by the Board.

4. DELEGATION OF POWERS TO THE COMMISSIONING COMMITTEE

4.1 Delegation to Sub-Committees

The Commissioning Committee may determine that certain of its powers shall be exercised by the Reach Out Sub-Committee, the Mental Health Provider Collaborative Executive Steering Group and any appropriate Governance Forums for other Provider Collaboratives that may emerge.

4.2 The composition and terms of reference of such sub-committees shall be that determined by the Commissioning Committee from time to time taking into account statutory and contractual requirements. The Commissioning Committee shall determine the reporting requirements in respect of these sub-committees. Sub-committees may not delegate to the Executive Steering Group unless expressly authorised by the Commissioning Committee.

5. SCHEME OF DELEGATION

5.1 Standing Financial Instructions set out in some detail the financial responsibilities of the Accountable Officer, the Executive Director of Finance (EDoF), the Executive Director of Strategy, People and Partnership (EDoSPP) and other directors. These responsibilities are summarised below.

Matters needing to be covered in the scheme of delegation not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of Responsibility	Overall Responsibility
Data Protection Act Requirements	Accountable Officer
Health & Safety Arrangements	Accountable Officer
Fire Safety	Accountable Officer

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs.

Summary of Abbreviations:

AO	**Accountable Officer**
CEO	**Chief Executive Officer**
EDoF	**Executive Director of Finance**
EDoSPP	**Executive Director of Strategy, People & Partnerships**
EDoQS	**Executive Director of Quality & Safety (Chief Nurse)**
ADEF	**Associate Director of Estates & Facilities**
DDoF	**Deputy Director of Finance**
DDoCT	**Deputy Director of Commissioning & Transformation**
FPP	**Finance, Performance and Productivity Committee**

6. SCHEME OF DELEGATION IMPLIED BY: THE CONSTITUTION

SO Ref	Delegated To	Duties Delegated
1.1	Chair	Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Company Secretary)
3.2 &3.5	Chair	Responsibility reserved to the Chair in calling meetings. If the Chair refuses to do so and at least one third of the whole number of Directors wishes for a meeting to take place, they may do so after a set period of time has elapsed.
3.24	Chair	Determining arrangements for Board meetings
6	Company Secretary	Register(s) of interests.
4.5	CEO	Preparation of the scheme of delegation to officers (for approval by the Board)
10	Company Secretary	Custody of the seal and sealing of documents
11.1	CEO	Approve and sign all documents which will be necessary in legal proceedings
11.1	CEO or Nominated Officers	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
12.1	CEO	Existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs.
9	CEO	The procedure for making all contracts by on behalf of the Trust shall comply with the Regulatory Framework; these standing orders (except where waived or suspended, and the Trust SFI''s. Such contracts involving charitable funds shall comply with the requirements of the Charities Act and the Trust Deed.

7. PART 1 - ALL TRUST ACTIVITIES - SCHEME OF DELEGATION IMPLIED BY: STANDING FINANCIAL INSTRUCTIONS

SFI Ref	Delegated To	Duties Delegated
(I) 1.3.6	EDoF	Responsible for: Implementing the Trust's financial policies and coordinating corrective action; Ensuring detailed financial procedures and systems are prepared and documented; Ensuring financial records are maintained in order to disclose the Trust's financial position
(I) 1.3.7	All Directors & Employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to the requirements of NHS Improvement, the Terms of Authorisation, The Constitution, Financial Instructions and financial procedures.
(I) 1.3.10	CEO	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
(I) 1.3.13	EDoF	Periodical ad hoc additions to SFI's by "Financial Items".
(I) 2.1.1	Audit Committee	Provide independent and objective view on internal control and clinical governance arrangements.
(I) 2.2	EDoF	Carry out work to counter fraud and corruption.
(I) 2.2	EDoF	Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption.
(I) 2.4	Head of Internal Audit	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
(I) 2.5	Audit Committee	Ensure cost-effective external audit.
(I) 3	EDoF EDoF CEO	Submit budgets. Monitor performance against budget. Submit to Board financial estimates and forecasts. Delegate budget to budget holders
(I) 3.2	a.) Budget manager b.) Senior budget manager/holder c.) Budget holder d.) EDoF and CEO	Management of Budgets Responsibility of keeping expenditure within budgets a.) At individual budget level (pay and non-pay) b.) At service level c.) For the totality of services covered by service delivery manager or functional director d.) Approving expenditure-tender price over £50,000 or where no funding exists
(I) 3.3	EDoF	Devise and maintain systems of budgetary control.

(I) 4	CEO	Prepare Annual accounts and reports.
(I) 5	EDoF	Banking arrangements.
(I) 6.3	EDoF	Appropriate recovery action on outstanding debts
(I) 8.3	Remuneration Committee	Report in writing to the Board its advice and its bases about remuneration, terms of service and termination of directors and senior employees' contracts as defined in the terms of reference.
(I) 8.4	EDoF	Processing of payroll
(II) 3.1 and (III) 3.1	CEO	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
(II) 3.2.3 and (III) 3.2.3	EDoF	Prompt payment of accounts.
(II) 3.3.1 and (III) 3.3.1	EDoF / DDoF	Ensure there are robust arrangements for control of expenditure through purchase cards
(I) 9.1	EDoF	Application for loan or overdraft facility or use of working capital facility
(I) 9.1.4	Board	Agreement of long term borrowing plans
(I) 9.2.1	EDoF or DDoF	Authorisation of Public Dividend Capital
(I) 9.3	EDoF	Formulation of the treasury management policy
(I) 10	ADEF EDoF	a.) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations b.) Financial monitoring and reporting on all capital scheme expenditure
(I) 10.1.1	CEO	Capital Schemes a.) Ensure that there is an appraisal and approval process for capital expenditure b.) Management of schemes to deliver on time and to budget c.) Ensure that capital investment does not exceed available resources, including revenue consequences
(II) 5	EDoF	Investment of funds
(I) 11.1	EDoF	Maintenance of asset registers and asset control procedures
(I) 11.2	CEO	Overall responsibility for fixed assets, although all employees have a responsibility to ensure that assets are securely maintained

(I) 11.2	All Senior Staff	Responsibility for security of Trust assets including notifying discrepancies to EDoF, and reporting losses in accordance with Trust procedure.
(I) 12	EDoF a.) All employees b.) EDoF & Local Counter Fraud Specialist	Responsible for systems of control over stores and receipt of goods a.) Where a criminal offence is suspected ➢ Criminal offence of a violent nature ➢ Other b.) Where a fraud is suspected
(I) 13.2	EDoF All employees	Prepare procedures for recording and accounting for losses and special payments and informing the local counter fraud specialist of all frauds and informing police in cases of suspected arson or theft. a.) Notification of losses of cash Up to £25,000 – notify EDoF Over £25,000 – notify Audit Committee b.) Fruitless payments and constructive losses Up to £25,000 – notify EDoF Over £25,000 – notify Audit Committee c.) Damage or loss of buildings, fittings, furniture and equipment Up to £5,000 – notify DDoF £5,000 - £25,000 – notify EDoF Over £25,000 – notify Audit Committee
(II) 4 and (III) 4	EDoF EDoF EDoF IAOs	Responsible for the accuracy and security of the computerised financial data of the Trust Fulfilling the role of SIRO Identification of Information Asset Owners (IAOs) for all information asset systems Identification of Information Asset Administrators (IAAs)
(I) 14	EDoF & Service Directors	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
(II) 5	EDoF	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee).
(II) 6 and (III) 5	CEO	Retention of document procedures

(II) 7 and (III) 6	CEO & EDoF EDoF	Risk management programme Insurance arrangements
(I) 15	All Directors, Clinicians, Managers and other staff	Responsible for ensuring highest possible standards of business conduct are maintained at all times and that no action brings the Trust into disrepute.
(I) 15.18	Company secretary	The keeping of a Declaration of Interests Register

SFI Ref	Delegated To	Powers Delegated
(I) 6		Healthcare and operating income contracts
	a.) CEO and EDoF	a.) Agreement of main healthcare contracts
	b.) CEO or EDoF	b.) Healthcare contract variations
(I) 6.2	EDoF or nominated deputy	Setting of fees and charges
		a.) Private patient, income generation and other patient related services
		b.) Price of NHS Contracts
		Charges for all NHS Contracts, be they block, cost per case, cost and volume. Spare capacity
(I) 7		Petty cash disbursements (not applicable to central cashiers office)
	Cashier	Expenditure up to £40 per item
	DDoF or nominated deputy	Expenditure between £40 and £500
	Budget manager	Reimbursement of patients monies up to £50
	Budget holder	Reimbursement of patients monies between £50 and £100
(I) 8		Pay and Personnel
	a.) Budget manager, budget holder	a.) Authority to fill funded post on the establishment with permanent staff
	b.) CEO and EDoF	b.) Authority to appoint staff to post not on the formal establishment
	c.) CEO or EDoF	c.) Additional increments – the granting of additional increments to staff within budget
	d.) EDoF	d.) Upgrading & regrading – all requests for upgrading/regrading shall be dealt with in accordance with Trust procedure
		Establishments
	e.) Budget manager, budget holder	e.) Addition to the agreed establishment with specifically allocated finance
	f.) CEO and EDoF	f.) Addition to the agreed establishment without specifically allocated finance
		Pay
	g.) Budget manager	g.) Authority to complete standing data forms effecting pay, new starters, variations & leavers
	h.) Budget manager	h.) Authority to complete and authorise positive reporting forms
	i.) Budget manager	i.) Authority to authorise overtime
	j.) Line manager	j.) Authority to authorise travel & subsistence expenses
(I) 8		Agency and locum staff

SFI Ref	Delegated To	Powers Delegated
	a.) Budget holder	a.) Non-medical consultancy staff Where aggregate commitment in any one year (or total commitment) is less than £25,000
	b.) Accountable director	b.) Where aggregate commitment in any one year is up to £50,000
	c.) CEO and EDoF	c.) Where aggregate commitment in any one year is above £50,000
	d.)	d.) Booking of Bank and Trust Locums, incl Medical Locums, Nursing and Clerical
	1.) Budget manager	1.) Up to £5,000
	2.) Budget holder	2.) Up to £25,000
	e.) Senior budget manager/budget holder	e.) Booking of Agency and Agency Locums, incl Medical Locums, Nursing and Clerical Up to £25,000
(I) 8.3	Responsible Executive Director CEO	Variation to establishment of any department provided funding is available Staff, including agency staff, appointments
(I) 8.5	EDoF	Authorise redundancy payments
(II) 3 and (III) 3		Non pay revenue and capital expenditure/requisitioning/ordering/payment of goods & services
	a.) CEO and EDoF	a.) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement
	b.) CEO and EDoF	b.) Approval of contracts exceeding 3 years in duration, regardless of value
(II) 3 and (III) 3		Agreements/licences/PFI a.) New Leases or Extensions to existing leases with a value of:
	a.1) ADEF	1.) Up to £49,999
	a.2) EDoF	2.) Between £50,000 and £249,999
	a.3) CEO	3.) Between £250,000 and £499,999
	a.4) Board	4.) Over £500,000
	b.) Board	b.) Letting of premises including granting and termination of leases
	c.) ADEF	c.) Approval of rent based on professional assessment
		d.) PFI contract variations (whole life cycle costs)
	d.1) ADEF or nominated delegate	1.) Up to £50,000

SFI Ref	Delegated To	Powers Delegated
	d.2) EDoF	2.) Between £50,000 and £249,999
	d.3) CEO	3.) Over £250,000
(I) 13.1		Disposals and Condemnations
		a.) Where items are obsolete, redundant, irreparable or cannot be repaired cost effectively
	a.1) Budget Manager	1.) With current/estimated purchase price <£50
	a.2) ADEF or nominated delegate	2.) With current/estimated purchase price >£50
	a.3) EDoF	3.) Disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)
	b.) ADEF and EDoF	b.) Disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)
(I) 13.2		a.) Bad debts and claims abandoned
	a.1) DDoF	1.) Up to £5,000
	a.2) EDoF	2.) Over £5,000
	b.) Company Secretary	b.) Compensation under legal obligation
		c.) Ex gratia payments
	c.1) Company Secretary	1.) Under £1,100
	c.2) EDoF	2.) Between £1,000 and £25,000
	c.3) CEO	3.) Over £25,000

8. PART 2 - PROVIDER - SCHEME OF DELEGATION IMPLIED BY: STANDING FINANCIAL INSTRUCTIONS

SFI Ref	Delegated To	Duties Delegated
(I) 3.2		Management of Budgets
		Responsibility of keeping expenditure within budgets
	a.) Budget holder	a.) Approving expenditure-tender price up to £25,000 where funding exists
	b.) Accountable director	b.) Approving expenditure-tender price up to £50,000 where funding exists
(I) 6		Healthcare and operating income contracts
		a.) Local SLA's for non-healthcare income
	a.1.) Budget holder and DDoF	1.) From £5,000 to £49,999
	a.2.) EDoF	2.) £50,000 to £249,999
	a.3.) CEO and EDoF	3.) £250,000 to £499,999
	a.4.) Board	4.) Over £500,000
(II) 1		Quotation, tendering & contract procedures
	a.) Budget holder	a.) Obtaining 3 written quotations for goods/services between £5,000 to £49,999
	b.) Budget holder	b.) Obtaining 4 written quotations for goods/services between £50,000 to £99,999
	c.) Budget holder	c.) Obtaining quotations using Contracts finder for all procurement exercises exceeding £25,000
		d.) Single tender and quotation dispensation:
	d.1) DDoF	1.) From £5,000 to £99,999
	d.2) CEO and EDoF	2.) £100,000 to £249,999
	d.3) Board	3.) Over £250,000
	EDoF/DDof	Invoice authorisation for agreed SLAs or Contracts
(II) 3		Non pay revenue and capital expenditure/requisitioning/ordering/payment of goods & services
		a.)
	a.1) Budget manager	1.) Stock/nonstock requisitions up to £5,000
	a.2) Budget holder	2.) Requisitions between £5,000 and £24,999

	a.3) Senior Officer a.4) EDoF or CEO	3.) Requisitions between £25,000 and £49,999 4.) Requisitions over£50,000
(I) 10.1	a.) EDoF b.) FPP c.) Board	a.) To approve business cases up to £249,999 b.) To approve business cases between £250,000 and £1,999,999 c.) To approve business cases exceeding £2,000,000

9. PART 3 - COMMISSIONER - SCHEME OF DELEGATION IMPLIED BY: STANDING FINANCIAL INSTRUCTIONS

SFI Ref	Delegated To	Duties Delegated
(I) 3.2	 a.) Budget holder/manager b.) DDoCT c.) DDoCT + DDoF + EDoQS d.) CEO + EDoF	Virements within Agreed Budgets Approval of budget virements/movements within approved revenue and capital budgets. a.) £50,000 b.) £250,000 cumulative spend c.) £500,000 cumulative spend d.) Over £500,000 cumulative spend
(I) 6	 a.) Budget Holder/Manager/Head of Services b.) Exec Director/Finance Manager c.) Finance Controller/Director of Commissioning Finance	Sales Orders and Credit Notes Approval of sales orders and credit notes to third parties for services provided or recharges made by the ICB. a.) £0 - £49,999 b.) £50,000 – £250,000 c.) Up to £2,000,000

	d.)	CFO	d.)	Over £2,000,000
(III) 1				Quotation, tendering & contract procedures
	a.)		a.)	Informal Price Testing for goods/services between £0 to £9,999
	b.)		b.)	Obtaining 3 written quotations for goods/services between £10,000 to £49,999
	c.)	Budget holder	c.)	Competitive Tendering exceeding £50,000
(I) 10.1				Approval of Business Cases
	a.)	CEO/CFO	a.)	Existing Budget - Unlimited
	b.)	CEO/CFO	b.)	Additional Investment - Up to £1,000,000
	c.)	FPC	c.)	Additional Investment – Up to £2,500,000
	d.)	Board	d.)	Over £2,500,000
	e.)	FPC	e.)	New Investment – Up to £2,500,000
	f.)	Board	f.)	New Investment – Up to £2,500,000
NEW				Approval of Business Cases for Decommissioning Delegated authority to approve business cases for decommissioning of existing services.
	a.)	CEO/CFO	a.)	Up to £1,000,000
	b)	FPC	b.)	Up to £2,500,000
	c.))	Board	c.)	Over £2,500,000
NEW				Approval of Business Cases for Disinvestment
	a.)	FPC	a.)	Up to £2,500,000
	b.)	Board	b.)	Over £2,000,000
NEW				Contract awards, signatures and variations
	a.)	Head of Contracts	a.)	Up to £2,000,000
	b.)	Associate Director of Finance/Head of Primary Care Contracts and Commissioning (Primary Care contracts)/Executive Directors/CEO/CFO – within budget	b.)	Unlimited

NEW	a.) Budget Holder /Manager/ Head of Service b.) Executive Director / Finance Manager c.) Finance Controller/ Director of Commissioning Finance d.) CEO/CFO	Purchase requisitions, purchase credit notes, invoices, non-purchase order invoices and mandate payments a.) £0 - £49,999 b.) £50,000 - £250,000 c.) Up to £2,000,000 d.) Over £2,000,000
NEW	a.) Designated staff – MH Commissioning Team b.) MH High Risk and Complex Case Panel c.) Director of Joint Commissioning	Approval of Mental Health inpatient packages and Section 117 aftercare packages Packages up to £3,500 per week a.) £0 – £3,500 b.) Up to £3,500 c.) Up to £10,000

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Standing Financial Instructions (SFIs)

April 2023

POLICY NO & CATEGORY	SFI 01	Corporate Governance
VERSION NO & DATE	6.1	May 2023
RATIFYING COMMITTEE	Board of Directors	
DATE RATIFIED	3 May 2023	
NEXT ANTICIPATED REVIEW DATE:	May 2024	
EXECUTIVE DIRECTOR	Executive Director of Finance	
POLICY LEAD	Executive Director of Finance	
POLICY AUTHOR ***(if different from above)***	Deputy Director of Finance & Head of Financial Services	
FORMULATED VIA		

Version Control

This document has been updated to reflect the Trust's responsibilities as a Lead Provider and Commissioner.

It is now in Three Parts.

Part 1: **All Trust Activities**

Section 8	Contracting for Commitment of Expenditure – removed, included in Part 2
Section 9	Contracting for Provision of Services – removed, included in Part 2
Section 11	Non-Pay Expenditure – removed, included in Part 2
Section 17	Information Technology – removed, included in Part 2
Section 19	Charitable Funds – removed, included in Part 2
Section 20	Retention of Records – removed, included in Part 2
Section 21	Risk Management and Insurance – removed, included in Part 2

Part 2: **As a Provider**

Section 8	Contracting for Commitment of Expenditure – previously Part 1
Section 9	Contracting for Provision of Services - previously Part 1
Section 11	Non-Pay Expenditure – previously Part 1
Section 17	Information Technology – previously Part 1
Section 19	Charitable Funds – previously Part 1
Section 20	Retention of Records – previously Part 1
Section 21	Risk Management and Insurance – previously Part 1
Section 23	Business Development – previously Part 1

Part 3: **As a Commissioner**

Section 8	Contracting for Commitment of Expenditure – previously Part 1
Section 9	Contracting for Provision of Services - previously Part 1
Section 11	Non-Pay Expenditure – previously Part 1
Section 17	Information Technology – previously Part 1
Section 20	Retention of Records – previously Part 1
Section 21	Risk Management and Insurance – previously Part 1
Section 23	Business Development – previously Part 1

This April 2023 version will need the sections and numbering corrected throughout prior to receipt by Audit Committee.

POLICY REQUIREMENT

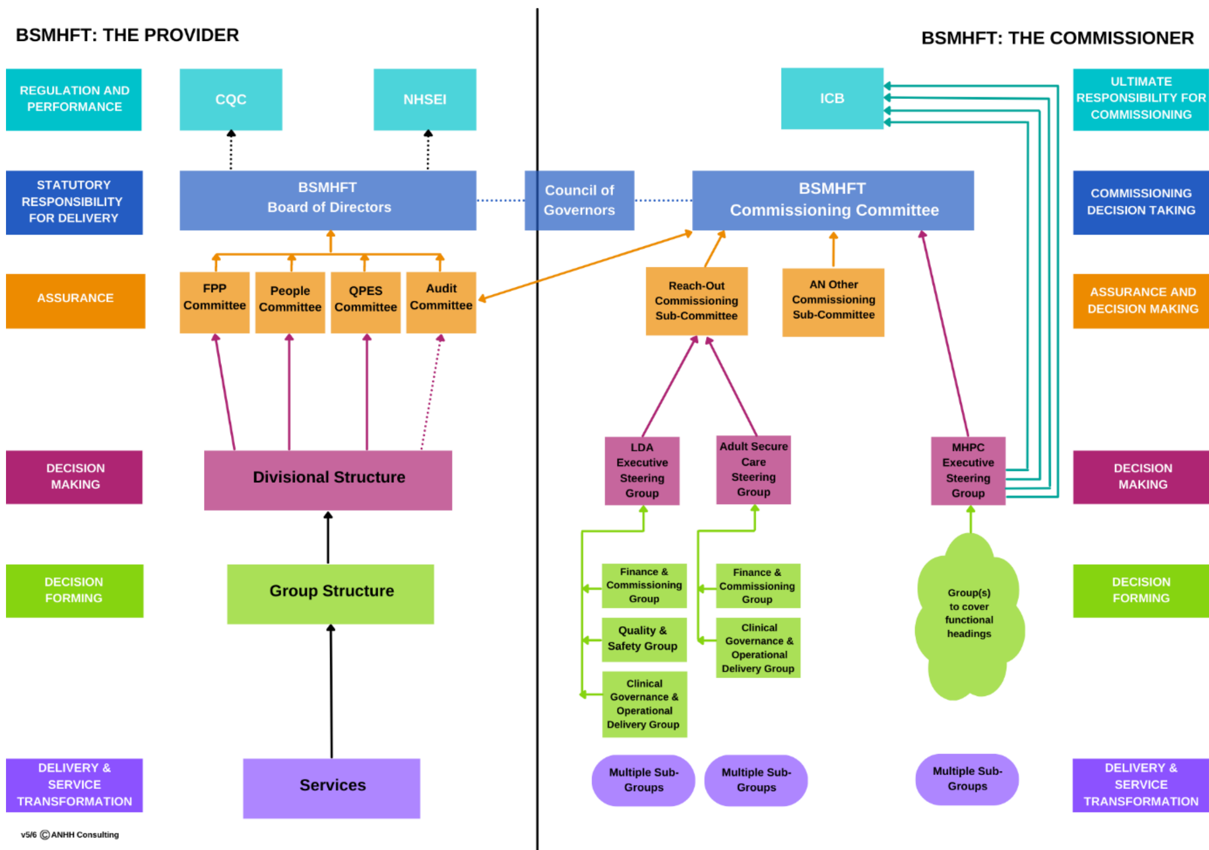
All staff are required to follow Trust Standing Financial Instructions without exception. Non-compliance with SFIs is a disciplinary matter which could result in dismissal.

FOREWORD

These Standing Financial Instructions (SFIs), set out the financial governance arrangements adopted by the Trust (including subsidiaries, the Commissioning Committee (Board in Committee – incorporating ReachOut and the MHPC), and any other Operations). They are designed to ensure that financial transactions are carried out in accordance with the law and with Government policy and the latest Code of Governance for NHS Provider Trusts (April 2023) to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board and the Commissioning Committee and Delegation of Powers (Scheme of Delegation) adopted by the Trust.

The Standing Financial Instructions have been updated (April 2023) to reflect the new Governance Architecture within the Trust.

The new architecture is shown in the diagram below. To ensure clear separation between the Trust's provider and commissioning roles, as required by legislation, a Commissioning Committee ("CoCo") has been established as the ultimate assurance and decision taking forum for commissioning and lead provider responsibilities. The CoCo will be the "Board in Committee", i.e., it will have the equivalent authority to the Board. Accordingly, the Constitution also has been amended to incorporate Standing Orders for CoCo.



The Trust will continue to have two Memoranda of Understanding with the external auditors, one for audit of SSL (the Trust's trading arm subsidiary) Accounts, and the other for consolidated Accounts

that will incorporate SSL, the Trust's provider accounts, and the Trust's lead provider accounts (currently Reach Out and the Birmingham and Solihull Mental Health Provider Collaborative).

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PART 1

(Instruments for All Trust Activities)

1 INTRODUCTION

1.1 WHY STANDING FINANCIAL INSTRUCTIONS ARE IMPORTANT

1.1.1 NHS Foundation Trusts are limited by Acts of Parliament in what they can do. These SFIs set out the financial responsibilities and policies adopted by the Trust (including subsidiaries, the Commissioning Committee ("**CoCo**") (Board in Committee – incorporating ReachOut and the MHPC, and any other Operations). They are designed to ensure that financial transactions are carried out in accordance with the law and with Government policy and the latest Code of Governance for NHS Provider Trusts (April 2023) to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board and the Commissioning Committee and Delegation of Powers (Scheme of Delegation) adopted by the Trust.

1.1.2 These SFIs are issued in accordance with the Directions of the Secretary of State under the provisions of Sections 99(3), 97(A)(4) and (7) of the National Health Service Act 1977, the Health Act 2009, Health and Care Act 2022 any other change in legislation concluding with the Health and Social Care Act 2022, for the regulation of the conduct of the Trust in relation to all financial matters. They have the same authority as the Standing Orders of the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with any detailed departmental and financial procedure notes. All financial procedures must be approved by the Executive Director of Finance. The SFI's can be found on the Trust's Intranet via the Finance Pages.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Executive Director of Finance or other nominated officers, MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust Standing Orders and Scheme of Delegation.

1.1.5 Failure to comply with SFIs is a disciplinary matter which could result in dismissal. Non-compliance with these SFIs will be monitored and will be reported regularly to the Audit Committee.

1.1.6 The key points from each section in this document have been summarised at the front of each respective section for ease of reference. However, these summaries are not a substitute for reading the whole of this document.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a) "**Trust**" means the Birmingham & Solihull Mental Health NHS Foundation Trust (including subsidiaries, the CoCo and any other Operations)
b) "**Board of Directors**" and/or "**Board**" mean the Board of Directors as constituted in accordance with the constitution of the Trust.

c) “**Commissioning Committee**” and/or “**CoCo**” mean the BSMHFT Board in Committee for all Provider Collaboratives for which the Trust has Lead Provider responsibility.
d) “**Council of Governors**” means the Council of Governors as constituted in accordance with the constitution of the Trust.
e) “**Budget**” means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
f) “**Budget Owner**” means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
g) “**Chief Executive**” means the chief officer of the Trust and the accounting officer
h) “**Executive Director of Finance**” means the Chief Financial Officer of the Trust.
i) “**Company Secretary**” means the Company Secretary of the Trust.
j) “**The Chair**” is the Chair of the Board of Directors, the Commissioning Committee (Board in Committee), and the Council of Governors.
k) “**Scheme of Delegation**” means the Reservation of Powers to the Board and Delegation of Powers adopted by the Trust.

1.2.2 Wherever the title Chief Executive, Executive Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "**employee**" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board and the CoCo exercise financial supervision and control by:

a) formulating the financial strategy
b) requiring the submission and approval of budgets within approved allocations/overall income
c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)
d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Trust’s Scheme of Delegation. This will be kept under review by the Board.

1.3.4 It is acknowledged that the Chief Executive is ultimately accountable to the Board, and as accountable officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust system of internal control.

1.3.5 The Chief Executive and Executive Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 The Executive Director of Finance is responsible for:

a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies
b) ensuring that detailed financial procedures and systems, including separation of duties and internal checks, are documented and maintained to supplement these instructions
c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time and
d) without prejudice to any other functions of directors and employees to the Trust, the duties of the Executive Director of Finance include:
    i. the provision of financial advice to the Trust, the Board, the CoCo, and Governors of the Trust, and employees
    ii. the design, implementation and supervision of systems of financial control
    iii. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All directors and employees, individually and together, are responsible for:

a) the security of the property of the Trust
b) avoiding loss
c) exercising economy and efficiency in the use of resources
d) conforming to the requirements of NHS England (July 2022), the Terms of Authorisation, Constitution, Standing Orders, SFIs, Financial Procedures and Scheme of Delegation.

1.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Executive Director of Finance.

1.3.10 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.11 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Executive Director of Finance.

1.3.12 Wherever possible and subject to the availability of establishments resources, procedures should be designed to achieve the maximum possible separation of

duties, such that one individual is not enabled to initiate, manage and complete a financial transaction or process.

1.3.13 Standing Financial Instructions will be temporarily added to as an ad hoc basis by the issue of a "Financial Items" circular within the Trust. The issue of this Circular is the responsibility of the Executive Director of Finance.

2 AUDIT

(see also Section 16.2 – re theft, arson, fraud, other losses and police involvement)

Key Points

It is the responsibility of all employees that robust controls are in operation over all financial processes. The Audit Committee will monitor the effectiveness of systems and controls.

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders, the Board has formally established an Audit Committee, with clearly defined and approved terms of reference which include overseeing the process for the appointment of the internal auditors. This Committee will provide an independent and objective view of internal control.

a) Overseeing Internal and External Audit services
b) Reviewing systems
c) Monitoring compliance with Standing Financial Instructions
d) Reviewing schedules of losses and special payments and making recommendations to the Board
e) Reviewing the policies and procedures for all work relating to fraud and corruption
f) Review of risks.

2.1.2 Where the Audit Committee feel there is evidence of ultra-vires transactions, evidence of improper acts (other than fraud and corruption), or if there are other important matters that the committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

2.2. FRAUD, BRIBERY AND CORRUPTION

2.2.1 Compliance with the Secretary of State directions on fraud and corruption is not now obligatory for Foundation Trusts but the Chief Executive and the Executive Director of Finance shall apply best practice taking into account the Secretary of State’s directions.

2.2.2 The Fraud Act 2006 details the main offences of fraud. An act of fraud can be defined as a dishonest intent to cause a financial gain for themselves, or someone else, and cause a loss, or risk of loss to another. There are three main offences; false representation; failing to disclose information; and abuse of position. The maximum penalty that can be imposed for someone who has committed fraud is ten-years’ imprisonment.

2.2.3 Corruption can be defined as dishonest, fraudulent, or illegal conduct by those in power; this can include bribery and kickbacks. The Bribery Act 2010 details the main offences for bribery in the UK. An act of bribery can be defined as the offering, giving, requesting, or accepting of a financial or other advantage in order to induce improper behaviour. Similar to fraud, the maximum penalty an individual can receive if they have committed fraud is ten years’ imprisonment. Organisations can receive an unlimited fine or reputational damage.

2.2.4 Any employee discovering or suspecting fraud or bribery must either immediately inform the Executive Director of Finance or inform the Local Counter Fraud Specialist who will then appropriately inform the Executive Director of Finance and/or Chief Executive. The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust and will attend Audit Committee meetings as required. For further information please refer to the Trust's Anti-Fraud, Bribery and Corruption Policy.

2.3 ROLE OF THE EXECUTIVE DIRECTOR OF FINANCE

2.3.1 The Executive Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function
b) managing internal audit and ensuring that the internal audit is adequate
c) deciding at what stage to involve the police in cases of misappropriation and other irregularities
d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:
    i. a clear statement on the effectiveness of internal control
    ii. major internal financial control weaknesses discovered
    iii. progress on the implementation of internal audit recommendations
    iv. progress against plan over the previous year
    v. strategic audit plan covering the coming three years
    vi. a detailed plan for the coming year.

2.3.2 The Executive Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) access at all reasonable times to any land, premises or employee of the Trust
c) the production of any cash, stores or other property of the Trust under an employee's control
d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal audit is an independent appraisal function of the Trust, designed to assist the Board and all levels of management to fulfil their corporate governance responsibilities.

2.4.2 The Internal Audit service will be subject to appropriate competitive procurement in line with these SFIs.

2.4.3 The terms of reference, the respective responsibilities of each party, the agreed services and total fee payable, together with the agreed qualitative and quantitative levels of performance shall be specified in the contract between both parties.

2.4.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise

of any function of a pecuniary nature, the Executive Director of Finance must be notified immediately.

2.4.5 The Executive Director of Finance is responsible for the appointment of Internal Auditors in line with a process as agreed with the Audit Committee and will manage the Internal Audit contract.

2.4.6 The services provided under the Contract will be planned, carried out and managed in accordance with the NHS Internal Audit Standards and Internal Audit Manual.

2.4.7 The Internal Audit Provider will retain the right to plan, perform and report audit work independently.

2.4.8 The Internal Audit Provider will liaise with the Trust's Chief Executive, Executive Director of Finance, Company Secretary and the Audit Committee when drawing up a detailed audit plan for the forthcoming year. The plan will be based on a demonstrable assessment of risk and will show what areas are to be addressed, why they should be addressed and the benefits to the organisation of each risk and area audited.

2.4.9 Internal Audit will review, appraise and report upon:

a) the effectiveness of the internal control system (financial, organisational and clinical)
b) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
c) the adequacy and application of financial and other related management controls
d) the integrity and suitability of management information and relevant and data
e) the extent to which the Trust assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    i. fraud and other offences
    ii. waste, extravagance, inefficient administration
    iii. poor value for money or other causes.

2.4.10 The Internal Audit Provider will attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.4.11 The Internal Audit Provider shall be accountable to the Executive Director of Finance. The reporting system for internal audit shall be agreed between the Executive Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the prevailing guidance. The reporting system shall be reviewed at least every three years.

2.4.12 The Head of Internal Audit will liaise with the appointed external auditor and other organisations as necessary. Internal and external audit plans should be coordinated and maximise added value to the Trust.

2.5 ROLE OF EXTERNAL AUDIT

2.5.1 The external auditor is appointed by the Council of Governors. The Audit Committee must ensure that the auditor provides a cost-efficient service. Should there appear to be a problem this should be resolved in accordance with the Audit Code for NHS Foundation Trusts.

2.5.2 The amount of fees payable other than for the statutory audit should not exceed 25% of audit fee. Assignments over £10,000 require the approval of the Audit Committee. Competitive tendering is required in line with these SFIs.

3 SERVICE AND BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

Key Points: All budgets should be set in accordance with the aims and objectives set out in the annual plan.

All budget virements should be appropriately authorised in line with the procedure set out below.

Any failure to comply with the budgetary control procedures will be reported to Audit committee and may result in disciplinary action.

3.1 PREPARATION AND APPROVAL OF SERVICE AND BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board, the CoCo, and Council of Governors an annual business plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:

a) a statement of the significant assumptions on which the plan is based.
b) details of major changes in workload, delivery of services or resources required to achieve the plan.
c) a summary Financial Plan.
d) such other requirements as may be determined by the Independent Regulator for Foundation Trusts.

3.1.2 The Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the Annual Plan
b) accord with workload and manpower plans
c) be produced following discussion with appropriate budget holders
d) be prepared within the limits of available funds; and
e) identify potential risks.

3.1.3 The Executive Director of Finance shall monitor financial performance against budget and service plan, periodically review them, and report to the Board.

3.1.4 All budget owners must provide information as required by the Executive Director of Finance to enable budgets to be compiled.

3.1.5 Service changes and developments must be financially appraised and include the FULL recovery of overheads and margin, unless agreed with the Executive Director of Finance.

3.1.6 The Executive Director of Finance has a responsibility to ensure that adequate training is delivered to all new members of staff that will have financial responsibilities before they take up their new responsibilities.

3.1.7. Budget owners are responsible for ensuring that they are adequately trained so that allocated budgets can be managed successfully. Where necessary the Executive Director of Finance will provide training to assist in budget management.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) the amount of the budget available as predetermined by the contracted service specification.
b) the purpose(s) of each budget heading.
c) individual responsibilities and group objectives.
d) authority to exercise virement/budget journal.
e) definition of planned levels of service.
f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget owners must not exceed the budgetary total or virement limits set by the Board. Confirmation from all parties must be received before budget virements will be entered into the ledger. Authorisation requirements for budget moves are detailed below:

a) Budget moves within agreed programme start points: -

i. Pay moves within report – approval must be given by team/ward manager and programme manager to ensure a consistent approach across the programme.
ii. Pay moves within programme – approval must be given by the 'giving' manager and 'receiving' manager, and overall approved by their programme manager.
iii. Non Pay moves within report – approval must be given by team/ward manager.
iv. Non Pay moves within programme – approval must be given by the 'giving' manager and 'receiving' manager.
v. Operating Income moves within report - approval must be given by team/ward manager.
vi. Operating Income moves within programme – approval must be given by the 'giving' manager and 'receiving' manager.

b) Budget moves between programmes within agreed service area start points

i. Pay, Non Pay and Operating Income budget moves between programmes – approval must be given by the 'giving' and 'receiving' managers and their programme managers.

c) Budget moves between service areas

i. Pay, Non Pay and Operating Income budget moves between divisions – approval must be given by the 'giving' and 'receiving' managers, programme managers and service directors.

d) Budget Transfers Healthcare Income.

i. All budget moves relating to Healthcare Income will need to be approved by the Deputy Director of Finance or the Executive Director of Finance.

e) Budget Transfers Reserves

i. All budget moves from reserves will need to be approved by the Deputy Director of Finance or the Executive Director of Finance.

f) **Budget Transfers Estates & Facilities**
   i. All budget moves relating to estates & facilities will need to be approved by an estates manager.

g) **Budget Transfers between Pay & Non Pay (excluding savings)**
   i. Any disputes in the transfer of budget between service areas or Directorates will be escalated to the relevant Executive Director for resolution.

3.2.3 Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after proper authorisation - i.e. by the Chief Executive, or the Chair and Chief Executive jointly, or the Board as appropriate within delegated limits.

3.2.4 Unless approved by the Chief Executive, individually or jointly with the Chair, after taking the advice of the Executive Director of Finance, budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.5 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive, or Executive Director of Finance.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Executive Director of Finance will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board and the CoCo in a form approved by the Board and the CoCo containing:
   i. income and expenditure to date and forecast year-end position.
   ii. movements in working capital; detailed balance sheet analysis including debtors and creditor movements.
   iii. Cash flow forecasts.
   iv. capital project spend and projected outturn against plan.
   v. explanations of any material variances from plan.
   vi. details of any corrective action where necessary and the Chief Executive's and/or Executive Director of Finance's view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget owner, covering the areas for which they are responsible.
c) investigation and reporting of variances from budgets.
d) monitoring of management action to correct variances.
e) arrangements for the authorisation of budget transfers.
f) adequate on-going training to budget holders and budget managers to help them manage successfully.

3.3.2 Each Budget owner is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Executive Director of Finance or Chief Executive.

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement.

c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

3.3.3 The Executive Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local, or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

3.4 CAPITAL EXPENDITURE

3.4.1 Expenditure on fixed assets for the Trust must follow the correct delegation and reporting lines specifically designed for approval of capital expenditure detailed in the delegation of powers.

3.4.2 Fixed assets should not be purchased from revenue funds.

3.5 PERFORMANCE MONITORING

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Board and to NHS England.

3.5.2 The internal monitoring of the Trustwide and service area business plans will take place through periodic performance reviews, as defined by the Chief Executive.

4 ANNUAL ACCOUNTS AND REPORTS

Key Points

The Trust is required to prepare an annual report, annual accounts and forward plans which must comply with any directions given by the Trusts regulator.

4.1 ANNUAL ACCOUNTS

4.1.1 The Trust (through its Chief Executive and Accountable Officer) shall prepare in respect of each Financial Year annual accounts in such form as NHS England may, with the approval of the Treasury, direct.

4.1.2 In preparing its annual accounts, the Trust shall comply with any directions given by NHS England with the approval of the Treasury as to:

a) The methods and principles according to which the accounts are to be prepared; and
b) The information to be given in the accounts.

4.1.3 The Trust shall:-

a) Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
b) Provide financial information to NHS England in accordance with the timetable prescribed by NHS England.

4.2 ANNUAL REPORT AND FORWARD PLANS

4.2.1 The Trust shall prepare annual reports and send them to NHS England. The reports are to give:-

4.2.2 Information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and the Patients' constituency is representative of those eligible for such membership; and

4.2.3 Any other information that NHS England requires.

4.2.4 The Trust shall comply with any decision NHS England makes as to:-

a) the form of the reports
b) when the reports are to be sent
c) the periods to which the reports are to relate.

4.2.5 The Trust shall give information as to its forward planning in respect of each financial year to NHS England. This information shall be prepared by the Board, who must have regard to the views of the Council of Governors.

4.2.6 The annual report shall also be held at the Trust Headquarters (Uffculme Centre) for public inspection and shall be made available via the Trust's website.

4.2.7 The Trust's annual accounts, any report of the auditor on them and annual report must be presented to the Council of Governors at a public meeting together with, where applicable, summary financial statements.

5 BANKING ARRANGEMENTS

Key Points

All funds must be held in the name of the Trust. No employees other that the Executive Director of Finance shall open any bank accounts in the name of the Trust and the Trust address will not be used for unofficial Trust business.

5.1 GENERAL

5.1.1 The Executive Director of Finance is responsible for managing the Trust's banking arrangements and that of any wholly owned subsidiaries and for advising the Trust on the provision of banking services and the operation of accounts.

5.1.2 All funds of the Trust shall be held in accounts in the name of the Trust. No employee other than the Executive Director of Finance shall open any bank account in the name of the Trust.

5.1.3 Non-Trust bank accounts must not be opened using Trust addresses, with the exception of wholly owned subsidiaries where the registered address is a Trust address.

5.1.4 The Board shall approve the banking arrangements.

5.2 BANK AND GBS ACCOUNTS

5.2.1 The Executive Director of Finance is responsible for:

a) bank accounts and Government Banking Service (GBS) accounts;
b) establishing separate bank accounts for the Trust non-exchequer funds;
c) approving the use of any Working Capital facility arrangements the Trust has
d) reporting to the Board all arrangements made with the Trust bankers for accounts to be overdrawn.

5.3 BANKING PROCEDURES

5.3.1 The Executive Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

a) the conditions under which each bank account is to be operated;
b) the limit to be applied to any overdraft; and
c) those authorised to sign cheques or other orders drawn on the Trust accounts.

5.3.2 The Executive Director of Finance must advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3.3 The Executive Director of Finance may enter into a formal agreement with other bodies for payment to be made on behalf of the Trust by electronic funds transfer (e.g. BACS). Where such an agreement is entered into, the Executive Director of Finance shall ensure satisfactory security arrangements are made.

6 INCOME, FEES, AND CHARGES

Key Points:

The Executive Director of Finance must approve all contracts for income. It is the employees' responsibility to inform the Executive Director of Finance of any income generated outside of contract.

6.1 INCOME SYSTEMS

6.1.1 The Executive Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Executive Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust will price its service contracts with NHS commissioners according to national tariffs published by the Department of Health. In areas where national tariff arrangements do not apply, the Trust shall follow the Department of Health's advice in the "approved costing guidance" in setting prices for NHS service contracts.

6.2.2 The Executive Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuations shall be taken as necessary.

6.2.3 All employees must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Executive Director of Finance shall approve all contracts for income.

6.2.4 Only designated staff, identified by the Executive Director of Finance, may raise invoices on behalf of the Trust.

6.3 DEBT RECOVERY

6.3.1 The Executive Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures and statutory accounting procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated by designated staff identified by the Executive Director of Finance.

7 SECURITY OF CASH, CHEQUES, CONTROLLED DOCUMENTS AND RELATED ARRANGEMENTS

Key Points

Employees who handle cash, cheques and controlled documents must follow the procedures set out by the Executive Director of Finance but are responsible for local operation of controls.

An employee, who receives payments directly in any form, must pass payments immediately to a cashier or holder of a safe or cash box.

7.1 The Executive Director of Finance shall prescribe systems and procedures for any handling cash, petty cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:-

7.1.1 approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

7.1.2 ordering and securely controlling any such stationery.

7.1.3 the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

7.1.4 arrangements for safe-keeping of duplicate keys and for the replacement of lost keys.

7.1.5 procedures for receiving and banking of cash, cheques and other forms of payment.

7.1.6 circumstances in which unofficial funds may be deposited in safes (see also 7.10 below).

7.2 Employees shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques etc. Employees who are appointed with this responsibility must ensure they adhere to the 'Control of Cash Floats, access to Safes and Banking procedures' or any other procedures issued by the Executive Director of Finance.

7.3 Any employee whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash-box which will normally be deposited in a safe. The employee concerned shall hold only one key.

7.4 During the absence (e.g., on holiday) of the holder of a safe or cash-box key, the employee who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.5 All cash, cheques and other forms of payment received by any other employee shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained.

7.6 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance.

7.7 Official money may never be used for the encashment of private cheques.

7.8 The opening of coin operated machines (including telephones) and the counting and recording of the takings must at all times be undertaken by two employees together. The coin-box keys shall be held only by a nominated employee.

7.9 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

7.10 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.11 Maximum limits for cash holdings shall be agreed with the Executive Director of Finance or designated staff and shall not be exceeded without their express permission in writing.

7.12 Reimbursement to members of staff, or patients, for individual items of expenditure out of petty cash shall not exceed the limits set out in the Scheme of Delegation.

8 EMPLOYMENT TERMS & CONDITIONS

Key points

All budget owners must ensure they follow the employment procedures approved by the Trust and only recruit up to the funded establishments.

Budget managers are responsible for ensuring that commencement notifications, change notifications (e.g., when an employee changes grade or hours), and termination notifications are promptly sent to Finance.

All expense claims should be approved by the relevant budget owner and submitted in a timely manner.

Any failure to comply with the employment procedures will be reported to Audit committee and may result in disciplinary action.

8.1 REMUNERATION AND TERMS OF SERVICE

8.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee's remit or by Advance Letter from the Department of Health.

8.1.3 An annual review of staff on ad-hoc pay arrangements will be undertaken annually by the Deputy Director of Human Resources.

8.1.4 The Trust will remunerate the Chair and Non-Executive Directors in accordance with instructions issued by the Council of Governors.

8.2 FUNDED ESTABLISHMENT

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any service area or directorate may not be varied without the approval of the Executive Director lead for that area, following the Trust's organisational change policy and procedures.

8.3 STAFF APPOINTMENTS

8.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so within the limit of their approved budget and funded establishment.

8.3.2 The Trust will have a recruitment & selection policy which will be used for all recruitment processes and is up to date with legislation, collective agreements, NHS guidelines and good practice.

8.4 PROCESSING OF PAYROLL

8.4.1 The Executive Director of Finance is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;
b) ensuring that pay information is accurately reflected in the financial records of the Trust;
c) making payment on agreed dates; and
d) agreeing methods of payment.

8.4.2 The Executive Director of Finance will in conjunction with the incumbent payroll agency issue instructions regarding:

a) verification and documentation of data;
b) the timetable for receipt and preparation of payroll and related data and the payment of employees;
c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d) security and confidentiality of payroll information;
e) checks to be applied to completed payroll before and after payment;
f) authority to release payroll data under the provisions of the Data Protection Act;
g) methods of payment available to various categories of employee;
h) procedures for payment by cheque or bank credit to employees;
i) procedures for the recall of cheques and bank credits
j) pay advances and their recovery;
k) maintenance of regular and independent reconciliation of pay control accounts;
l) separation of duties for preparing records and handling cash; and
m) a system to ensure the recovery from leavers of sums of money and property owed by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;
b) the certification of staff expense claims. The certification by the Budget Holder or Budget Manager shall be taken to mean they are satisfied that the journeys made were authorised, that expenses claimed were properly and necessarily incurred and that allowances are properly payable by the Trust. Eligible employees authorised claims for reimbursement of expenses shall be in a form approved by the Executive Director of Finance. Completed and authorised claims, supported by receipts as appropriate, shall be submitted to the budget manager on a regular basis in accordance with an agreed timetable, and as soon as practicable after the expense has been incurred
c) claims over six months old may not be paid, except at the discretion of the Executive Director of Finance or nominated officer
d) completing time records and other notifications in accordance with the Executive Director of Finance 's instructions and in the form prescribed by the Executive Director of Finance; and

e) submitting termination notifications in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Deputy Director of Human Resources must be informed immediately.

8.4.4 Regardless of the arrangements for providing the payroll service, the Executive Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.5 Payment to an individual shall not be made in advance of the normal pay day, unless there are extenuating circumstances, supported in writing by the appropriate Budget owner, authorised by the Executive Director of Finance or nominated officer, and will not exceed the net pay due at the time of payment. Only in exceptional circumstances will an advance be made for payments for other outstanding payments other than basic salary.

8.4.6 All new employees shall be paid monthly by bank credit transfer (BACS), unless otherwise agreed by the Executive Director of Finance. No employee will be able to transfer from payment by bank credit transfer to payment in cash.

8.5 CONTRACTS OF EMPLOYMENT

8.5.1 The Board shall delegate responsibility to the Director responsible for HR for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation.

8.5.2 Budget owners are responsible for dealing with variations to, and termination of, contracts of employment. Budget owners must inform Finance and HR, immediately after a change has been made, and in the case of terminations, as soon as the termination date is known.

8.5.3 The Board shall delegate responsibility to the Chief Executive or Executive Director of Finance for the authorisation of variations from Agenda for Change – Terms and Conditions of Service Handbook.

8.5.4 Any salary payments outside of the Pay Circular Agenda for Change or Pay Circular Medical & Dental must be approved by either the Chief Executive or Executive Director of Finance or the committees which determine pay in relation to Board members.

9 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL & INVESTMENTS

Key Points

The trust must remain within the borrowing limit set by its regulator, NHS England. Only the Executive Director of Finance can borrow funds in the name of the Trust.

9.1 EXTERNAL BORROWING

9.1.1 Any application for a loan or overdraft or the use of any Working Capital Facility will only be made by the Executive Director of Finance or by an employee so delegated by him/her.

9.1.2 The Executive Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

9.1.3 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Executive Director of Finance.

9.1.4 All long term borrowing must be consistent with the plans outlined in the current Business Plan approved by the Board.

9.2 PUBLIC DIVIDEND CAPITAL

9.2.1 The annual Public Dividend Capital Dividend must be calculated in accordance with the guidance issued by NHS England and authorised by the Executive Director of Finance or nominated officer.

9.3 INVESTMENTS OF SURPLUS CASH

9.3.1 The Trust may invest surplus cash outside of the Government Banking System.

9.3.2 A treasury management policy will be formulated by the Executive Director of Finance and approved by the Board.

9.3.3 The Executive Director of Finance is responsible for short term investment of surplus cash and will ensure cash surpluses are only invested in safe harbours as defined by the Treasury Management policy.

9.3.4 All long term investments and investments outside of the Treasury Management policy must be approved by the Board.

10 CAPITAL INVESTMENT

Key Points

Capital investment relates to purchase of assets which will remain in use by the Trust for periods of greater than one year and cost £5,000 or more. Capital investment requires a business case to be approved by a nominated committee before the item can be acquired.

10.1 CAPITAL INVESTMENT

10.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

10.1.2 For every capital expenditure proposal the Chief Executive shall ensure that a business case, prepared to a standard format as determined by the Board, is produced for approval by Capital Review Group.

10.1.3 Approval of the business case is in accordance with the scheme of delegation, provided the amount has already been included in the Capital Programme and approved by the Board.

10.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of 'Estatecode'.

10.1.5 The Executive Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

10.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure;
b) authority to proceed to tender;
c) approval to accept a successful tender.

10.1.8 The Chief Executive, taking due account of the Standing Financial Instructions and the Scheme of Delegation document, will issue a scheme of delegation for capital investment management in accordance with 'Estatecode' guidance.

10.1.9 The Executive Director of Finance, taking due account of the 'Scheme of Delegation' document, shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11 FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Key Points

All assets of the Trust must be securely maintained, separately identifiable and recorded within the Trusts Fixed Asset register. All losses, disposals or damages must be reported to the Executive Director of Finance.

11.1 ASSET REGISTERS

11.1.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

11.1.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in sufficient detail to allow full disclosure within the annual financial statements in accordance with International Financial Reporting Standards and any reporting guidance issued by NHS England.

11.1.3 Additions to the fixed asset register must be clearly identified, comply with accounting standards, the Trust's capital policy and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
c) lease agreements in respect of assets held under a finance lease and capitalised.

11.1.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.1.5 The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.1.6 The value of each asset shall be independently valuated on a regular basis and reviewed for impairment.

11.1.7 The value of each asset shall be depreciated over the assets useful economic life. The economic life and residual value of the assets will reviewed on a regular basis.

11.1.8 Buildings should be designated protected or non-protected.

11.2 SECURITY OF ASSETS

11.2.1 The overall control of assets is the responsibility of the Chief Executive however all employees have a responsibility to ensure that assets are securely maintained.

11.2.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance. This procedure shall make provision for:

a) recording managerial responsibility for each asset;
b) identification of additions and disposals;
c) physical security of assets;
d) periodic verification of the existence condition , and title to, assets recorded;
e) identification and reporting of all costs associated with the retention of an asset; and
f) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Finance.

11.2.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

11.2.5 Any damage to the Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.2.6 Where practical, assets should be marked as Trust property.

12 STORES AND RECEIPT OF GOODS

Key points

Stores of goods should be kept to a minimum with a stocktake where levels exceed £10,000 undertaken on an annual basis.

12.1 Stores of consumables and equipment for immediate use exceeding £10,000 should be:

15.1.1 kept to a minimum;

15.1.2 subjected to annual stocktake;

15.1.3 valued at the lower of cost and net realisable value.

12.2 Subject to the responsibility of the Executive Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Finance. The management of Pharmaceutical stocks shall be the responsibility of a designated Director of Pharmacy, but must comply with the systems of control set by the Executive Director of Finance.

12.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/officer. Wherever practicable, stocks should be marked as health service property.

12.4 The Executive Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.5 Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year. Trust stock held centrally in a warehouse should be subject to a continuous stocktaking process based on volume, value, and frequency of use.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Finance.

12.7 The designated Manager/officer shall be responsible for a system approved by the Executive Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Executive Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses, and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.8 For goods supplied via the NHS Supply Chain central warehouses. The authorised person shall check receipt against the delivery note before generating a goods received note on the e-procurement system.

12.9 All delivery points must be correctly identified and signposted.

13 DISPOSALS AND CONDEMNATIONS, LOSSES, AND SPECIAL PAYMENTS

Key Points

Employees must notify the Executive Director of Finance of any proposed disposals.

Any employee discovering or suspecting a loss of any kind must either immediately inform the Executive Director of Finance or inform the Local Counter Fraud Specialist.

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The Executive Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.2 When it is proposed to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Executive Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate and the Estatecode guidance issued by the Dept. of Health. The disposal shall be authorised in accordance with the Scheme of Delegation. Where appropriate and in conjunction with guidance issued by the regulator, NHS England, shall be notified and agree with any disposal of commissioned assets.

13.1.3 All unserviceable articles, or items beyond economic repair shall be:-

a) condemned or otherwise disposed of by an employee authorised within the Scheme of Delegation
b) recorded by the Condemning Officer in a form approved by the Executive Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Director of Finance.

13.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 Special payments are those which fall outside the normal day-to-day business of the Trust, or exceptionally, those for which no statutory authority exists. They fall into one of five (5) main categories:

a) Compensation payments made under legal obligation.
b) Extra contractual payments to contractors.
c) Ex-gratia payments.
d) Extra statutory or extra regulatory payments.
e) Fruitless payments.

13.2.2 The Executive Director of Finance must prepare procedural instructions on the recording of and accounting for losses and special payments.

13.2.3 Any employee discovering or suspecting a loss of any kind must either immediately inform the Executive Director of Finance or inform the Local Counter Fraud Specialist who will then appropriately inform the Executive Director of Finance and/or Chief

Executive. Where a criminal offence is suspected, the Executive Director of Finance must inform the police if theft or arson is involved. If the case involves suspicion of fraud, then the particular circumstances of the case will determine when the police are notified.

13.2.4 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if the value is less than £50,000, the Executive Director of Finance must immediately notify:

a) the Board
b) the Local Counter Fraud Specialist.
c) the External Auditor

13.2.5 The Executive Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.6 The Executive Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. A report shall be presented to the Audit Committee periodically.

14 PATIENTS' PROPERTY

Key Points

Patients and/or guardians must be informed on admission that the Trust does not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

14.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "**property**") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital.

14.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

14.2.1 notices and information booklets,

14.2.2 hospital admission documentation and property records,

14.2.3 the oral advice of administrative and nursing staff responsible for admissions,

14.2.4 ensuring that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

14.3 The Executive Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Detailed procedures are contained in, “The Management of Patient’s Property Guidance”. Separate accounts for patients' monies shall be opened and operated under arrangements agreed by the Executive Director of Finance.

14.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. This will need to be ratified by the Trust’s Legal Services Department. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

14.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

14.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose unless any variation is approved by the donor in writing.

15 STANDARDS OF BUSINESS CONDUCT

Key points

Staff must comply with national guidance, Trust policies (and particularly the Declarations and Pay Policies) and ABPI Code of Professional Conduct.

15.1 POLICY

15.1.1 Staff must comply with the national guidance relating to the Nolan principles, Trust policies and Values (Compassionate, Inclusive, Committed) and the ABPI Code of Professional Conduct. Key expectations and responsibilities are stated below but staff should refer to these for full detail on what is required.

15.2 PRINCIPLES OF CONDUCT IN THE NHS

15.2.1 The Nolan Committee set out Seven Principles of Public Life, which should apply to all in the public service. These are:

a) **Selflessness** - Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends
b) **Integrity** - Holders of public office should not place them under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties
c) **Objectivity** - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
d) **Accountability** - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
e) **Openness** - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
f) **Honesty** - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
g) **Leadership** - Holders of public office should promote and support these principles by leadership and example.

15.3 THE BRIBERY ACT 2010

15.3.1 Under the Bribery Act 2010, the Trust's Policy and the terms and conditions of an employee's contract, it is an offence for staff to accept any inducement or reward for:

a) doing, or refraining from doing anything in their official capacity
b) showing favour or disfavour to any person in their official capacity.

15.4 CONFIDENTIALITY

15.4.1 Employees must comply with Trust policies relating to confidentiality.

15.4.2 Employees in the course of their duties may gain access to business information in relation to the running of the Trust. Employees may also gain access to information that relates to staff, patients and / or other clients. Such information is regarded by the Trust as CONFIDENTIAL. Therefore, all members of staff must not disclose such information either in the course of their duties whilst in employment or at any time after the termination of their contract, to any person who does not have the right to this information.

15.4.3 Employees are also not permitted to release in any form the whole or part of any document belonging to the Trust, except where express consent by a Director has been given, in relation to the proper performance of an employee's duties.

15.5 CASUAL GIFTS

15.5.1 Casual gifts offered by contractors or others may not be in any way connected with an employee's performance of duties so as to constitute an offence under the terms and conditions of their employment contract.

15.5.2 Employees should:-

a) refuse all gifts, benefits, hospitality, or sponsorship of any kind which might reasonably be seen to compromise their personal or professional judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused;
b) declare and register gifts or benefits valued in excess of £50, received from patients/service users or their relatives (either individually or if several small gifts have been received from the same or closely related source, and they total £50 over a 12-month period). These should only be accepted if they are for the benefit of the Trust or specific wards. Low cost branded promotional goods such as post it notes, diaries or pens can be accepted and need not be declared if under the value of £6. If over this value, then they would need to be declared;
c) consult their line managers or the Company Secretary/Deputy Company Secretary if in doubt. *Note: when the Declarations Policy is due for renewal it goes to the Policy Development Management Group (PDMG).*

15.6 HOSPITALITY

15.6.1 Reasonable hospitality (e.g., lunches to refreshments, meals, travel and accommodation), valued at between £25 and £75 may be accepted but must be declared to the Company Secretary. All offers of foreign travel or accommodation should only be accepted in exceptional circumstances and require senior approval and should be declared with an explanation as to why acceptance is acceptable to the Company Secretary. Any hospitality from pharmaceutical companies must comply with the Association of British Pharmaceutical Industries (ABPI) guidelines and the Trust's Commercial Sponsorship, Gifts and Hospitality and Conflict of Interest Policy and Procedure.

15.6.2 Trust staff should decline all other offers of gifts, hospitality, or entertainment. Staff should consult their line manager if in doubt. Further Guidance is available in the Trust's Sponsorship, Gifts and Hospitality Policy. If any hospitality should be accepted, then it must be reported to the Trust Company Secretary at the earliest opportunity.

15.7 INTEREST OF OFFICERS IN CONTRACTS

15.7.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest whilst not being a contract to which he or a close family member is a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Company Secretary of the fact that he is interested therein.

15.8 PRIVATE TRANSACTIONS

15.8.1 Trust staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had or may have official dealings on behalf of the Trust.

15.8.2 An officer must also declare to the Company Secretary any other employment or business or other relationship of theirs, persons living together as partners, or other immediate family members, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

15.8.3 All members of staff are required, upon appointment, to adhere to the NHS Code of Conduct and Code of Accountability.

15.9 CANVASSING OF AND RECOMMENDATIONS BY DIRECTORS IN RELATION TO APPOINTMENTS

15.9.1 Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate from such an appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

15.9.2 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Financial Instructions shall not preclude a director from giving written testimonial of a candidate's ability, experience, or character for submission to the Trust.

15.9.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

15.10 RELATIVES OF DIRECTORS OR OFFICERS

15.10.1 Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship may disqualify a candidate and, if appointed, render him/her liable to instant dismissal on the grounds of gross misconduct.

15.10.2 The Directors and every officer of the Trust with recruitment responsibility shall disclose to the Deputy Director of Human Resources any relationship with a candidate

of whose candidature that Director or Officer is aware. It shall be the duty of the Deputy Director of Human Resources to report to the Board any such disclosure made that they consider being a material nature.

15.10.3 On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

15.10.4 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the Standing Order headed `Disability of Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

15.10.5 Staff must ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant management capacity. Contracts may be awarded to such businesses, but scrupulous care must be taken to ensure that the tendering and selection processes are conducted impartially, and that staff who are known to have a relevant interest take no part in the selection process and requirements of the declaration process in respect of procurement and contracts is followed. If there is any doubt the advice of the Company Secretary should be sought.

15.11 EMPLOYMENT

15.11.1 Staff shall not engage in outside employment which may conflict with the Trust's business or be detrimental to it or its reputation.

15.11.2 Staff are also reminded of their responsibility to ensure that work undertaken in addition to their substantive contractual duties with the Trust is not detrimental to their employment and does not impair their ability to perform their duties for the Trust. This must be declared, in accordance with the Working Time Directive.

15.12 PRINCIPLES OF PRIVATE WORK

15.12.1 For medical staff:-

a) Consultants and Associate Specialists employed under the Terms and Conditions of Service for Hospital Medical and Dental staff are permitted to carry out private practice in NHS Hospitals subject to the conditions outline in the handbook, "A Guide to the Management of Private Practice in the NHS". Consultants who have signed new contracts with the Trust will be subject to the terms applying to private practice in those contracts.
b) All medical staff are entitled to fees for other work outside the NHS contractual duties under "Category 2" (Paragraph 37 of the Terms and Conditions for Medical and Dental staff) e.g., examinations and reports for life insurance purposes.
c) Doctors in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours.
    i. All private work should be notified to the Company Secretary.

15.12.2 All other types of NHS staff employed by the Trust are encouraged to refrain from carrying out private work. Under exceptional circumstances employees may request

formal agreement from their line-manager to engage in private work. If an employee does engage in private work the following criteria must be complied with:

a) They do not use their NHS titles or the Trust's name in advertising their private work.
b) They do not use any NHS resource including Trust buildings or facilities, stationary, secretarial support, equipment or postage.
c) It does not adversely affect their capacity to perform their NHS duties.
d) Private work is only undertaken at times when staff are off duty or on annual leave or that declarations of category 2 or fee-paying work are made in line with the requirements of the Declarations Policy and the Pay Policy.
e) They do not leave business cards or place posters in Trust premises.
f) Appropriate adherence is paid to Working Time Regulations and issues of Health and Safety in relation to working hours.

15.12.3 If agreed, it is an Audit Committee requirement that the line manager must formally notify the arrangement to the Trust Company Secretary as a Declaration of Interest.

15.12.4 Furthermore, it should be noted that any remuneration received from external organisations or individuals through lecturing, teaching activities or for services provided during Trust time, is income that belongs to the NHS and should therefore be paid into the relevant directorate budget.

15.13 REWARDS FOR INITIATIVE

15.13.1 The Trust will ensure that it is in position to identify potential intellectual property rights (IPR), so that it may ensure that its staff receive any rewards or benefits e.g., royalties in respect of any work carried out by Trust employees. Appropriate specifications and provisions will be incorporated into contractual agreements. Patents or IPR should be declared in line with the declarations policy. Permission should be sought in advance to enter into any agreements with other bodies regarding product development, research work, development of pathways etc where this impacts on the organisations own time, uses its equipment resources or intellectual property.

15.13.2 Rewards may be given voluntarily to Trust staff who within the course of their duties have produced innovative work of outstanding benefit to the NHS. Similar rewards may also be applied to other activities such as publishing articles and giving lectures.

15.13.3 In the case of collaborative research work with commercial suppliers or other organisations, the Trust will ensure that it obtains a fair reward for the input provided. The Trust will also ensure that involvement with a particular manufacturer does not influence the purchase of other supplies or services from that organisation.

15.14 COMMERCIAL SPONSORSHIP

15.14.1 Acceptance by Trust staff of commercial sponsorship for attendance at relevant conferences/course is only acceptable on provision of the staff seeking permission in advance and the manager is satisfied that acceptance will not compromise any purchasing decisions. Permission should be sought in advance from the Company Secretary if intending to seek sponsorship from ‘discretionary advisors’ and where there is any doubt advice should be sought from the Company Secretary.

15.14.2 Pharmaceutical companies may offer to sponsor a post for the Trust. The sponsorship must not affect the purchasing decisions made by the Trust and this will be monitored. Pharmaceutical companies may request collaboration in drug trials on their product. These will in all cases, be regulated by the local ethical committee. Any financial arrangements must comply with the Association of British Pharmaceutical Industries (ABPI) regulations and the Declarations Policy and must be declared and approved in advance by the Executive Director of Finance.

15.14.3 Under no circumstances will the Trust agree to “linked deals”, whereby sponsorship is linked to the purchase of particular products or services.

15.14.4 In circumstances where a firm offers free equipment, the free loan of equipment, or to provide equipment at what is, prima facie, less than cost:-

a) the individual who has been approached must seek authority from their manager and notify in advance from Executive Director of Finance, in order to ensure that this offer can in no way be construed as an inducement for future purchase
b) great caution must be exercised. In such cases, managers will be expected to ensure that the transaction will bear external scrutiny.

15.15 COMMERCIAL IN CONFIDENCE

15.15.1 Trust staff must avoid using or making public, internal information of “commercial significance”, particularly if its disclosure would prejudice the principle of a fair purchasing system.

15.15.2 This information does not relate to service delivery and activity levels, which should be publicly available as outlined in the NHS guidelines on openness.

15.16 PROFESSIONAL CODES OF CONDUCT

15.16.1 Professional Staff are reminded that they are also bound by their own codes of conduct within their profession. Professional staff are expected to be aware of their code of conduct.

15.17 WHISTLE BLOWING (RAISING CONCERNS)

15.17.1 Managers should create a climate for staff to report any inappropriate behaviour in the workplace. Trust staff must feel that their legitimate views will be welcomed and, where appropriate, acted on positively. The Trust will seek to offer practical support to staff. Refer to the Trust’s ‘Whistleblowers Policy’ for further guidance.

a) All Trust staff have a clear duty to inform their managers of any instances of malpractice towards service users
b) The Trust expects openness to be fostered so that staff should be encouraged freely to contribute their views on all aspects of Trust activities, especially the delivery of care to service users
c) All Trust staff have a clear duty to inform their managers of financial irregularities
d) All Trust staff have a clear duty to inform their managers of any instances of unprofessional conduct.

15.18 DECLARATION OF INTERESTS

15.18.1 The Trust shall maintain a hospitality register, detailing both hospitality accepted and that which has been offered but declined. The register will be held by the Trust Company Secretary.

15.18.2 The Trust shall maintain a declaration of interests' register which will be held by the Company Secretary. Staff with delegated authority to commit the Trust to contractual agreements and/or to incur expenditure are expected to submit an annual return to the Company Secretary - a nil return is also required, when applicable. Staff should refer to the Declarations and Pay Policies for detail on what is required.

15.19 SUSTAINABILTY AND CLIMATE CHANGE

15.19.1 The Trust (supported by Summerhill Services Limited (SSL) its subsidiary shall ensure that on an annual basis (within the Annual Report and Accounts) it declares its performance it is already delivering against the sustainability agenda/green plan.

15.19.2 The monitoring and reporting of this will be held by the SSL Estates Team.

PART 2

(BSMHFT as a Provider)

1 CONTRACTING FOR COMMITMENT OF EXPENDITURE

Key Points

All procurement activity shall ultimately be governed by the UK Public Contracts Regulations 2015 (the "Regulations"). All Employees who are involved in the exercise of purchasing or procuring activities must follow the procedures set out by the Executive Director of Finance.

An employee who is involved in any such activities must declare any conflict of interest for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk, as set out in the Declarations Policy.

1.1 LEGISLATION AND GUIDANCE GOVERNING PUBLIC PROCUREMENT

1.1.1 All public procurement activity is legislated by the UK Public Contracts Regulations 2015 (the "Regulations") (as Amended in 2022) and prescribes procedures for awarding all forms of contracts.

a) These Regulations shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions
b) Only the Chief Executive Officer, or delegated authority, may authorise the wavering of any activity that does not comply with this legislation.

1.1.2 The Trust shall comply as far as is practicable with the requirements published by the Department of Health (DoH), Cabinet Office (CO), NHSi through regional manager, the management function of NHS Supply Chain known as Supply Chain Co-ordination Limited (SCCL) or successor organisation and other central government functions that publish policy notes on best practice and mandatory requirements of how to undertake public procurement exercises.

1.2 CONDUCT

1.2.1 All staff involved in the act of committing the Trust to expenditure have a duty to comply with Standing Orders and SFIs.

a) They must ensure the procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions.
b) All exercises must seek and demonstrate Value for Money (VFM) by obtaining the maximum benefit with the resources available. Demonstrating the right balance between quality and cost; as well as achieving the right balance between economy, efficiency, and effectiveness.
c) All undertakings must adhere to the UK Procurement Principles that set out to ensure a 'level playing field' for suppliers in which to conduct business.
   i. These principles legally apply to procurement activity above the UK Public Contracts Regulations 2015 (the Regulations) thresholds.
   ii. However, staff will need to apply the principle of "proportionately" to all procurement activity regardless of spend.

1.2.2 All staff must follow the Standards of Business, Section 22, and ensure they conduct themselves accordingly at all times when involved in making decisions around commitment of public monies.

1.2.3 All personnel involved in tendering and contacting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being commenced. Any suspicions of bribery offences should be reported to the Local Counter Fraud Specialist.

1.2.4 The advantage referred to in the Bribery Act 2010 does not just relate to financial gain, it can also relate to other incentives including but not limited to holidays, lavish gifts, and tickets to events. There are four main offences under the Bribery Act 2010:

a) Offering a bribe;
b) Accepting a bribe;
c) Bribing a foreign public official; and
d) Failing to prevent bribery (also known as the corporate offence).

1.2.5 An employee who is involved in any activates for the commitment of spend must declare any conflict of interest directly to the Company Secretary and Head of Procurement for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk.

1.3 ESTIMATING THE CONTRACT VALUE

1.3.1 The contract value is to be estimated net of VAT, and should reflect the total amount payable by the Trust.

1.3.2 Contract value is treated as cumulative; a rolling twelve-month contract with no explicit end date is defined with in the Regulations as a Contract value of 4 years.

1.4 SPEND THRESHOLDS AND ACTIVITY REQUIRED

1.4.1 All activity is governed by the Standing Financial Instructions and the processes required to evaluate Value For Money (VFM) are dependent on the commitment of funds, as defined in 1.3.2.

a) £0-£4,999 – Spot purchase – see 1.5
b) £5,000 – £99,999– Quotations – see 1.6
    i. Below £50,000 three (3) quotations are required
    ii. Above £50,000 four (4) quotations are required
c) £100,000+ - Tendering – see 1.7.
    i. Tendering may be undertaken below £100,000 where the requirement for a full evaluation and contract is required to deliver a strategically important requirement
    ii. "Mini-competition" is a Tendering activity, under an existing framework and shall follow the same principles within these instructions as Tendering
d) Award against framework
    i. Award against a compliant framework in line with the framework's terms and conditions for value.
    ii. An authorised waiver for framework award is required.

1.5 SPOT PURCHASE

1.5.1 Where the requirement is valued at £0 - £4,999 an authorised officer, in accordance with the Scheme of Delegation, may commit spend via the Purchase to Pay (P2P) system.

1.5.2 Any such commitment shall have a brief rationale for how it demonstrates value for money held by the authoriser of the individual spend.

1.6 QUOTATIONS

1.6.1 General Position on quotations

a) Quotations are required where formal tendering procedures are not adopted
b) All Quotation activity shall be recorded on the relevant Waiver form for spend of £5,000 to £100,000 or locally if £0 - £4,999;
   i. Where Competitive Quotations are undertaken, the budget holder is required to set out what process was undertaken, any exceptions and a value for money statement. A single tender waiver must be completed for evidence of value for money.
   ii. Where Non-Competitive Quotations are sought, the budget holder is required to set out the reason why a competitive process is not being followed and how the proposed supplier can deliver value for money in a single tender waiver.
   iii. These forms must be approved by the Head of Procurement and Executive Director of Finance / Chief Executive depending on the value.

1.6.2 Competitive Quotations

a) Quotations should be obtained based on specifications or terms of reference prepared by, or on behalf of, the Trust.
b) Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
c) All quotations should be treated as confidential and should be retained for inspection.
d) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.
e) Terms and conditions must be evaluated as part of any quotation award decision.

1.6.3 Non-Competitive Quotations

a) Non-competitive quotations in writing may be obtained in the following circumstances:
   i. the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the

opinion of the responsible officer, possible or desirable to obtain competitive quotations;

ii. The supply of goods or manufactured articles of any kind which are required as a matter of urgency and are not obtainable under existing contracts;

iii. Where the goods or services are for building and engineering maintenance where the responsible works manager can confirm there is a proprietary system/solution in place or specialist experience of the Trust is of commercial benefit to maintain an existing supplier.

1.6.4 Quotations that fall our side Financial Limits

a) As the markets and required specification with dictate the quoted price, appropriate approval must be sought for additional funding to be made available before a quotation can be accepted that falls outside the fall outside of the financial limits allocated for this good, service or building works .

1.7 TENDERING

1.7.1 The available procurement procedures available to be undertaken shall be shaped by the category of activity being tendered. The Common Procurement Vocabulary (CPV) codes are directly linked to the allocation of thresholds:

a) Light Touch Regime (LTR) Services
    i. Defined as only the CPV codes listed within Schedule 3 of the Regulations
b) Works
    i. Defined as only the CPV codes listed within Schedule 2 of the Regulations
c) Supplies and Services
    i. Defined as all other CPV codes not listed as LTR or Works

1.7.2 Exceptions and instances where formal tendering need not be applied.

a) Formal tendering procedures need not be applied where:
    i. The estimated expenditure or income does not, or is reasonably not expected to, exceed £100,000.
    ii. Where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with;
    iii. Regarding disposals as set out in clause 16;
b) Formal tendering procedures may be waived by the Executive Director of Finance in the following circumstances:
    i. Where explicitly defined within the Regulations that there is an exemption
    ii. Where the requirement is covered by an existing contract, such that it would not lead to a material change;
    iii. Complaint routes to market exist that provide access to the Trust, these may take the form of;
        - National Contracts, through the management function of NHS Supply Chain known as Supply Chain Co-ordination Limited (SCCL) or by successor organisation Central Government

Functions that tender on behalf of the wider public sector, i.e., Crown Commercial Services (CCS) or successor organisation

- Procurement Hubs that have undertaken compliant procurement activity to provide their members with “Frameworks”. Any such access must be assessed and all requirements of the framework owner must be met. This may take the form of a “Direct Award” or “Mini-Competition”
- Contracts let by other public bodies that have made a provision for other public sector organisations to access. Any such access must be assessed and all requirements of the contract owner must be met
- Where a consortium or collaborative arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members; of which the Trust is a member

iv. Where the timescale genuinely precludes competitive tendering. Failure to plan the work is not a justification for wavering formal tendering;

v. Where specialist expertise is required and is available from only one source;

vi. When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

vii. There is a clear benefit to be gained from maintaining continuity with an earlier project. However. in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

viii. For the provision of legal advice and services as defined in the Regulations as eligible for an exemption

- The Executive Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of legal advice and services

c) The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

d) Where it is agreed by the Chief Executive Officer or Executive Director of Finance that competitive tendering is not applicable and should be waived, a single tender waiver must be completed and the reasons should be documented and recorded by the completion and approval of a waiver form and reported to the Audit Committee.

1.7.3 Contracting/Tendering Procedure

a) All tendering activity shall be undertaken using Electronic Tender Documentation (ETD) and the Trust’s eSourcing system

b) All Tendering activity above threshold shall follow the prescribed procedures and mandated timescales within the regulations

i. Where below threshold, tendering procedures shall follow the principles of the prescribed procedures and ensure reasonable timescales are allocated.

1.7.4 Participation

a) The Trust is required to publish all relevant notices. Where an opportunity is advertised, the Trust must publish all opportunities over £25,000 on Contracts Finder.
b) The Trust operates an electronic tendering system. All invitations to participate must be requested and received using the eSourcing system.
c) The mandatory questions relating to mandatory and discretionary grounds for exclusion shall be asked of all participants, irrelevant of value
d) All Tenders shall as a minimum include the following documentation:
   i. A full outline of the procedure methodology to be undertaken.
   ii. Evaluation criteria and scoring methodology.
   iii. The terms and conditions of contract.
   iv. Response deadliness and requirements.
e) Approved supplier lists
   i. As a public sector body the Trust may not hold its own "approved supplier list", where "approved supplier" is defined as a list of suppliers eligible to bid for business opportunities.
   ii. All opportunities must be advertised and competition sought in a proportional and compliant manner.
   iii. Evaluation methodologies must be sufficient to ensure bidders can be evaluated to ensure, as a minimum, they are;
      - Of good standing,
      - Suitably experienced,
      - Capable of delivering the contract
      - Have capacity to carry out the contract.

1.7.5 Opening of tenders

a) All tenders shall be accepted only via the eSorucing system, and shall be received within an "electronic seal". Bids shall not be able to be opened until the submission deadline has passed and the "seal is broken".
b) Tenders shall be opened by the Head of Procurement, or delegated officer, and shall be recorded within the audit log of the eSourcing System.
c) The officer opening the Tender must be independent of the tenders lead procurement officer.

1.7.6 Admissibility

a) All tenders that meet all of the following shall be accepted
   i. Received on time.
   ii. Are Complete, i.e. all documents required have been submitted.
   iii. Bidder meets all of the participation requirements.

1.7.7 Late tenders

a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered at the discretion of the Chief Executive or their nominated officer. For example:
   i. Technical issues that prevented the bidder form meeting the submission deadline.
   ii. That accepting the late tender is in the best interest of the competitiveness of the procurement exercise.
b) Once the seal is "broken" through the electronic portal no further late tenders can be received by the Trust.

1.7.8 Evaluation of formal tenders

a) Clarifications may be sought form bidders following receipt of tenders.
   i. These must be carried out in an open fair, and equitable manner such that no perception of basis can be demonstrated.
   ii. Any such clarification is for clarifying existing information and is not for the purposes of changing / re-submitting a response.
   iii. Must be recorded within the eSourcing system.
   iv. There must be absolutely no communication outside of the eSourcing system in relation to the relevant tender.
b) The published evaluation methodology for the specific tender must be followed. Deviation from this methodology is not permitted.
c) All evaluations must be recorded, and justifications for any scores allocated must be recorded within the eSourcing system.
d) The final award decision must demonstrate that it will deliver the level of quality of goods or provision of service in line with the Trust specification and Value for Money achieved.

1.7.9 Abnormally low tenders

a) The Trust has a requirement under Regulation 69 of the regulations to evaluate all tender values submitted and where a tender appears to be abnormally low in relation to the works, supplies or services, the Trust has to require an explanation of the price / costs in the proposed tender from the tenderer concerned.
   i. Before rejecting an apparently abnormally low tender, the Trust must request in writing details of the constituent elements of the tender which are considered relevant for the appraisal or verification of its apparent anomaly, such as:
      - the economics of the manufacturing process, of the services provided or of the construction method;
      - technical solutions chosen or any exceptionally favourable conditions available to the tenderer for the supply of the products or services or for the execution of the work;
      - the originality of the work, supplies or services proposed by the tenderer;
      - Compliance with the environmental, labour, and social obligations referred to in Regulation 56(2); or

- Compliance with the subcontracting obligations established in Regulation 71; and
- The possibility of the tenderer obtaining State aid, Regulation 69(2)

ii. In view of the evidence supplied by the tenderer upon consultation, the Trust shall verify those constituent elements and reach a final decision on whether to reject the apparently abnormally low tender or not.

1.7.10 Award of Tenders

a) All contract awards following a tender process must include:
   i. All bidders informed of the outcome, via an "intent to award" notice. Any such communication must provide the relevant level of detail to de-brief the participants on the outcomes of the process
   ii. A stand still period (10 days Alcatel Period) Good practice to adhere to.
   iii. A notice to the successful supplier(s) following the end of the standstill period, to conclude the award process.

b) Only following the completion of the standstill period may the Trust enter into a contract.

c) Only in exceptional circumstances may a supplier begin delivery of goods/services to the Trust prior to the contract being finalised and signed.

d) On completion of award, a Regulation 84(1) report must be completed. This report must be stored within the eSourcing system for audit purposes.
   i. A Regulation 84(1) report is not required for contracts called off under a framework agreement, if;
      - The framework agreement is with a single supplier and is awarded in accordance with Regulation 33(7), or
      - The framework agreement is with more than one supplier but the call-off contract is awarded without reopening competition in accordance with Regulation 33(8)(a)
   ii. Note that in all other cases a Regulation 84(1) report will be required for a call-off contract.

1.7.11 Tender reports to the Board

a) Reports to the appropriate Executive/Committee/Decision Making Group identified in the Scheme of Delegation will be made on all contract values exceeding £250,000.

1.8 ITEMS WHICH SUBSEQUENTLY BREACH THRESHOLDS AFTER ORIGINAL APPROVAL

1.8.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Executive Director of Finance.

a) Where a procurement exercise has been undertaken using a process complaint below a threshold, and the result is above the threshold it shall be abandoned, as it cannot be awarded, and compliant process undertaken.

b) Where contracts are varied over their duration, any material change that sufficiently alters the nature of the contract from its original award shall be assessed under the regulations relating to material change. Where it is identified

that these variations are triggering a "material change", then the variation shall not be authorised and a new procurement undertaken to award a complaint contract that incorporates this change.

1.9 PILOT EXERCISES

1.9.1 Any Pilot that is undertaken, must ensure;

a) That it is no longer than 18 months in duration
b) There is a clear audit of how the supplier(s) were appointed
c) The solution being trailed must not lock the Trust into any proprietary system / solution
d) A clear evaluation methodology must be published as part of the award, to enable a measurable and recorded outcome
e) On completion, if successful, the information must be used to generate a specification and the requirement tendered accordingly.

1.9.2 Pilot exercises must not be used as an excuse for avoiding tendering procedures.

1.10 TRANSPARENCY OF AWARDED CONTRACTS

1.10.1 All contracts entered into on behalf of the Trust must be signed by a duly authorised individual, as per the scheme of delegation.

a) All contracts awarded must fully comply with;
   i. These Standing Financial Instructions
   ii. All applicable legislation
   iii. Have clear definitions and appropriate markings to highlight any elements that are "commercially confidential" in line with the latest FIOA and associated guidance
b) The Head of Procurement shall be informed when a contract has been let and provided with;
   i. A copy of the final signed contract
   ii. A summary statement of the process undertaken to award the contract and how this was compliant with these SFI's
c) Once awarded, all contracts in excess of £25,000 inclusive of VAT must have the correct contract award notice(s) published:
   i. ALL contracts must be published to the Trust publicly facing contracts register
   ii. As per Regulation 112 for the Regulations, contracts awarded over £25,000 must also be published on the UK Government website: "Contracts Finder" (or successor).

1.11 PRIVATE FINANCE FOR CAPITAL PROCUREMENT

1.11.1 The Trust may market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply.

1.11.2 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

1.11.3 The Trust must comply with NHS Englands "Roles and Responsibilities in the approval of NHS Foundation Trust PFI schemes" and consider the "Risk Evaluation for Investment decisions by NHS Foundation Trusts".

1.11.4 Where the sum exceeds the thresholds set out in the Single Oversight Framework, the proposal must be submitted to NHS England. NHS England does not have any role in approving such plans, but it will consider the impact on the Trust's financial risk rating.

1.11.5 The proposal must be specifically agreed by the Board.

1.11.6 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

1.12 COMPLIANCE REQUIREMENTS FOR ALL CONTRACTS

1.12.1 The Board may only enter into contracts on behalf of the Trust within its statutory powers and shall comply with:

a) The Trust's Constitution, Terms of Authorisation, Standing Orders and Standing Financial Instructions;
b) other statutory provisions;
c) Any relevant guidance published by the Independent Regulator and the Department of Health and guidance on the Procurement and Management of Consultants;
d) Such of the NHS Standard or Model Contract Conditions as are applicable
e) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited
f) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

1.13 PERSONNEL AND AGENCY OR TEMPORARY STAFF CONTRACTS

1.13.1 The Executive Director responsible for human resources shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Nationally or regionally contracts negotiated on behalf of the NHS should be used wherever possible, as specific NHS terms and conditions will be included to minimise risk to the Trust.

1.14 IN-HOUSE SERVICES

1.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also

determine from time to time that in-house services should be market tested by competitive tendering.

1.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering:

a) The specification must not be biased towards the in-house service
b) A decision shall be made, and rationale recorded, as to where an external third party is required to mitigate any conflicts of interest such that:
   i. The Trust can assure the market that the exercise being undertaken is fair, transparent and a "level playing field"
   ii. The evaluation panel is independent of the in-house service
   iii. How the in-house team and the decision making process shall be segregated and kept independent.

1.14.3 The outcome of the procurement shall be presented as a contract recommendation to the Board and an internal contract shall be awarded in the same manner as a normal tender conclusion.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

1.14.4 Award to Wholly Owned Subsidiary shall follow Teckal guidelines and 8.14.4. most recent case law informing this guidance.

1.15 APPLICABILITY OF SFIs ON TENDERING AND CONTRACTING TO FUNDS HELD IN TRUST

1.15.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

2 CONTRACTING FOR PROVISION OF SERVICES

Key Points

All contracting activity shall ultimately be governed by the UK Public Contracts Regulations 2015 (the Regulations). All Employees who are involved in the exercise of commissioning or biding actives must follow the procedures set out below.

An employee who is involved any such activates must declare any conflict of interest directly to the Executive Director of Finance for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk.

2.1 SERVICE CONTRACTS

2.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding Service Contracts with NHS commissioners for the provision of both the mandatory services specified in the Terms of Authorisation and also other services. On behalf of the Chief Executive, the Executive Director of Finance will lead on the agreement of contracts with commissioners.

2.1.2 All service contracts should aim to implement the agreed priorities contained within the Annual Plan. In discharging this responsibility, the Executive Director of Finance should take into account:

a) the standards of service quality expected, including those published by the Secretary of State under Section 46 of the 2006 Act;
b) the relevant national service frameworks and guidelines published by the National Institute of Clinical Excellence;
c) national tariffs published by the Department of Health or other agreed local pricing mechanisms where national tariffs do not apply;
d) the need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;
e) the provision of reliable information on cost, quality and volume of services;
f) previously agreed developments or investments plans;
g) payment terms and conditions; and
h) amendments to contracts and extra-contractual arrangements/SPA’s.

2.1.3 Contracts should be so devised as to achieve activity and performance targets, minimise risks and maximise the Trust’s opportunity to generate income.

2.1.4 The Executive Director of Finance shall produce regular reports detailing actual and forecast contract income where appropriate linked to activity with a detailed assessment of the impact of the variable elements of income.

2.1.5 Any pricing of contracts at marginal cost must be agreed by the Executive Director of Finance and reported to the Board.

2.1.6 Services provided to non-NHS organisations with a value greater than £250,000 over a 3 year period or the period of the contract if longer, must be performed under a legal contract and approved by the Finance, Performance & Productivity Committee and over £2m by the Board.

2.1.7 The risks and revenue streams associated with non-NHS activities should be appropriately insured with commercial (i.e. non-NHS RESOLUTION) underwriters.

3 NON-PAY EXPENDITURE

Key points

Employees, in choosing goods and services, shall always obtain the best value for money for the Trust.

Logs of purchase card activity must be submitted to the Finance department on a monthly basis.

3.1 DELEGATION OF AUTHORITY

3.1.1 The Board will approve the level of non-pay expenditure via budget setting on an annual basis and the Chief Executive will determine the level of delegation to budget owners via budget setting.

3.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services using the e-procurement system; and
b) the maximum level of each requisition and the system for authorisation above that level.

3.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

3.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

3.2.1 Any employee authorised to requisition goods or services shall comply with procedures issued by the Executive Director of Finance and, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement Department shall be sought. In case of any area of doubt, the Executive Director of Finance shall make the final adjudication.

3.2.2 The Executive Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below).

3.2.3 The Executive Director of Finance will:

a) agree with the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and regularly reviewed;
b) prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;
c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
   i. Certification that:
      - goods have been duly received, examined and are in accordance with specification and the prices are correct;
      - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
      - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
      - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
      - the account is arithmetically correct;
      - the account is in order for payment
   ii. Instructions to employees regarding the handling and payment of accounts within the Finance Department

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as paragraph 11.2.4).

3.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to NPV) and the intention is not to circumvent cash limits or other budgetary constraints;
b) the appropriate budget owner must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet its commitments;
c) the Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed;
d) the budget owner is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered;
e) Some items of expenditure may be paid for in advance, these are limited to: training places, travel and hotel accommodation.

3.2.5 Official Orders must:

a) be consecutively numbered;
b) be in a form approved by the Executive Director of Finance;
c) state the Trust terms and conditions of trade; and
d) only be available to, and used by, those duly authorised by the Chief Executive.

3.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Executive Director of Finance and that:

a) all contracts [other than for a simple purchase permitted within the Scheme of Delegation or delegated budget], leases, tenancy agreements and other commitments which may result in a liability are notified to the appropriate person set out in the Scheme of Delegation in advance of any commitment being made
b) All orders are placed in advance of commitment to the supplier and goods or services being delivered
c) contracts above specified thresholds (see Scheme of Delegation) are advertised and awarded in accordance with section 8;
d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
    i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
    ii. conventional hospitality, such as lunches in the course of working visits;
e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive;
f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, incidental purchases from petty cash and items obtained through the legitimate use of a Trust Purchase Card;
g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds, delegated limits or rules on virement/budget journal;
i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance;
k) petty cash records are maintained in a form as determined by the Executive Director of Finance;
l) all requisitions, orders and petty cash disbursements are to be correctly coded and made available for checking by the Finance Department;
m) certification of satisfactory delivery of the goods or services to the Finance Department is completed through the part-delivery advice (PDA) or "goods received note" process within 48 hours of receipt.

3.2.7 The Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

3.3 DELEGATED ORDERING, USE OF PURCHASING CARDS

3.3.1 The Executive Director of Finance in conjunction with the Trust's Finance Department, shall ensure that there are robust arrangements for controlling expenditure by Nominated Managers through the use of "purchase cards" to include:

a) a requirement for all holders of such cards to confirm in writing that they have understood the relevant terms and conditions provided to them by the issuing bank and their responsibility with regard to security and use of the card.
b) controls including the use of purchasing activity logs (recording all purchases made with the card) which will then be submitted to the Finance Department on a monthly basis (or as requested) within prescribed timescales.
c) written confirmation from the card holder that they will ensure that their card is only used to make "bona fide" Trust purchases.
d) a requirement for any inadvertent personal use of such cards to be reimbursed to the Trust immediately and in full.

4 INFORMATION TECHNOLOGY

Key points

The role of Senior Information Risk Officer (SIRO) is undertaken by the Executive Director of Finance. All IT systems will have an Information Asset Owner (IAO).

4.1 The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery and business continuity plans.

4.2 The Executive Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust. This includes fulfilling the role of SIRO, which comprises the following duties:-

4.2.1 Understand how the strategic business goals of the Trust may be impacted by information risks.

4.2.2 Act as an advocate for information risk on the Board and in internal discussions.

4.2.3 Take ownership of risk assessment processes for information risk.

4.2.4 Review and agree actions in respect of identified information risk.

4.2.5 Ensure the Trust's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.

4.2.6 Provide a focal point for the resolution/ discussion of information risk issues where necessary.

4.2.7 Ensure the Board is adequately briefed on information risk issues.

4.3 The Executive Director of Finance will identify Information Asset owners for all IT systems. IAO's have responsibility to:

4.3.1 Understand and address risks to the information asset/ system they 'own'.

4.3.2 Provide assurance to the Senior Information Risk Officer (SIRO) on the security and use of the assets.

4.3.3 Ensure completion of relevant documentation prior to the implementation of a new system.

4.3.4 Lead and foster a culture that values, protects and uses information for the public good.

4.3.5 Perform annual Data Protection Health check on systems/ asset and Confidentiality Audits.

4.3.6 Knows what information the asset holds, and what enters and leaves it and why knows who has access and why and ensures their use of it is monitored.

4.3.7 Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs, and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons,

deletion or modification, theft, or damage, having due regard for the Data Protection Act, Human Rights Act and the Freedom of Information Act.

4.3.8 Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

4.3.9 Ensure that adequate controls exist such that the computer operation is separated from development, maintenance, and amendment.

4.3.10 Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

4.4 The Executive Director of Finance shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

4.5 The Executive Director of Finance shall ensure that contracts for computer services for applications with any organisation or agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission, and storage. The contract should also ensure rights of access for audit purposes.

4.6 Where another health organisation or any other agency provides a computer service for applications, the Executive Director of Finance shall periodically seek assurances that adequate controls are in operation.

5 CHARITABLE FUNDS

Key points

Charitable funds are gifts or donations received by the Trust Charity. In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of Charitable Funds.

5.1 INTRODUCTION

5.1.1 "**Charitable funds**" are those gifts, donations and endowments held on trust for purposes relating to the NHS mental health services in Birmingham & Solihull Mental Health NHS Foundation Trust.

5.1.2 Birmingham & Solihull Mental Health NHS Foundation Trust Charity (Caring Minds) is a registered charity with the Charity Commission. The trustees of the charity are the Board of Birmingham & Solihull Mental Health NHS Foundation Trust. The Board has delegated the decision making process to a sub-committee which meets periodically and reports to the Board. The trustees are responsible for the management of the charitable funds and define how these responsibilities are to be discharged. The trustees have accountability to the Charity Commission. Charitable funds are totally separate to exchequer funds; they are administered separately and have their own set of accounts.

5.1.3 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Executive Director of Finance shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

5.1.4 In so far as it is possible to do so, these Standing Financial Instructions will apply to the management of Charitable Funds.

5.2 ADMINISTRATION OF FUNDS

5.2.1 The Executive Director of Finance shall arrange for the administration of all charitable funds in conjunction with the Legal Services department. They shall ensure that every charitable fund has a governing instrument and shall produce detailed procedures on the financial management of charitable funds, for the guidance of directors and employees. Such guidelines shall identity:

a) the restricted nature of certain funds
b) the circumstances under which new funds may be established
c) how to proceed when offered funds
d) recommendations on the wording of wills
e) procedures for fund-raising, including trading activities.

5.2.2 The Executive Director of Finance shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines. The Executive Director of Finance may

recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific wards or departments.

5.2.3 In respect of legacies and bequests, the Executive Director of Finance shall:

a) where necessary, obtain grant of probate or apply for grant of letters of administration
b) be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and
c) be directly responsible, in conjunction with the Legal Services Solicitor, for the appropriate treatment of all legacies and bequests.

5.2.4 The Executive Director of Finance shall be responsible, along with the Company Secretary, for alerting the Board to any irregularities regarding the use of the Trust's name or its registration numbers in fund-raising.

5.2.5 The Executive Director of Finance shall be responsible, with the Company Secretary, for the appropriate treatment of all income, including fund-raising, trading activities, dividends and interest.

5.2.6 The exercise of the Trust's dispositive discretion (how it uses the funds) shall be managed by the Charitable Funds Committee in conjunction with the Board.

5.2.7 The Executive Director of Finance shall identify all costs directly incurred in the administration of charitable funds for charging to the appropriate charitable fund accounts.

5.2.8 The Executive Director of Finance shall ensure that liability to taxation and excise duty is managed appropriately.

5.3 INVESTMENT MANAGEMENT

5.3.1 The Board shall be responsible for all aspects of the management of the investment of charitable funds. The issues on which the Executive Director of Finance shall be required to provide advice to the Board in conjunction with the Company Secretary shall include:

a) the formulation of investment policy within the powers of the Trust
b) the terms of appointment and choice of advisers (which shall be subject to written agreements signed by the Chief Executive)
c) any pooling of investment resources
d) conditions for the participation by the Trust in common investment funds
e) the authorised use of charitable fund assets and policy guidelines for raising charges
f) the review of the performance of brokers and fund managers
g) the reporting of investment performance.

5.4 BANKING SERVICES

5.4.1 The Executive Director of Finance shall ensure that appropriate banking services are available to the Trust as corporate trustee. These shall permit the separation of liquid funds to each charity if required by the Charity Commission.

5.5 ACCOUNTS, AUDITS AND REPORTS

5.5.1 The Charitable Funds Committee shall ensure that regular reports are made to the Board with regard to, the receipt of funds, investments, and the disposition of resources.

5.5.2 The Executive Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales and, in conjunction with the Legal Services Solicitor, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Charity Commission for adoption by the Board.

5.5.3 The Executive Director of Finance shall maintain all financial records to enable the production of reports as above. The Executive Director of Finance shall ensure that the records, accounts, and returns receive adequate scrutiny.

6 RETENTION OF RECORDS

6.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained under the direction contained in " Records Management Code of Practice 2021", and to enable requests under the Freedom of Information Act (2000), to be met.

6.2 The records held in archives shall be capable of retrieval by authorised persons.

6.3 Records held under the '' Records Management Code of Practice 2021" shall be managed, including destruction in accordance with the Trust Policies, which will comply with Data Protection and National Information Governance requirements.

7 RISK MANAGEMENT AND INSURANCE

7.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Clinical Governance Committee.

7.2 The programme of Risk Management shall include:

7.2.1 a process for identifying and quantifying risks and potential liabilities;

7.2.2 engendering among all levels of staff an understanding and a positive attitude towards the control of risk;

7.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

7.2.4 mitigation plans to offset the impact of adverse events;

21.2.5 the Provider Board Assurance Framework.

7.3 INSURANCE: RISK POOLING SCHEMES ADMINISTERED BY NHS RESOLUTION

7.3.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme , this decision shall be reviewed annually.

7.4 INSURANCE ARRANGEMENTS WITH COMMERCIAL INSURERS

7.4.1 The Executive Director of Finance shall ensure that appropriate and adequate commercial insurance arrangements are in place.

8 BUSINESS DEVELOPMENT

This section relates to all business development activity for new business, retention of existing business, or expansion of existing business. This includes formal tenders, applications for funding, external business cases for funding, and grant applications.

8.1.1 All business development activity must be fully assessed for the strategic fit and the delivery, financial and clinical risk associated with the opportunity by completion of a Business Development Assessment Proforma by the Business Development team.

8.1.2 Approval must be sought prior to submission as follows:

a) business developments over £150,000 by the Executive Team
b) business developments under £150,000 by the Director of Finance or Director of Strategy, People, and Partnerships.

8.1.3 The financial model must be agreed with the Director of Finance prior to submission.

8.1.4 The delivery/clinical model must be agreed with the Director of Operations (or relevant Executive Director) prior to submission.

8.1.5 The overall submission must be agreed with the Director of Strategy, People and Partnerships prior to submission.

8.1.6 Partner evaluation and due diligence must be carried out before entering into any partnership arrangements associated with the business development, and this must be approved by the Executive Team before any agreement is entered into.

8.1.7 Where a business development may meet the definition of a ‘significant transaction’, the Trust’s Significant Transactions Policy (March 2020) must be followed.

PART 3

(BSMHFT as a Commissioner)

1 CONTRACTING FOR COMMITMENT OF EXPENDITURE

Key Points

*All procurement activity shall ultimately be governed by the UK Public Contracts Regulations 2015 (the "**Regulations**").*

All Employees who are involved in the exercise of purchasing activities must follow the procedures set out by the Executive Director of Finance.

All Employees who are involved in the exercise of procuring activities must follow the procedures set out by the Executive Director of Strategy, People, and Partnerships.

An Employee who is involved in any such activities must declare any conflict of interest for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk, as set out in the Declarations Policy.

1.1 LEGISLATION AND GUIDANCE GOVERNING PUBLIC PROCUREMENT

1.1.1 All public procurement activity is legislated by the UK Public Contracts Regulations 2015 (the "Regulations") (as Amended) and prescribes procedures for awarding all forms of contracts.

a) These Regulations shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions
b) Only the Chief Executive Officer, or delegated authority, may authorise the wavering of any activity that does not comply with this legislation.

1.1.2 The Trust shall comply as far as is practicable with the requirements published by the Department of Health (DoH), Cabinet Office (CO), NHSi through regional manager, the management function of NHS Supply Chain known as Supply Chain Co-ordination Limited (SCCL) or successor organisation and other central government functions that publish policy notes on best practice and mandatory requirements of how to undertake public procurement exercises.

1.2 CONDUCT

1.2.1 All staff involved in the act of committing the Trust to expenditure have a duty to comply with Standing Orders and SFIs.

a) They must ensure the procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions
b) All exercises must seek and demonstrate Value for Money (VFM) by obtaining the maximum benefit with the resources available. Demonstrating the right balance between quality and cost; as well as achieving the right balance between economy, efficiency, and effectiveness
c) All undertakings must adhere to the UK Procurement Principles that set out to ensure a 'level playing field' for suppliers in which to conduct business
   iii. These principles legally apply to procurement activity above the UK Public Contracts Regulations 2015 (the Regulations) thresholds
   iv. However, staff will need to apply the principle of "proportionately" to all procurement activity regardless of spend.

1.2.2 All staff must follow the Standards of Business, Section 22, and ensure they conduct themselves accordingly at all times when involved in making decisions around commitment of public monies.

1.2.3 All personnel involved in tendering and contacting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being commenced. Any suspicions of bribery offences should be reported to the Local Counter Fraud Specialist.

1.2.4 The advantage referred to in the Bribery Act 2010 does not just relate to financial gain, it can also relate to other incentives including but not limited to holidays, lavish gifts, and tickets to events. There are four main offences under the Bribery Act 2010:

a) Offering a bribe;
b) Accepting a bribe;
c) Bribing a foreign public official; and
d) Failing to prevent bribery (also known as the corporate offence).

1.2.5 An employee who is involved in any activates for the commitment of spend must declare any conflict of interest directly to the Company Secretary and Head of Procurement for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk.

1.3 ESTIMATING THE CONTRACT VALUE

1.3.1 The contract value is to be estimated net of VAT, and should reflect the total amount payable by the Trust.

1.3.2 Contract value is treated as cumulative; a rolling twelve month contract with no explicit end date is defined with in the Regulations as a Contract value of 4 years.

1.4 SPEND THRESHOLDS AND ACTIVITY REQUIRED

1.4.1 All activity is governed by the Standing Financial Instructions and the processes required to evaluate Value For Money (VFM) are dependent on the commitment of funds, as defined in 1.3.2.

a) £0-£4,999 – Spot purchase – see 1.5
b) £5,000 – £99,999– Quotations – See 1.6
   i. Below £50,000 three (3) quotations are required
   ii. Above £50,000 four (4) quotations are required
c) £100,000+ - Tendering – See 1.7.
   i. Tendering may be undertaken below £100,000 where the requirement for a full evaluation and contract is required to deliver a strategically important requirement
   ii. "**Mini-competition**" is a Tendering activity, under an existing framework and shall follow the same principles within these instructions as Tendering
d) Award against framework
   i. Award against a compliant framework in line with the framework's terms and conditions for value.

ii. An authorised waiver for framework award is required.

1.5 SPOT PURCHASE

1.5.1 Where the requirement is valued at £0 - £4,999, an authorised officer, in accordance with the Scheme of Delegation, may commit spend via the Purchase to Pay (P2P) system.

1.5.2 Any such commitment shall have a brief rationale for how it demonstrates value for money held by the authoriser of the individual spend.

1.6 QUOTATIONS

1.6.1 General Position on quotations

a) Quotations are required where formal tendering procedures are not adopted
b) All Quotation activity shall be recorded on the relevant Waiver form for spend of £5,000 to £100,000 or locally if £0 - £4,999;
   i. Where Competitive Quotations are undertaken, the budget holder is required to set out what process was undertaken, any exceptions and a value for money statement. A single tender waiver must be completed for evidence of value for money.
   ii. Where Non-Competitive Quotations are sought, the budget holder is required to set out the reason why a competitive process is not being followed and how the proposed supplier can deliver value for money in a single tender waiver.
   iii. These forms must be approved by the Head of Procurement and Executive Director of Finance / Chief Executive depending on the value.

1.6.2 Competitive Quotations

a) Quotations should be obtained based on specifications or terms of reference prepared by, or on behalf of, the Trust.
b) Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
c) All quotations should be treated as confidential and should be retained for inspection.
d) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.
e) Terms and conditions must be evaluated as part of any quotation award decision.

1.6.3 Non-Competitive Quotations

a) Non-competitive quotations in writing may be obtained in the following circumstances:
   i. the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
   ii. The supply of goods or manufactured articles of any kind which are required as a matter of urgency and are not obtainable under existing contracts;
   iii. Where the goods or services are for building and engineering maintenance where the responsible works manager can confirm there is a proprietary system/solution in place or specialist experience of the Trust is of commercial benefit to maintain an existing supplier.

1.6.4 Quotations that fall our side Financial Limits

a) As the markets and required specification with dictate the quoted price, appropriate approval must be sought for additional funding to be made available before a quotation can be accepted that falls outside the fall outside of the financial limits allocated for this good, service or building works.

1.7 TENDERING

1.7.1 The available procurement procedures available to be undertaken shall be shaped by the category of activity being tendered. The Common Procurement Vocabulary (CPV) codes are directly linked to the allocation of thresholds:

a) Light Touch Regime (LTR) Services
   i. Defined as only the CPV codes listed within Schedule 3 of the Regulations
b) Works
   i. Defined as only the CPV codes listed within Schedule 2 of the Regulations
c) Supplies and Services
   i. Defined as all other CPV codes not listed as LTR or Works

1.7.2 Exceptions and instances where formal tendering need not be applied.

a) Formal tendering procedures need not be applied where:
   i. The estimated expenditure or income does not, or is reasonably not expected to, exceed £100,000.
   ii. Where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with;
   iii. Regarding disposals as set out in clause 16;
b) Formal tendering procedures may be waived by the Executive Director of Finance in the following circumstances:
   i. Where explicitly defined within the Regulations that there is an exemption
   ii. Where the requirement is covered by an existing contract, such that it would not lead to a material change;

iii. Complaint routes to market exist that provide access to the Trust, these may take the form of;
   - National Contracts, through the management function of NHS Supply Chain known as Supply Chain Co-ordination Limited (SCCL) or by successor organisation Central Government Functions that tender on behalf of the wider public sector, i.e., Crown Commercial Services (CCS) or successor organisation
   - Procurement Hubs that have undertaken compliant procurement activity to provide their members with “Frameworks”. Any such access must be assessed and all requirements of the framework owner must be met. This may take the form of a “Direct Award” or “Mini-Competition”
   - Contracts let by other public bodies that have made a provision for other public sector organisations to access. Any such access must be assessed and all requirements of the contract owner must be met
   - Where a consortium or collaborative arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members; of which the Trust is a Lead Provider.

iv. Where the timescale genuinely precludes competitive tendering. Failure to plan the work is not a justification for wavering formal tendering;

v. Where specialist expertise is required and is available from only one source;

vi. When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

vii. There is a clear benefit to be gained from maintaining continuity with an earlier project. However. in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

viii. For the provision of legal advice and services as defined in the Regulations as eligible for an exemption
   - The Executive Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of legal advice and services

c) The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

d) Where it is agreed by the Chief Executive Officer or Executive Director of Finance that competitive tendering is not applicable and should be waived, a single tender waiver must be completed and the reasons should be documented and recorded by the completion and approval of a waiver form and reported to the Audit Committee.

1.7.3 Contracting/Tendering Procedure

a) All tendering activity shall be undertaken using Electronic Tender Documentation (ETD) and the Trust's eSourcing system.
b) All Tendering activity above threshold shall follow the prescribed procedures and mandated timescales within the regulations.
   i. Where below threshold, tendering procedures shall follow the principles of the prescribed procedures and ensure reasonable timescales are allocated.

1.7.4 Participation

a) The Trust is required to publish all relevant notices. Where an opportunity is advertised, the Trust must publish all opportunities over £25,000 on Contracts Finder.
b) The Trust operates an electronic tendering system. All invitations to participate must be requested and received using the eSourcing system.
c) The mandatory questions relating to mandatory and discretionary grounds for exclusion shall be asked of all participants, irrelevant of value.
d) All Tenders shall as a minimum include the following documentation:
   i. A full outline of the procedure methodology to be undertaken.
   ii. Evaluation criteria and scoring methodology.
   iii. The terms and conditions of contract.
   iv. Response deadliness and requirements.
e) Approved supplier lists
   i. As a public sector body the Trust may not hold its own "approved supplier list", where "approved supplier" is defined as a list of suppliers eligible to bid for business opportunities.
   ii. All opportunities must be advertised and competition sought in a proportional and compliant manner.
   iii. Evaluation methodologies must be sufficient to ensure bidders can be evaluated to ensure, as a minimum, they are;
      - Of good standing,
      - Suitably experienced,
      - Capable of delivering the contract.
      - Have capacity to carry out the contract.

1.7.5 Opening of tenders

a) All tenders shall be accepted only via the eSourcing system, and shall be received within an "electronic seal". Bids shall not be able to be opened until the submission deadline has passed and the "seal is broken".
b) Tenders shall be opened by the Head of Procurement, or delegated officer, and shall be recorded within the audit log of the eSourcing System.
c) The officer opening the Tender must be independent of the tenders lead procurement officer.

1.7.6 Admissibility

a) All tenders that meet all of the following shall be accepted
   i. Received on time

ii. Are Complete, i.e., all documents required have been submitted.
iii. Bidder meets all of the participation requirements.

1.7.7 Late tenders

a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered at the discretion of the Chief Executive or their nominated officer. For example:
   i. Technical issues that prevented the bidder form meeting the submission deadline.
   ii. That accepting the late tender is in the best interest of the competitiveness of the procurement exercise.
b) Once the seal is "broken" through the electronic portal no further late tenders can be received by the Trust.

1.7.8 Evaluation of formal tenders

a) Clarifications may be sought form bidders following receipt of tenders.
   i. These must be carried out in an open fair, and equitable manner such that no perception of basis can be demonstrated.
   ii. Any such clarification is for clarifying existing information and is not for the purposes of changing / re-submitting a response.
   iii. Must be recorded within the eSourcing system.
   iv. There must be absolutely no communication outside of the eSourcing system in relation to the relevant tender.
b) The published evaluation methodology for the specific tender must be followed. Deviation from this methodology is not permitted.
c) All evaluations must be recorded, and justifications for any scores allocated must be recorded within the eSourcing system.
d) The final award decision must demonstrate that it will deliver the level of quality of goods or provision of service in line with the Trust specification and Value for Money achieved.

1.7.9 Abnormally low tenders

b) The Trust has a requirement under Regulation 69 of the regulations to evaluate all tender values submitted and where a tender appears to be abnormally low in relation to the works, supplies or services, the Trust has to require an explanation of the price / costs in the proposed tender from the tenderer concerned.
   i. Before rejecting an apparently abnormally low tender, the Trust must request in writing details of the constituent elements of the tender which are considered relevant for the appraisal or verification of its apparent anomaly, such as:
      - the economics of the manufacturing process, of the services provided or of the construction method;
      - technical solutions chosen or any exceptionally favourable conditions available to the tenderer for the supply of the products or services or for the execution of the work;
      - the originality of the work, supplies or services proposed by the tenderer;

- Compliance with the environmental, labour, and social obligations referred to in Regulation 56(2); or
- Compliance with the subcontracting obligations established in Regulation 71; and
- The possibility of the tenderer obtaining State aid, Regulation 69(2)

ii. In view of the evidence supplied by the tenderer upon consultation, the Trust shall verify those constituent elements and reach a final decision on whether to reject the apparently abnormally low tender or not.

1.7.10 Award of Tenders

a) All contract awards following a tender process must include:
   i. All bidders informed of the outcome, via an "intent to award" notice. Any such communication must provide the relevant level of detail to de-brief the participants on the outcomes of the process.
   ii. A stand still period (10 days Alcatel Period) Good practice to adhere to.
   iii. A notice to the successful supplier(s) following the end of the standstill period, to conclude the award process.

b) Only following the completion of the standstill period may the Trust enter into a contract.

c) Only in exceptional circumstances may a supplier begin delivery of goods/services to the Trust prior to the contract being finalised and signed.

d) On completion of award, a Regulation 84(1) report must be completed. This report must be stored within the eSourcing system for audit purposes.
   i. A Regulation 84(1) report is not required for contracts called off under a framework agreement, if;
      - The framework agreement is with a single supplier and is awarded in accordance with Regulation 33(7), or
      - The framework agreement is with more than one supplier but the call-off contract is awarded without reopening competition in accordance with Regulation 33(8)(a)
   ii. Note that in all other cases a Regulation 84(1) report will be required for a call-off contract.

1.7.11 Tender reports to the CoCo

a) Reports to the appropriate Executive/Committee/Decision Making Group identified in the Scheme of Delegation will be made on all contract values exceeding £250,000.

1.8 ITEMS WHICH SUBSEQUENTLY BREACH THRESHOLDS AFTER ORIGINAL APPROVAL

1.8.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Executive Director of Finance.

a) Where a procurement exercise has been undertaken using a process complaint below a threshold, and the result is above the threshold it shall be abandoned, as it cannot be awarded, and compliant process undertaken.

b) Where contracts are varied over their duration, any material change that sufficiently alters the nature of the contract from its original award shall be assessed under the regulations relating to material change. Where it is identified that these variations are triggering a "material change", then the variation shall not be authorised and a new procurement undertaken to award a complaint contract that incorporates this change.

1.9.1 PILOT EXERCISES

1.9.1 Any Pilot that is undertaken, must ensure;

a) That it is no longer than 18 months in duration.
b) There is a clear audit of how the supplier(s) were appointed.
c) The solution being trailed must not lock the Trust into any proprietary system / solution.
d) A clear evaluation methodology must be published as part of the award, to enable a measurable and recorded outcome.
e) On completion, if successful, the information must be used to generate a specification and the requirement tendered accordingly.

1.9.2 Pilot exercises must not be used as an excuse for avoiding tendering procedures.

1.10 TRANSPARENCY OF AWARDED CONTRACTS

1.10.1 All contracts entered into on behalf of the Trust must be signed by a duly authorised individual, as per the Scheme of Delegation.

a) All contracts awarded must fully comply with;
   i. These Standing Financial Instructions
   ii. All applicable legislation
   iii. Have clear definitions and appropriate markings to highlight any elements that are "*commercially confidential*" in line with the latest FOIA and associated guidance.
b) The Head of Procurement shall be informed when a contract has been let and provided with;
   i. A copy of the final signed contract
   ii. A summary statement of the process undertaken to award the contract and how this was compliant with these SFIs.
c) Once awarded, all contracts in excess of £25,000 inclusive of VAT must have the correct contract award notice(s) published:
   i. ALL contracts must be published to the Trust publicly facing contracts register.
   ii. As per Regulation 112 for the Regulations, contracts awarded over £25,000 must also be published on the UK Government website: "Contracts Finder" (or successor).

1.11 PRIVATE FINANCE FOR CAPITAL PROCUREMENT

1.11.1 The Trust may market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply.

1.11.2 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

1.11.3 The Trust must comply with NHS Englands "Roles and Responsibilities in the approval of NHS Foundation Trust PFI schemes" and consider the "Risk Evaluation for Investment decisions by NHS Foundation Trusts".

1.11.4 Where the sum exceeds the thresholds set out in the Single Oversight Framework, the proposal must be submitted to NHS England. NHS England does not have any role in approving such plans, but it will consider the impact on the Trust's financial risk rating.

1.11.5 The proposal must be specifically agreed by the Board.

1.11.6 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

1.12 COMPLIANCE REQUIREMENTS FOR ALL CONTRACTS

1.12.1 The Board may only enter into contracts on behalf of the Trust within its statutory powers and shall comply with:

a) The Trust's Constitution, Terms of Authorisation, Standing Orders and Standing Financial Instructions;
b) And other statutory provisions;
c) Any relevant guidance published by the Independent Regulator and the Department of Health and guidance on the Procurement and Management of Consultants;
d) Such of the NHS Standard or Model Contract Conditions as are applicable.
e) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
f) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

1.13 PERSONNEL AND AGENCY OR TEMPORARY STAFF CONTRACTS

1.13.1 The Executive Director responsible for human resources shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Nationally or regionally contracts negotiated on behalf of the NHS should be used wherever possible, as specific NHS terms and conditions will be included to minimise risk to the Trust.

1.14 IN-HOUSE SERVICES

1.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also

determine from time to time that in-house services should be market tested by competitive tendering.

1.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering:

a) The specification must not be biased towards the in-house service
b) A decision shall be made, and rationale recorded, as to where an external third party is required to mitigate any conflicts of interest such that:
   i. The Trust can assure the market that the exercise being undertaken is fair, transparent and a “level playing field”
   ii. The evaluation panel is independent of the in-house service
   iii. How the in-house team and the decision-making process shall be segregated and kept independent.

1.14.3 The outcome of the procurement shall be presented as a contract recommendation to the Board and an internal contract shall be awarded in the same manner as a normal tender conclusion.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

1.14.4 Award to Wholly Owned Subsidiary shall follow Teckal guidelines and 8.14.4 most recent case law informing this guidance.

1.15 APPLICABILITY OF SFIS ON TENDERING AND CONTRACTING TO FUNDS HELD IN TRUST

1.15.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust’s trust funds and private resources.

2 CONTRACTING FOR PROVISION OF SERVICES

Key Points

All contracting activity shall ultimately be governed by the UK Public Contracts Regulations 2015 (the Regulations). All Employees who are involved in the exercise of commissioning or biding actives must follow the procedures set out below.

An employee who is involved any such activates must declare any conflict of interest directly to the Executive Director of Finance for it to be recorded and appropriate actions to be undertaken to mitigate the associated risk.

2.1 SERVICE CONTRACTS

2.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable legally binding Service Contracts with NHS commissioners for the provision of both the mandatory services specified in the Terms of Authorisation and also other services. On behalf of the Chief Executive, the Executive Director of Finance will lead on the agreement of contracts with commissioners.

2.1.2 All service contracts should aim to implement the agreed priorities contained within the Annual Plan. In discharging this responsibility, the Executive Director of Finance should take into account:

a) the standards of service quality expected, including those published by the Secretary of State under Section 46 of the 2006 Act;
b) the relevant national service frameworks and guidelines published by the National Institute of Clinical Excellence;
c) national tariffs published by the Department of Health or other agreed local pricing mechanisms where national tariffs do not apply;
d) the need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;
e) the provision of reliable information on cost, quality and volume of services;
f) previously agreed developments or investments plans;
g) payment terms and conditions; and
h) amendments to contracts and extra-contractual arrangements/SPA's.

2.1.3 Contracts should be so devised as to achieve activity and performance targets, minimise risks and maximise the Trust's opportunity to generate income.

2.1.4 The Executive Director of Finance shall produce regular reports detailing actual and forecast contract income where appropriate linked to activity with a detailed assessment of the impact of the variable elements of income.

2.1.5 Any pricing of contracts at marginal cost must be agreed by the Executive Director of Finance and reported to the CoCo.

2.1.6 Services provided to non-NHS organisations with a value greater than £250,000 over a 3-year period or the period of the contract if longer, must be performed under a legal contract and approved by the Finance, Performance & Productivity Committee and over £2m by the Board.

2.1.7 The risks and revenue streams associated with non-NHS activities should be appropriately insured with commercial (i.e., non-NHS RESOLUTION) underwriters.

3 NON-PAY EXPENDITURE

Key points

Employees, in choosing goods and services, shall always obtain the best value for money for the Trust.

Logs of purchase card activity must be submitted to the Finance department on a monthly basis.

3.1 DELEGATION OF AUTHORITY

3.1.1 The CoCo will approve the level of non-pay expenditure via budget setting on an annual basis and the Chief Executive will determine the level of delegation to budget owners via budget setting.

3.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services using the e-procurement system; and
b) the maximum level of each requisition and the system for authorisation above that level.

3.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

3.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

3.2.1 Any employee authorised to requisition goods or services shall comply with procedures issued by the Executive Director of Finance and, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement Department shall be sought. In case of any area of doubt, the Executive Director of Strategy, People, and Partnerships shall make the final adjudication.

3.2.2 The Executive Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below).

3.2.3 The Executive Director of Finance will:

a) agree with the CoCo regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and regularly reviewed;
b) prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;
c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
   i. Certification that:
      - goods have been duly received, examined and are in accordance with specification and the prices are correct;
      - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
      - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
      - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
      - the account is arithmetically correct;
      - the account is in order for payment
   ii. Instructions to employees regarding the handling and payment of accounts within the Finance Department

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as paragraph 11.2.4).

3.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to NPV) and the intention is not to circumvent cash limits or other budgetary constraints;
b) the appropriate budget owner must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet its commitments;
c) the Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed;
d) the budget owner is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered;
e) Some items of expenditure may be paid for in advance, these are limited to: training places, travel and hotel accommodation.

3.2.5 Official Orders must:

a) be consecutively numbered;
b) be in a form approved by the Executive Director of Finance;
c) state the Trust terms and conditions of trade; and
d) only be available to, and used by, those duly authorised by the Chief Executive.

3.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Executive Director of Finance and that:

a) all contracts [other than for a simple purchase permitted within the Scheme of Delegation or delegated budget], leases, tenancy agreements and other commitments which may result in a liability are notified to the appropriate person set out in the Scheme of Delegation in advance of any commitment being made
b) all orders are placed in advance of commitment to the supplier and goods or services being delivered
c) contracts above specified thresholds (see Scheme of Delegation) are advertised and awarded in accordance with section 8;
d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
    i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
    ii. conventional hospitality, such as lunches in the course of working visits
e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive;
f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, incidental purchases from petty cash and items obtained through the legitimate use of a Trust Purchase Card;
g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds, delegated limits or rules on virement/budget journal;
i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance;
k) petty cash records are maintained in a form as determined by the Executive Director of Finance;
l) all requisitions, orders and petty cash disbursements are to be correctly coded and made available for checking by the Finance Department;
m) certification of satisfactory delivery of the goods or services to the Finance Department is completed through the part-delivery advice (PDA) or “goods received note” process within 48 hours of receipt.

3.2.7 The Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

3.3 DELEGATED ORDERING, USE OF PURCHASING CARDS

3.3.1 The Executive Director of Finance in conjunction with the Trust's Finance Department, shall ensure that there are robust arrangements for controlling expenditure by Nominated Managers through the use of "purchase cards" to include:

a) a requirement for all holders of such cards to confirm in writing that they have understood the relevant terms and conditions provided to them by the issuing bank and their responsibility with regard to security and use of the card
b) controls including the use of purchasing activity logs (recording all purchases made with the card) which will then be submitted to the Finance Department on a monthly basis (or as requested) within prescribed timescales
c) written confirmation from the card holder that they will ensure that their card is only used to make "bona fide" Trust purchases
d) a requirement for any inadvertent personal use of such cards to be reimbursed to the Trust immediately and in full.

4 INFORMATION TECHNOLOGY

Key points

The role of Senior Information Risk Officer (SIRO) is undertaken by the Executive Director of Finance. All IT systems will have an Information Asset Owner(IAO).

4.1 The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery and business continuity plans.

4.2 The Executive Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust. This includes fulfilling the role of SIRO, which comprises the following duties:-

4.2.1 Understand how the strategic business goals of the Trust may be impacted by information risks.

4.2.2 Act as an advocate for information risk on the Board and in internal discussions.

4.2.3 Take ownership of risk assessment processes for information risk.

4.2.4 Review and agree actions in respect of identified information risk.

4.2.5 Ensure the Trust’s approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.

4.2.6 Provide a focal point for the resolution/ discussion of information risk issues where necessary.

4.2.7 Ensure the Board is adequately briefed on information risk issues.

4.3 The Executive Director of Finance will identify Information Asset owners for all IT systems. IAO’s have responsibility to:

4.3.1 Understand and address risks to the information asset/ system they ‘own’.

4.3.2 Provide assurance to the Senior Information Risk Officer (SIRO) on the security and use of the assets.

4.3.3 Ensure completion of relevant documentation prior to the implementation of a new system.

4.3.4 Lead and foster a culture that values, protects and uses information for the public good.

4.3.5 Perform annual Data Protection Health check on systems/ asset and Confidentiality Audits.

4.3.6 Knows what information the asset holds, and what enters and leaves it and why knows who has access and why and ensures their use of it is monitored.

4.3.7 Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs, and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons,

deletion or modification, theft, or damage, having due regard for the Data Protection Act, Human Rights Act and the Freedom of Information Act.

4.3.8 Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

4.3.9 Ensure that adequate controls exist such that the computer operation is separated from development, maintenance, and amendment.

4.3.10 Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

4.4 The Executive Director of Finance shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

4.5 The Executive Director of Finance shall ensure that contracts for computer services for applications with any organisation or agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission, and storage. The contract should also ensure rights of access for audit purposes.

4.6 Where another health organisation or any other agency provides a computer service for applications, the Executive Director of Finance shall periodically seek assurances that adequate controls are in operation.

5 RETENTION OF RECORDS

5.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained under the direction contained in " Records Management Code of Practice 2021", and to enable requests under the Freedom of Information Act (2000), to be met.

5.2 The records held in archives shall be capable of retrieval by authorised persons.

5.3 Records held under the "Records Management Code of Practice 2021" shall be managed, including destruction in accordance with the Trust Policies, which will comply with Data Protection and National Information Governance requirements.

6 RISK MANAGEMENT AND INSURANCE

6.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Clinical Governance Committee.

6.2 The programme of Risk Management shall include:

6.2.1 a process for identifying and quantifying risks and potential liabilities;

6.2.2 engendering among all levels of staff an understanding and a positive attitude towards the control of risk;

6.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

6.2.4 mitigation plans to offset the impact of adverse events;

21.2.5 the Commissioning Board Assurance Framework, and Lead Provider Risk Register.

6.3 INSURANCE: RISK POOLING SCHEMES ADMINISTERED BY NHS RESOLUTION

6.3.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme , this decision shall be reviewed annually.

6.4 INSURANCE ARRANGEMENTS WITH COMMERCIAL INSURERS

6.4.1 The Executive Director of Finance shall ensure that appropriate and adequate commercial insurance arrangements are in place.

7 BUSINESS DEVELOPMENT

This section relates to all business development activity for new business, retention of existing business, or expansion of existing business. This includes formal tenders, applications for funding, external business cases for funding, and grant applications.

7.1.1 All business development activity must be fully assessed for the strategic fit and the delivery, financial and clinical risk associated with the opportunity by completion of a Business Development Assessment Proforma by the Business Development team.

7.1.2 Approval must be sought prior to submission as follows:

a) business developments over £150,000 by the Executive Team
b) business developments under £150,000 by the Director of Finance or Director of Strategy, People and Partnerships.

7.1.3 The financial model must be agreed with the Director of Finance prior to submission

7.1.4 The delivery/clinical model must be agreed with the Director of Operations (or relevant Executive Director) prior to submission

7.1.5 The overall submission must be agreed with the Director of Strategy, People and Partnerships prior to submission.

7.1.6 Partner evaluation and due diligence must be carried out before entering into any partnership arrangements associated with the business development, and this must be approved by the Executive Team before any agreement is entered into.

7.1.7 Where a business development may meet the definition of a ‘significant transaction’, the Trust’s Significant Transactions Policy (March 2020) must be followed.

10.6.4. 10.6d. HSE - NHS Chief Executive Letter and Report on MSDs and V&A Interventions - March 2023

John Crookes

Health and Safety Executive
10 South Colonnade
Canary Wharf
London
E14 4PU

http://www.hse.gov.uk/

By email

28th March 2023

To: all NHS Trust and Board Chief Executives

Health and Safety Executive (HSE) - Recommendations for Managing Violence and Aggression and Musculoskeletal Disorders in the NHS

Please find attached HSE's summary findings on the management of risks from workplace violence and aggression (V&A) and musculoskeletal disorders (MSDs) in the NHS, following an inspection programme carried out between 2018 and 2022.

HSE is recommending that you consider the four main categories where management failings have been identified (Risk Assessment, Training, Roles and Responsibilities, and Monitoring and Review) and satisfy yourself that your Trust / Board is managing these areas in such a way as to comply with health and safety law.

This document is being circulated to all NHS Trusts and Boards in Great Britain via internal NHS EPRR channels. Copies of the recommendations are also being shared with relevant NHS employer and employee groups, employee representative groups and trade unions.

For HSE to be assured that suitable action has been taken, we will be undertaking further interventions with the NHS over the next 12 months. These interventions will follow a two-step approach as follows:

Step One: Several high-level interventions by appointment between NHS Trust Chief Executives and HSE Field Operations Division (FOD) Operational managers, to discuss what is being done at senior management level to address the risks from V&A and MSDs.

These interventions will focus on the findings from the 2018-22 inspections as detailed in the attached summary report. In addition, they will explore the following areas:

- steps taken by your organisation over recent years at senior level to address the risks from V&A and MSDs;
- leadership in ensuring that sufficient organisational attention, resources and priority are given to the reduction of V&A and MSD risks.

Step Two: Inspectors will carry out several site inspections to seek assurance that what was described to us, in the high-level interventions, is being delivered on the ground.

Inspectors will engage with a cross-section of management and the workforce to assess the measures taken. Feedback on findings, including details of any action required, will be given at the end of the visits, at senior level where possible.

If you have any queries on the above, please do not hesitate to contact us at public.services-sector@hse.gov.uk

Yours faithfully,

John Crookes HM Principal Inspector of Health and Safety

Head of Health and Social Care Services Sector
Transport and Public Services Unit, Operational Strategy Branch
Health and Safety Executive

Enc: Summary Report

MANAGING VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN THE NHS

A Summary of findings from April 2018 – March 2022 inspections of NHS Trusts / Boards focusing on workplace violence and aggression and musculoskeletal disorders.

- Between 2018 and 2022, HSE carried out a series of inspections to assess the management and control of risk from musculoskeletal disorders (MSDs) and violence and aggression (V&A) in the NHS.
- HSE selected these two areas for proactive inspection because they aligned with HSE's strategic priority of reducing work-related ill health. Violence and aggression is a stressor and therefore a contributory factor to work-related stress, which along with MSDs are the two most common causes of new and long-standing, work-related ill health [Statistics - Work-related ill health and occupational disease (hse.gov.uk)](https://www.hse.gov.uk)
- A total of 60 NHS trusts and boards (hereby referred to as NHS Employers for ease of reference) were visited across Great Britain (England, Scotland and Wales). This included acute, mental health and community trusts, but not specialist trusts such as ambulance services and represents approximately one in four of these NHS employers. Twenty organisations were inspected in each of three work years (2018-19, 2019-20, and 2021-22).
- In 38 (63%) of the NHS employers inspected over the course of the three work years at least one contravention of health and safety law in respect of management of risk from MSDs or V&A was identified. In 26 (43%) of the organisations inspected they were found to have contraventions across both areas.
- The level of contraventions of the law for V&A (60%) was slightly higher than that of MSDs (47%).
- The rate of contraventions of health and safety law that were found across each of the inspection years was as follows:

Contravention Rate		
	MSDs	V&A
2018-19	**10 (50%)**	**11(55%)**
2019-20	**11 (55%)**	**14 (70%)**
2021-22	**7(35%)**	**11 (55%)**
TOTAL	**28 (47%)**	**36 (60%)**

- Whilst this summary necessarily focuses on the issues identified during the inspections, it is important to note that nearly 40% of NHS employers were compliant or only needed some verbal advice (37%).

- The common feature where contraventions were identified were management failings. These are failings of the management systems and relate to the following four categories:

  - Risk assessment

    - This refers to the steps taken by NHS employers to conduct suitable and sufficient risk assessments to control the risk to employees from MSDs and V&A.

    - Issues identified during the visits included:

      - assessments being too generic, with high-risk areas not being identified;
      - assessments not including non-clinical workers who were exposed to the risk;
      - inconsistencies in the approach to risk assessment across the same organisation.

  - Training

    - This refers to the training on controlling risk from MSDs and V&A provided to employees.

    - Issues identified during the visits included:

      - training was too generic and lacked evidence it was based on a training needs analysis;
      - where training was identified as being mandatory, in practice it was optional for relevant workers to attend;
      - non-clinical workers who were exposed to the risk were not included in training;
      - no suitable assessment of the competency of the trainers.

  - Roles and Responsibilities

    - This refers to the allocation of specific roles and responsibilities within the organisation to effectively supervise and manage the risk to employees from MSDs and V&A.

- Issues identified during the visits included:

    - a lack of clarity over roles and responsibilities;
    - a lack of wider organisational awareness of who does what;
    - inadequate provision of time and resource given to those with roles and responsibilities;
    - no suitable assessment of the competence of those with specific roles and responsibilities to carry out that work.

- Monitoring and Review

    - This refers to conducting effective monitoring and review of existing risk control measures to ensure they are effective and that the risks to employees from MSDs and V&A are being effectively managed.

    - Issues identified during the visits included:

        - failure to actively monitor and review control measures to ensure they are effective;
        - insufficient time and resource being allocated to monitoring and review;
        - failure to use available data sources (eg absence data, incident reporting) in the review process;
        - a lack of clarity over what should be reported and how, leading to non-reporting.

- **In particular, the inspections found that, whilst NHS employers generally do have policies and procedures for MSDs and V&A in place, these are often not monitored or reviewed to ensure that they work in practice or remain effective.**

- These findings have been shared with a number of NHS stakeholder groups at national level and NHS unions. It is expected that all NHS employers will review their management systems for these common failings and take any remedial action identified by that review process.

END

11. FEEDBACK ON BOARD DISCUSSIONS

12. RESOLUTION

The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

Date & Time of Next Meeting

2 August 2023, 09:00-12:30