Board of Director Part I

Schedule Wednesday 4 October 2023, 9:00 AM — 12:30 PM BST
Organiser Hannah Sullivan

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
Time: 09:00AM, WEDNESDAY 4 OCTOBER 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: Zobia Khalil **Assistant Psychologist- Dementia and Frailty**

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.	**SUSTAINABILITY**				
6.1	(a) Finance, Performance & Productivity Committee Chair's Assurance Report August (b) Finance, Performance & Productivity Committee Chair's Assurance Report September	*B. Claire*	*10:00*	*Attached*	Assurance
	c) Finance Report	*D. Tomlinson & R. Sollars*	*10:10*	*Attached*	Assurance
6.2	Integrated Performance Report - Front sheet Enclosure 1: Integrated Performance Report	*D. Tomlinson*	*10:20*	*Attached*	Assurance
6.3	EPRR Annual Compliance	*L. Flanagan*	*10:30*	*Attached*	Assurance
7.	**PEOPLE**				
7.1	(a) People Committee Chair's Assurance Report August (b) People Committee Chair's Assurance Report September	*A. Baines*	10:40	*Attached*	Assurance
8.	**QUALITY**				
8.1	(a) QPES Chair's Assurance Report August (b) QPES Chair's Assurance Report September	*L. Cullen*	10:50	*Attached*	Assurance
8.2	Patient Safety Report	*S. Forsyth /*	11:00	*Attached*	Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
		Lisa Pim			
8.3	Infection, Prevention & Annual Control Report	*S. Forsyth / Lisa Pim*	11:20	*Attached*	Assurance
8.4	Safeguarding Annual report	*M. Homer*	11:30	*Attached*	Assurance
8.5	AHP Strategy update	*A.Jowett*	11:45	*Attached*	Assurance
8.6	Guardian of Safe Working Reports	*S. Pantall*	12:00	*Attached*	Assurance
9.	**GOVERNANCE & RISK**				
9.1 9.2	Review and update of the BAF – Cover sheet Updated combined Board Assurance Framework (BAF)	*D. Tita*	*12:10*	*Attached*	Assurance
9.3	Commissioning BAF	*D. Tita*	*12:15*	*Attached*	Assurance
9.4	Effectiveness Reports on Board Committees	*D. Tita*	*12:18*	*Attached*	Assurance
9.5	Annual Report from Remuneration Committee	*D. Tita*	*12:20*	*Attached*	Assurance
9.6	Cover sheet & BSMHFT Risk Appetite Framework	*D. Tita*	*12:23*	*Attached*	Approval
9.7	**9.7** Cover sheet – Risk Management Policy **9.7.1** BSMHFT Risk Management Policy	*D. Tita*	*12:25*	*Attached*	Approval
9.8	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:30*	*Verbal*	-
9.9	Any Other Business *(at the discretion of the Chair)*				
10.	**FEEDBACK ON BOARD DISCUSSIONS**	*Chair*	*12:30*	*Verbal*	-
11	**RESOLUTION** The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
	Date & Time of Next Meeting 6 December 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- Zobia Khalil

Assistant Psychologist- Dementia and Frailty

1. Opening Administration:

Apologies for absence & Declarations of interest

2. Minutes of the previous meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	**BOARD OF DIRECTORS**
Date	**2 August 2023**
Location	**Plymouth Room, The Uffculme Centre, Trust Headquarters**

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	Trust Chair
	Roisin Fallon-Williams	Chief Executive
	David Tomlinson	Executive Director of Finance
	Vanessa Devlin	Executive Director of Operations
	Patrick Nyarumbu	Executive Director of Strategy, People & Partnerships
	Fabida Aria	Executive Medical Director
	Linda Cullen	Non-Executive Director
	Anne Baines	Non-Executive Director
	Bal Claire	Non-Executive Director
In Attendance	Hannah Sullivan	Corporate Governance and Membership Manager
	David Tita	Associate Director of Corporate Governance
	Lisa Pim	Deputy Director of Infection Prevention and Control
	James Ntalumbwa	Deputy Director of Nursing
	Shane Bray	Managing Director of Summerhill Supplies Services LTD
Apologies	Sarah Bloomfield	Chief Nurse Officer
	Steve Forsyth	Interim Chief Nurse Officer
	Winston Weir	Non-Executive Director
	Monica Shafaq	Non-Executive Director

Agenda item	Staff story	Action (Owner)
	Ms V Theay was in attendance at the meeting, supported by Ms K. Allen, to share her personal story and experiences of mental health and services within the Trust. Ms V Theay highlighted the challenges within inpatient eating disorder services and the restrictions for service users to be able to take control of their routines. With 24 hour care it is difficult for service users to have any rest bite and this can significantly impact on those who suffer with sensory challenges. The Board heard how eating disorder services are focused primarily on the physical goals to be achieved and there is little mental health support for service users. Ms V Theay relayed her personal experiences in relation to her discharge from services and the lack of support available from the Trust and external partners.	

	The Board thanked Ms V Theay for sharing her experiences and for highlighting a number of areas for improvements and exploration. Mr P Gayle confirmed that stories that are bought to the Board will be analysed on an annual basis to ensure the Board have oversight of actions agreed.	

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** Mr P Gayle welcomed all who were observing the meeting and then referred to the procedure for questions from the public at board meetings which had been detailed on the agenda. Mr D Tomlinson declared a conflict of interest as Director of Summerhill Services Limited.	
2.	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meetings held on the 7 June 2023 were approved as a true and accurate record of the meeting with the exception of including Ms M Shafaq onto the attendees list. **ACTION. Ms H Sullivan to amend the minutes to reflect the inclusion of Ms M Shafaq onto the attendees list.**	**H. Sullivan**
3.	**MATTERS ARISING / ACTION LOG** All matters arising were noted. There was one action that requires a timeline to be determined. Ms V Devlin confirmed the details will be included in the next Chief Executive report to the Board of Directors. **ACTION: Ms V Devlin to include the details from the action agreed in June 2023 in the next Chief Executive report to the Board of Directors in October 2023.**	**V. Devlin**
4.	**CHAIR'S REPORT** The Board received an overview of the Chair's key areas of focus since the last Board meeting. The Chair advised that the report was taken as read and highlighted the updates from recent visits noting the significant improvements at Perry Barr Custody Suite with staff moral much improved and positive. Mr P. Gayle highlighted the importance of the Board being visible across all sites and asked that Board members secure time in their schedules to visit staff across Birmingham and Solihull. Mr B. Claire queried whether the ongoing issues with DBS clearances has been resolved? Mr P. Gayle confirmed this has been resolved. The report was received and noted with no further questions.	
5.	**CHIEF EXECUTIVE'S AND DIRECTOR OF OPERATIONS REPORT** The Board received an update from the Chief Executives key areas of focus since the	

Agenda Item	Discussion	Action (Owner)
	last Board meeting. The key points were noted as: **Sustainability-** The Trust has seen its funding increase by £10m in the last month to cover the costs of the recently agreed pay award for Agenda for Change staff – this covers the £6m cost for staff directly employed by the Trust, as well as the funding we pass on to other organisations for services we commission. **Sustainability-** Discussions are underway between Directors of Strategy to identify opportunities to work at scale to address immediate pressures and waiting times for ADHD. The collaborative has been agreed to raise the lack of funding and commissioning gaps with the national team in order to help develop a direction. **Sustainability-** NHS England visit was successful with staff at The Barberry and a great opportunity to showcase our mental health services. **Quality-** The Trust has had a response from the CQC relating to the requirement to continue submitting monthly reports for the Section 31 notice. While we were hopeful that these conditions would have been removed, we have been advised that the CQC would need to conduct a further inspection to assure themselves before this can happen. **Quality-** We have in recent weeks finalised and agreed a next phase approach to our QI, alongside additional resources and an enhanced strategic role for Dr Renata Rowe. **Acute and Urgent Care-** Flexible working arrangements have been taken up by more staff to ensure a healthy work-life balance and this is being supported by senior leaders as part of the division's workforce retention efforts. There remains, however continuing pressures associated with lower than desired staffing levels and initiatives continue to be explored to improve the workforce numbers. A focus on staff health and wellbeing and a call for Health and Wellbeing champions to support implementation of the work is in force. **Secure Care & Offender Health (SCOH)-** Services continue to experience RMN shortages across the men's and women's services impacting on clinical activities. Ward managers and Clinical Nurse Managers/Matrons meet daily on each site to prioritise work and assess shortfalls. Recruitment continues. **Integrated Community Care and Recovery (ICCR)-** ICCR have been working closely with partners across Birmingham supporting the community integrator developments. Efficiencies can be made in joining community mental health transformation, and we have already been able to share the good practice and developments of our multi agency teams meetings, as part of community transformation. **Dementia & Frailty-** Progress continues to be made on finalising the update to the operational framework and the operating procedure for the therapies only pathway. Dr L Cullen highlighted the importance of promoting the wellbeing offers for staff, recognising the need for flexibility and need for qualitative feedback to be captured for analysis through the People Committee and staff story feedback. The Board were assured the People Committee are reviewing the wellbeing offers and initiatives and are promoting these through the divisions. The Board noted the report highlights the improvements within the divisions supported by the ongoing deep dives. The report continues to develop to showcase the triangulation across the staff support elements. The Board recognised the ongoing pressures on services and increase in waiting times and need to work collaboratively to ensure these are being managed appropriately. The Board noted the improvements made in service transitions and were assured service user narrative is being captured in real time to allow for a deeper analysis into areas for ongoing improvements.	

Agenda Item	Discussion	Action (Owner)
	Mrs R. Fallon- Williams thanked colleagues for their ongoing support in ensuring services continue to be delivered throughout the ongoing industrial actions for consultants and junior doctors. The Board noted the ongoing impact of the industrial action and need for planning throughout the winter. The report was received and noted with no further questions.	
6.	**QUALITY**	
6.1	**Quality, Patient Experience & Safety Committee Chair's Assurance Report June and July 2023** Dr L Cullen provided a summary of the key highlights within the report as follows: • Currently there are 24 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer (total 38 so 63%). This is a deteriorating position from previous month whereby 49% of complaints were pending an Investigating Officer. • It was noted the work taking place around Learning Disability and Autism (LDA), that the Trust system was under significant scrutiny from NHSE/I due to us being an outlier specifically for support plans, care plans, prevent plans and for people with diagnoses and mental health coming into an inpatient bed in home treatment and across the organisation. • The new Head of Safeguarding has developed a plan to better manage the high number of actions and learning from external reviews and this includes collating these centrally on a tracker. • We have had a response from the CQC relating to the requirement to continue submitting monthly reports for the Section 31 notice. While we were hopeful that these conditions would have been removed, we have been advised that the CQC would need to conduct a further inspection to assure themselves before this can happen. The Board were assured the CQC report recommendations are a continued focus at the committee monthly. It was agreed oversight should be triangulate across all of the Board committees on a quarterly basis. Dr L Cullen and Ms A Baines agreed to meet to agree the logistics. The Board noted the overall decrease in staff assaults and highlighted the opportunity to capture the improvements through a quality improvement approach. The report was received and noted with no further questions. **ACTION: Dr L Cullen and Ms A Baines agreed to meet to agree the logistics of quarterly oversight of CQC action plans at Board committees.**	**A.Baines/ L. Cullen**
6.2	**Patient Safety Report** Ms L Pim presented the patient safety report which was taken as read. The key highlights were noted as: • During quarter 1, 20 Serious Incidents were reported by the Trust via the Strategic Executive Information System (STEIS), NHS England's web based serious incident management system of which 9 occurred in the month of June. There are no indicators of special cause variation over this period and reporting. • In terms of completed reviews, 13 reports were submitted for consideration of closure during the quarter. The themes arising from Serious Incidents include family engagement and support. • During quarter 1 there has been a total of 7 inquests held, 2 of which occurred in June. 6 of which reached a conclusion of suicide and the other a narrative conclusion, no care issues were highlighted. However 2 inquests held in July have	

Agenda Item	Discussion	Action (Owner)
	resulted in PFD's being issued to the Trust. The Board thanked Ms L. Pim for the detailed report and noted the improvements in the evolving data being reported. They requested that going forward the data is rated to provide assurance on the balance. There was a detailed discussion in relation to the correlation between the increase in complaints and the unexpected deaths. The Board were informed the unexpected deaths have been complex and that there are a number in processes in place in line with the duty of candour to support the processes. The Board was assured the Quality, Patient Experience & Safety Committee have oversight of preventing future deaths and thematic reviews alongside the overview from the Clinical Governance Committee escalations. Collaborations with West Midlands Police continue to develop and strengthen through the community. Stakeholder meetings continue to take place and have highlighted the need to consider the human elements through robust processes. It was confirmed the development of a new patient safety framework is progressing well and the Board were assured this will recognise specific areas and balance the reportable data. A quality improvement approach will be considered to capture the human factor going forward. The report was received and noted with no further questions.	
7.	**PEOPLE**	
7.1	**People Committee Chair's Assurance Report April and May 2023** Ms A Baines provided a summary of the key highlights within the report as follows: • Staff network representatives have started to attend meetings to share their stories, escalated challenges and pressures and showcase good practice. • Recruitment timelines remain a challenge with some new recruits experiencing significant delays in the processes. • Bank and agency spend continue to increase, triangulation and oversight is across the Board committees. Guidance from NHS England has now been received. • There is a renewed focus for health and wellbeing offers with offers being redeveloped. • Concerns in relation to ongoing industrial actions were raised with growing impacts that remain ongoing. Thanks were noted to the medical workforce team for their ongoing support. The Board noted that the risks associated with recruitment delays will be mitigated through the Board Assurance Framework. The Board were assured the People Committee receive quarterly reports that provide the details for recruitment. It was confirmed the current target for recruitment is 75 days, operational management meetings continue to review the processes and develop mitigations of risks. The Board noted the increase in agency and temporary staffing is due to clinical activity. The Board acknowledged the need to understand the establishment and promote flexible working across the divisions to support staff wellbeing.	

Agenda Item	Discussion	Action (Owner)
	A deep dive into the challenges noted has been agreed through the Performance Delivery Group. The timeline will be confirmed. The report was received and noted with no further questions.	
8.	**SUSTAINABILITY**	
8.1	**Finance, Performance & Productivity Committee Chair's Assurance Report June and July 2023** Mr B Claire presented both the June and July reports which were taken as read. A summary of the key highlights within the report as follows: • The month 3 2023/24 Group position year to date is a deficit of £288k. This is £288k adverse to the break-even plan as submitted to NHSE on 5.4.23. The position comprises a £437k deficit for the Trust, £119k surplus for Summerhill Services Limited (SSL), a £62k surplus position for the Reach Out Provider Collaborative and a break-even position for the Mental Health Provider Collaborative (MHPC). • Month 3 2023/24 Group capital expenditure is £2.2m. This is £2.1m adverse to plan due to works progressing ahead of plan, mainly related to risk assessment works including door set expenditure. • The Committee were assured by the Business Development including Partnerships work, it was explained that these are our core principles, making sure we can deliver on our core services before we consider expanding. • Areas are being identified for deep dives. The Board noted the Mental Health Provider Collaborative plan will be submitted to the Commissioning Committee going forward for oversight and assurance. There was a detailed discussion in relation to digital offers and the timelines for the Trust to utilise ICT to full capacity. It was confirmed the Finance, Performance & Productivity Committee receive quarterly updates and are developing an overarching framework for oversight and assurance. It was confirmed the Executive Team will review the current approach and consider options for adoption. The report was received and noted with no further questions. **ACTION: Executive Team will review the current approach to digital and consider options for adoption.**	**Executive Team**
8.2	**Finance Report** Mr D Tomlinson provided a summary of the finance report. A summary of the key highlights within the report as follows: • Expected break- even for this financial year. • Out of area expenditure – YTD £4.6m, straight lined for the full year, would equate to £18m against a plan of £8m. • Savings - £14.7m target. YTD shortfall against plan of £1.9m. £2.4m unidentified plans. • Temporary staffing – YTD bank and agency spend £10.9m, straight lined for the full year, would equate to £44m. YTD agency expenditure has breached the NHSE ceiling by £225k: agency spend as percentage of pay bill is 4.0% YTD compared to ceiling of 3.7%. • FCAMHS low secure occupancy 40% - YTD income shortfall of £211k, straight lined for the full year, would equate to £0.8m.	

Agenda Item	Discussion	Action (Owner)
	The Board were assured there are a number of options for delivering services through partnership collaboratives. The Board recognised the ongoing challenges and pressures and need to make fundamental changes across the Trust. The report was received and noted with no further questions.	
8.3	**Audit Committee Chair's Assurance Report July 2023** The Board received the assurance report and noted the anxieties in relation to the Reaside Clinic. Mr P. Gayle thanked Mr B. Claire for the report.	
8.4	**Integrated Performance Report** The Board received the Integrated Performance Report and noted the improvements following the deep dives being formalised through the Performance Delivery Group. The Board were assured that the risks in area will allow for a focused follow through that will support triangulation across the Board Committees. Ms V. Devlin confirmed there has been positive learning from partnership organisations that has seen an improved report for the Trust. The Board were assured the Executive Team continue to challenge and support the transition. Mr P. Gayle queried whether the reports data in relation to Covid is legacy or live? Mrs R. Fallon- Williams confirmed the Trust continues to have Covid outbreaks and this remains a concern. Mr D. Tomlinson confirmed the report does present some data that is a carry over from pre- Covid reporting. The Board were assured by the improvements in the reduction for out of area placements. Mr P. Gayle thanked Mr D. Tomlinson and Ms V. Devlin for the report.	
8.5	**Summerhill Services Limited Business Report (SSL)** Mr S Bray was in attendance at the meeting to present the Summerhill Services Limited Business report. The Board received and noted the report with a summary of the key highlights within the report as follows: • SSL continue to work with, audit and manage the Trust wide supplier for laundry and linen Elis. Concerns noted with the current performance, options are being reviewed to explore the ability for SSL to provide the service. • SSL have been working collaboratively with NHS Supply Chain; Food (Tower 10) integrating the Multi-Temperature Distribution model to achieve value for money. • Water management is a well-documented and structured process for all members of the Trust and SSL staff. SSL and Trust operate and manage over 50 sites across BSOL, however, over the past year one building has been more challenging more than others – Forward House. Forward House provides the Trust and SSL with challenges in water management.	

Agenda Item	Discussion	Action (Owner)
	These challenges are managed via the Water Safety Group (WSG) examining the options available and agreeing the appropriate actions and recording the decisions. • Capital Programme 22/23 completed successfully. • Capital Programme 23/24 progressing. • Staff engagement continues to improve with the introduction of a Weekly and Bi Monthly news letters. SSL will be introducing a SSL Futures program, which combines an apprenticeship and graduate programme. • Implementation of new food management and tablet-based ward ordering software. Implementation plan formulated. The Board acknowledged the need to review the options for Reaside and develop an overall plan that considers staff experience and wellbeing. The delays in capital for planning were noted and implications are being raised at national level. The Board were assured SSL continue to work with experts to address the issues with water management to ensure the full use of facilities going forward. The report was received and noted with no further questions.	
9.	**GOVERNANCE & RISK**	
9.1	**Annual Medical Appraisal and Job Planning** The Board received and noted the report and were assured by the update provided. The Board formally approved the Annual Board Report and Statement of Compliance. Mr P. Gayle queried the current average of programmed activities. Dr F. Aria confirmed the offer of flexible working has seen a positive reduction in programmed activities. Mr P. Gayle thanked Dr F. Aria for the report. **DECISION: The Board formally approved the Annual Board Report and Statement of Compliance.**	
9.2	**Updated combined Board Assurance Framework (BAF)** The Board received the Board Assurance Framework and noted the significant improvements following the inclusion of all of the Board Committees recommendations. The Board were assured the Board Assurance Framework will be now maintained at divisional level. The Board were assured the Board Assurance Framework is reflected of the Trust's strategy and that operational risks are now reflected in the relevant risk registers. The Board were assured the Board Assurance Framework will be now maintained at divisional level. The Board noted the corporate risk register continues to be developed. The Board noted their thanks to Mr D. Tita for his continued dedication to improve the Board Assurance Framework.	
9.3	**Commissioning BAF** The Board received the Commissioning Board Assurance Framework and were	

Agenda Item	Discussion	Action (Owner)
	assured this is being developed in line with the recommendations from the Commissiong Committee. Mr P. Gayle thanked Mr D. Tita for the report.	
9.4	**Draft Board Risk Appetite Survey Monkey** The Board received and noted the report and approved the survey for adoption and implementation. Mr P. Gayle thanked Mr D. Tita for the report. **DECISION: The Board approved the survey for implementation.**	
9.5	**Questions from the Governors and Public** The Chair opened the meeting for members of the public to ask questions. A member of the public thanked the Board for the opportunity to ask questions and queried the following: S117 Aftercare is designed "to meet immediate need to cope with life outside of hospital" – Mental Health Code of Practice, para 33.5. What assurances have the Board been given by the organisation that by removing the 28-day early review of care for S117 Aftercare service users the organisation has put the best interests of these service users at the heart of its decision making and is thus meeting its legal duty to support these service users in a timely way with life outside of hospital? Given this legal duty, defined as "the duty to provide aftercare (which) begins when the patient leaves hospital" (Mental Health Act Code of Practice, para 33.10) and in order to minimise the potential for interruption to treatment and care which will support people to recover in a meaningful way, what, therefore, is the Board's expectation of the organisation re a timescale to assign a care coordinator and for an initial medical review which will identify the necessary ongoing care and treatment for those service users who are discharged from inpatient care through the SPOA into the care of BSMHFT under S117? What operational procedure/policy now outlines this timescale and what evidence does the Board see that assures you the organisation is meeting this and thus its legal duty to support the most at risk of re-admission to inpatient care? The Board thanked the member of the public for submitting the questions prior to the public meeting allowing the Board to consider the matters in detail. Ms R Fallon- Williams confirmed the S117 is a jointly owned policy whilst acknowledging this is an national issue. Ms V Devlin confirmed there had been a system partnership meeting in April where the Memorandum of Understanding was reviewed with the local authority, this highlighted the need for a full review. The partnership group is inclusive with members from across the partnerships and experts by experience. Ms V Devlin noted it would be positive for the member of the public to join future meetings to share their experiences and to offer areas for improvements and development of policies. The Board acknowledged the challenges and delays and need to shape the future. Ms R Fallon- Williams confirmed the Customer Relations Team were available for further discussions following the meeting to address any additional concerns.	

Agenda Item	Discussion	Action (Owner)
9.6	**Any Other Business** There was no further business.	
10.	**FEEDBACK ON BOARD DISCUSSIONS** There were no further discussions. Mr P. Gayle thanked all attendees for their participation and formally closed the meeting.	
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.	
	DATE & TIME OF NEXT MEETING Wednesday 4 October 2023, 09:00– 12:30	

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS – OCTOBER ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
August 2023 Item 2	**MINUTES OF THE PREVIOUS MEETING** Ms H Sullivan to amend the minutes to reflect the inclusion of Ms M Shafaq onto the attendees list.	H. Sullivan	October 23		Complete
August 2023 Item 3	**MATTERS ARISING / ACTION LOG** Ms V Devlin to include the details from the action agreed in June 2023 in the next Chief Executive report to the Board of Directors in October 2023.	V. Devlin	October 23		Included in report
August 2023 Item 6.1	**QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE CHAIR'S ASSURANCE REPORT JUNE AND JULY 2023** Dr L Cullen and Ms A Baines agreed to meet to agree the logistics of quarterly oversight of CQC action plans at Board committees.	A.Baines/ L. Cullen	October 23		
August 2023 Item 8.1	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE CHAIR'S ASSURANCE REPORT JUNE AND JULY 2023** Executive Team will review the current approach to digital and consider options for adoption.	Executive Team	October 23		On forward planner for discussion at Executive Team meeting

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	4 October 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.

BOARD OF DIRECTORS CHAIR'S REPORT

1. INTRODUCTION

I begin my report by firstly recognising the impact of pressures on our hardworking colleagues that we have seen continuing throughout the year and some of the causes that are compounding those pressures.

Visiting many of our services I have been made aware of the relentless operational pressures that our community services continue to experience with regards to service demand, waiting times and recruitment. However, I understand that transformational plans are taking place with regards our community services which should alleviate some of these pressures.

Our inpatient services also remain quite stretched with high demands for beds, coupled with recruitment challenges. In recognising the scale of these challenges, it is important to acknowledge the consequential impact this has on our staff. Our staff are continuing to work hard to provide the best quality of care to our patients and service users. As a Trust Board, we recognise the need to support our colleagues ensuring we prioritise the wellbeing of our colleagues and we will continue to be proactive in supporting them, offering Trust wellbeing support options.

2. CLINICAL SERVICES

2.1 NEDs are picking up pace and are visiting our Trust services, which will increase over the coming months. Most NEDs and governors now have the appropriate level DBS certificate on file to undertake service visits. The uptake of governors attending visits is low and I would encourage our governors to connect with our NEDs to attend a site visit with them.

2.2 I have spent time visiting staff across Trust sites on a weekly basis and have been humbled by their dedication to delivering the best possible services. I have visited Endeavor Court, Ashcroft Services supported by Mustak Mirza, Lyndon Clinic, the Barberry, Hillis Lodge, Northfield, I met with staff from our Liaison Psychiatry services based at Good Hope Hospital.

Finally, I met the staff at Reservoir Court and had the opportunity to meet the Dementia and Frailty Team and see/ hear about the good work they are doing. I also had the opportunity to meet with our colleagues in the CMHT also working very well whilst coping with service challenges due to increased numbers of people requiring their service.

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3. PEOPLE

3.1 I met with Andy Cave and Richard Burden from Healthwatch, and they shared with me how positive it has been to maintain these regular meetings to give them assurance on points of clarity about our inpatient and community services. I believe we need to strengthen our partnership working and in future the Chief Executive of Healthwatch (Andy Cave), will meet with our executive colleagues to respond to any operational queries they may have.

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 they allow me the opportunity to hear about future developments and challenges SSL experience.

3.3 I am pleased to confirm that following a robust recruitment process, Susan Bedworth has been appointed as a Non- Executive Director. Once all of the due diligence new starter paperwork and related assessment is completed, she will commence in post.

3.4 Anne Baines, Non- Executive Director has given notice and will be leaving the Trust at the end of September. At the time of writing this report the interviews for a new Non- Executive Director are scheduled for 13 September 2023 and so a further verbal update will be provided at the Council of Governors meeting on 14 September 2023. We want to thank Anne for her valued contributions throughout her time on the Board and wish her well in her future endeavors.

4. QUALITY

4.1 I was pleased to be able to meet with Mr. Andrew Mitchell, MP, at Good Hope Hospital with the intention of showcase the wonderful Psychiatric Liaison team at Good Hope Hospital. However, due to Andrew Mitchel double diary appointments and his time constraints he met with one of our staff members and asked him about the service but didn't get the chance to visit the area where the teams' offices are based. However, this visit allowed Mr. Mitchell to hear about the services provided firsthand to individuals within his constituency. We have agreed to re-book a visit for him to have more time to meet staff and the location where the team is based.

4.2 I was pleased to be able to meet with Mr. Gary Sambrook, MP, at Hillis Lodge. This was a great opportunity for us to meet and discuss the ongoing areas of development within his constituency. As above he too was constrained by time and will be returning to the site to undertake a full visit of the whole service.

5. SUSTAINABILITY

5.2 I can 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. The first session took place in August 2023.

5.3 The elections process for the Council of Governors has concluded Hannah Sullivan will provide a full update.

PHIL GAYLE
CHAIR

5. Chief Executive’s and Director of Operations Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**Item 5**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	4 October 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

The 7th period of industrial action by Junior Doctors is taking place on 2nd, 3rd and 4th October. Consultants will also be taking part in their 4th period of industrial action on the same dates. During this time a level of service equivalent to Christmas Day will be provided meaning that emergency care is in place. Dual action in particular, invariably impacts on all healthcare professionals in the organisation with many clinical and other activities needing to be rescheduled. We continue to support eligible employees to take strike action if they wish and ensure emergency cover is in place.

The number of junior doctors participating in Industrial Action increased from an average of 47% to 64% in August. The number of Consultants participating in action has remained consistent at around 36%. Data for September was not available at the time of writing this report.

The BMA balloted junior doctors in August regarding continuation of industrial action. Nationally, 71% of doctors entitled to vote responded and of those 98% voted in favour of continued action. The BMA wrote to the Secretary of State for Health and Social Care on 17th August seeking pay restoration for doctors in the Specialty and Associate Specialist (SAS) grades and that on 20th September they would decide to proceed with a ballot for industrial action by this grade of doctor.

Workforce Planning

Workforce planning for 2024/25 is due to commence with the People team meeting with our operational colleagues to start these conversations and understand priorities for the next financial year. We have seen some positive increases in our workforce numbers since April 2023 and retention has also improved with our turnover reducing to 8.8%.

First line manager training programme

The L&D team are re-launching the training package for first line managers. The modules will broadly cover Health and safety, H.R tool kit, ICT, Systems training, Leadership and management. This has now been expanded to include EDI, Health inequalities and Q.I modules.
Colleagues are not expected to complete every module, so that managers at different points in their careers can access what they require. It is however an expectation that the entire programme would be recommended for managers that are new to role. The first cohort of modules should all be available by October 2023.

Temporary Staffing Service (TSS) - Pastoral Care

As part of the Trust wide onboarding review a number of areas have been identified within TSS to improve the experience of our TSS colleagues, this includes streamlining processes, supporting TSS colleagues who are awaiting Averts training and taking steps to address inequalities. Further support has also been put in place around health and wellbeing.

CLINICAL SERVICES

Summary

The post pandemic period has presented service areas with challenges in particular in terms of filling staff vacancies and increasing demand on services. 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 have been working closely with partners across Birmingham supporting the community collaborator developments (previously named community integrator). The pilots in the West and East of the city are supporting front line care, which will improve access to health and social care services and increase productivity across the pathways.

Neighbourhood mental health teams (NMHT) continue to expand across BSol, by working with Primary Care Nurse (PCN) leads to ensure local needs are met along with the employment of mental health workers at the PCN level. The NMHTs have supported over 10000 people over the past 12 months.

Community Mental Health Teams had a focused Care Quality Commission (CQC) inspection in August, during which a number of concerns were raised. Service leads are working towards immediate improvement action plans and audits have been undertaken to ensure Clinical Governance Committee agendas have been updated.

Seven meet & greet facilitators have been recruited to our Community Hubs. As part of the project's communication and engagement strategy, Experts by Experience were engaged in the project and provided insightful suggestions on shaping the new role. Safety, first aid and mental health awareness training is underway for the newly appointed facilitators. The roles will become an established part of the community hubs front of house offer.

Performance 'deep dive' meetings are in process across the directorate to look at key areas of performance. These are in addition to our local Clinical Governance Committees. A detailed action plan has been devised to support improvements in our quality assurance processes across the areas of focus ie: Waiting times; Did Not Attend (DNA); Integrated care record (ICR) completion, and supervision and have already seen improvements in our Care Programme Approach.

Our Head of Service for Addictions, Homeless and Solar Service continues to work closely with partners across Solihull to ensure the oversite and coordination of the Solihull mental health delivery plan, which forms part of the wider locality delivery plan in Solihull.

Despite increasing staffing pressures and capacity pressures the directorate continues to support all teams with individual discussions within the leadership teams around their health and wellbeing, equality, diversity and inclusion and bullying and harassment. These sessions with teams have been very engaging and have generated further ideas to be taken forward to support our teams.

Secure Care & Offender Health (SCOH)

All prisoners based at (HMP) Birmingham have been offered testing and treatment for Hepatitis C. An HMIP Thematic review has taken place reviewing waiting times for prisoners requiring transfer to mental health facilities, the results will be analysed and

action plans formulated, with oversight of its delivery via the local clinical governance committee. A Quality Network review has also taken place which received positive feedback. We have an improving staffing position with the recent recruitment of new staff members.

Secure inpatient services continue to experience Registered Mental Health Nurse (RMN) shortages across the services. We are pleased to report that internationally educated nurses have commenced employment, which has had a positive impact. Ward managers and Clinical Nurse Managers/Matrons are meeting daily on each site to prioritise work and assess any shortfalls.

We are pleased to report that 7 Assistant Psychologists (Band 4) have been recruited, a number of vacancies remain and interviews for Band 7/8a Psychologists are scheduled to take place in September.

Our secure inpatient wards continue to experience high acuity levels and clinical activity and continue to be managed well and safely. In the women's service, seclusion and segregation hub and the shop environmental works have been completed. In forensic Child and Adolescent Mental Health Services (CAMHS), seclusion work commenced in August 2023, and is due for completion by March 2024.

Positive discussions have taken place with Community Mental Health Teams and Assertive Outreach Teams regarding the current challenges with enabling services users to move to step down facilities with the support of local community teams. The Forensic Intensive Recovery Support Team (FIRST) transformation workstream has taken place and work is now underway on the service definition and service operating procedure. FIRST is working with the safeguarding team to improve practice in relation to domestic homicide reviews.

Acute and Urgent Care

Transformation work within our Urgent Care Team and pathway continues, with positive feedback from the Integrated Care Board leads regarding how mental health services have helped to address complex issues and support patient flow over the last few months.

Staffing levels continue to be a challenge with Ward Managers frequently working in numbers, but we anticipate the arrival of new starters within the next month which will start to have a positive impact and start to reduce our vacancies.

Compliance to the autism awareness and Oliver McGowan training has increased, and 14 Learning Disability and Autism (LDA) leads have been identified within our Home Treatment Teams (HTT) to support the embedding process.

Mary Seacole House 1 (MSH1) was awarded Trust Team of the Month, and across the directorate there have been a number of innovative service user events over the summer, including a 'sports week' for all patients at Mary Seacole House.

Specialties Services

We are pleased to report in our older adult services that we have recruited to a number of vacant band 6 posts as well as the recruitment of internationally educated Nurses who are starting this month on Rosemary and Bergamot, this is having a positive impact on the service and vacancy levels.

Within our community mental health teams we will be celebrating Silver Sunday National Day for Older People, with a Coffee Morning planned for 1st October at Uffculme. Celebrity attendance of Jasper Carrot, Mushtaq Mohammed and Fred Ramsey has been confirmed.

Following a stakeholder event, we will be launching a quality improvement project to look at our dementia pathway working across the community mental health teams.

We continue our collaborative working across the ICS footprint in a number of initiatives the first is the North Hub CMHT Post Dementia Diagnostic Education Collaborative, working with Birmingham Hospices. In Hall Green Health Centre we are looking at the introduction of Cognitively therapy into Primary Care and improving dementia referrals to BSMHFT, we are exploring additional funding to help with this pilot and collation of the outcomes.

In our specialties services our focused work looking at our current Key Performance Indicators (KPIs) is resulting in improvements for example, our out-patient waiting lists for manualised interventions are slowly reducing. We have managed cancellations and DNA's well and have not had any unplanned days / nights of no occupancy / cancelled shifts. We are proud to report that our consultant scientist Dr Khalsa has presented at international congress on sleep and continues to publish highly respected papers.

A Clinical Associate Psychologist (CAP) will be starting in Deaf services in October. We believe this will be the first ever deaf CAP apprentice nationally and will be hugely beneficial in terms of what the service is able to offer.

We continue to focus on recruitment and retention in our Birmingham Healthy Minds (Talking Therapies Services) We have recently recruited Senior Employment Advisors and Employment advisors, via funding from the Department of Work and Pensions (DWP) until March 2025. We have recruited to a number of posts including within the services Senior Management team. Our high intensity trainees and our psychological wellbeing practitioners are due to qualify this autumn and have been successful in getting substantive roles within the service. We also have additional High and low intensity trainees due to start in autumn 2023, all these new colleagues are having a positive impact on service delivery and our vacancy position.The service has registered and commenced a Quality Improvement (QI) project regarding reduction of waiting times.

Mark Cox, Interim AD returned to his post as our Perinatal Service Manager in September, as Keish Dell has returned from maternity leave. We would like to thank him for his support and achievements for the services during the past year.

Within the perinatal service, working groups are being established with members of different disciplines to look at establishing best practice and resource guides for working with people with additional needs. This includes groups supporting people with neurodevelopmental (ND) or suspected ND diagnosis, working with LGBTQ+ families, supporting people with diabetes in the antenatal period, and reducing DNAs.Mark Cox, Dr Giles Berrisford and Cathy Coombs Consultant Clinical Psychologist presented a paper to the Mental Health Provider Collaborative on 31st August providing an update on the Long-Term Plan Ambition achievements and remaining challenges including funding.

In our bipolar service we are pleased to report that the waiting times from referral to assessment for the Mood on Track Programme has shown a reduction. The team are excited for a new cohort of undergraduate students to join the team for a year starting in September and October.We have been working with an animator and a group of service users to make an animation to illustrate the Mood on Track to service users which we hope will be widely shared by community teams and will encourage referrals and people to take up the offer of Mood on Track.

We are proud to report that that our inpatient occupational therapy team is now fully

staffed and we have 2 new occupational therapy assistants joining our Reservoir Court Team and Sage team in the next few months.

The Solihull CMHT occupational therapy staff have applied to the 'Fairer Futures Fund' to consider support for their Recovery through Activity group which aims to re-engage older people with mental health needs with everyday activities.

SUSTAINABILITY

2023-24 Funding

The Birmingham and Solihull system continues to experience significant financial challenges and our collective response to these is being managed through a new system Financial Recovery Board. We continue to work with partners to develop plans to utilise the recently announced additional funding for meeting winter pressures. We heard at our committee meeting that plans are already being developed to look ahead to the next financial year starting in April and we will be able to update further on funding and plans as they become clearer through the autumn.

West Midlands Mental Health, Learning Disability and Autism Provider Collaborative

Development of an All-Age West Midlands MH and LDA Strategy- A strategic framework has been developed and currently is being discussed with the Executive Teams of each Trust to agree common areas of future collaboration.

Development of the Regional Bed Strategy- Discussions with operational and clinical leads of Trusts are taking place to collate softer intelligence about local bed plans. In addition, as per the Long-Term Plan, NHS England have asked each ICB to develop a three-year local bed strategy, and the development of regional Trust based strategy will be aligned with the ICB work to ensure plans are robust and there are agreed areas for joint development.

Increase of Supervision Capacity for Psychological Therapies Programme- Development of the Regional Supervision Hub- Two-day awareness courses for c1350 staff have been commissioned and the training programmes will commence in November. Additional supervision capacity has also been secured from accredited practitioners and institutions and staff in Trusts will be offered online group supervision from November onwards for initially six months. An initial review will be conducted in the new year to determine whether to roll out the supervision for further six months.

Clinical Support Worker Role Development Programme- The first phase of the Developing Health Care Talent Programme is coming to an end. So far c100 staff trained and positive feedback from staff and managers has been received. Staff and managers' engagement sessions are taking place at the end of September and in early October to finalise the Competency Framework implementation plans for each Trust. The planning of the second phase has started and will focus on the development of clinical competencies framework and the expansion of the Developing Health Care Talent Programme.

Birmingham and Solihull (BSoL) Mental Health Provide Collaborative Update

The BSOL Mental Health Provider Collaborative has now reached its six-month period of operation, working across the system with partners to drive forward the activities of the collaborative at scale and pace.

Key activities currently underway

- Recruitment is underway for a Head of Quality which will operate across both the BSOL Mental Health Provider Collaborative and Reach Out. This will strengthen our approach to quality and enable cross fertilization of knowledge and experience across the collaboratives.
- A review of future bed requirements is being undertaken along with the development of a new model of care which focusses on purposeful admissions and supported discharges.
- The BSOL collaborative has been engaging in the Children and Young Peoples (CYP) Mental Health Scrutiny Inquiry across Birmingham which will see a series of recommendations for the collaborative to take forward.
- The Collaborative has supported the development of a system wide Co-production strategy to support the delivery of commissioning and transformation across the collaborative.
- Work continues on the activities required to shape our BSOL Mental Health Provider Collaborative Strategy with partners working together to drive forward the Health Needs Assessment and Experience of Care Campaign.

QUALITY

CQC

The Compliance team continues with its programme of assurance testing to review those actions marked as complete. Following our most recent engagement meeting with the CQC on August 31st, we are now once again awaiting feedback as to whether we continue with the monthly submissions for the Section 31 Notice. On the 22nd of August, the CQC issued the Trust with two additional Section 29A notices around clinical risk assessments and medicines management in CMHTs. We are currently working on the responses to these. The findings from the medicines management audits have shown positive outcomes and we will work with the service to establish how we maintain this improved picture going forward.

Quality Improvement (QI)

We have made some additional investment to our QI approach and recruitment has commenced to a number of roles to support further embedding and a focus on key strategic quality improvements, lead by Dr Renarta Rowe in her Deputy Medical Director for Quality role. Current work includes completing our NHS Impact self assessment for submission later in October which will give us an up to date picture of where our Strategic focus needs to be.

LOCAL NEWS

Birmingham City Council

Birmingham City Council has issued a s.114 Notice, making clear its significant financial challenge.As you will be aware, in June, the Council announced that it has a potential liability relating to equal pay claims in the region of £650m to £760m, with an ongoing liability accruing at a rate of £5m to £14m per month. Mandatory spending controls were immediately introduced.

The s.114 Notice is part of an overall strategy to restore the Council's finances but does not mean that the Council is unable to pay its staff, contractors, or suppliers. Difficult

decisions will need to be made in relation to how the Council serves its citizens and steps must be taken to significantly curtail spending in the short term.

Details of what this means will be set out in a Financial Recovery Plan, which the Council will be develop over the coming weeks.

Care Quality Commission's (CQC) System Pilot

NHS Birmingham and Solihull has been chosen alongside Dorset to take part in the Care Quality Commission's (CQC) pilot assessment to assist the regulator to develop a new inspection regime for Integrated Care Systems.

The initial stages of the inspection have already begun, with teams, including BSMHFT, contributing to a number of information requests, and a number of assessment activities are planned during October and November.

Celebration of World Patient Safety Day 17th September

We celebrated World Patient Safety Day as a Trust across the week that followed the 17th September, Staff were invited to offer safety pledges, and a wide range of patient safety materials were available and on display. The stall remained open all week and was manned by the Patient Safety Team.
We launched a Patient Safety Poster competition on the first day, formal judging of entries will be undertaken in December with the top 3 entries invited to a learning event to take place in April next year celebrating the trusts commitment to learning and improvement.

NATIONAL ISSUES

Lucy Letby Case

We are all very much aware of the horrific actions of Lucy Letby at the Countess of Chester and the devastating impact her actions have had on the families and colleagues involved as well as their wider impact for the public and the NHS as a whole.
An enquiry will now take place to examine and explore the entire circumstances surrounding the events, and we expect this to lead to extensive learning and potential changes. We are as a Trust at this juncture, reflecting on what is known now and how this can inform our actions and approaches to our patient safety and our culture.

Parliamentary Select Committee Invitation - Health and Social Care Committee

The Committee held a one off evidence session looking at the Right Care Right Person model for police response to mental health calls, following the publication of the National Partnership Agreement in July.

The Health and Social Care Committee is appointed by the House of Commons to examine the policy, administration and expenditure of the Department of Health and Social Care and its associated bodies.

Further details can be found on the following link:
Health and Social Care Committee - Summary - Committees - UK Parliament

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. SUSTAINABILITY

6.1. (a) Finance, Performance & Productivity Committee Chair’s Assurance Report August

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Finance, Performance & Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 October 2023**
Date(s) of Committee Meeting(s) reported	**23 August 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Integrated Performance Report 2. Finance Report 3. Strategy update – sustainability priority 4. Strategy update – clinical services priority 5. EPRR Annual Report 6. FPP Committee Annual Self-Assessment Monkey Survey Results
Alert:	The Committee wishes to alert the Trust Board to the following issues: - • Out of area inpatient activity challenges remain significant with a spend for the four months of £6.2m, significantly higher than plan. The main issue relates to PICU usage. Key areas of risk and dependencies have been identified as well as the expected benefits from each workstream supported by improvement metrics to track progress. • There are some improvements in efficiency achievement, although this mainly relates to interest receivable which does not offset significant under achievement in Out of area. It was recognised that there is more to do in terms of developing a robust pipeline of opportunities that will drive recurrent savings year on year. • Bank and agency expenditure is at its highest monthly spend in four years and is at £15m for the four months. A detailed agency reduction options appraisal has been submitted to senior management for its proposals to be incorporated in conjunction with impending ICB policies and restrictions. • Whilst the Trust is looking to achieve a break-even position for the year end, the above pose significant risks to the plan. And whilst there may be enough balance flexibility within the Trust's finances to achieve break-even, it was recognised by the executive team that is not sustainable going into next year. Additionally, it was recognised that our strategic and transformation programmes/projects are not all viewed through a financial lens – this is a cultural shift the executive team will be looking to correct going forward. • This has already been escalated by NHS/E whereby ICB systems have been identified through its financial governance. The Trust has been proactive in its response by establishing a vacancy control

	panel and an investment oversight group, but this focus from the centre is not likely to diminish unless there is a significant shift in financial assurance.	
Assurance:	The Committee was assured on the following matters: • The Committee was assured by the Strategy update for sustainability and clinical priorities. • Annual Self-Assessment- It was reported that all committees are demonstrating consensus that committees are delivering on core business, statutory and regulatory. • The Committee took a significant amount of assurance from the detail provided regarding the planned improvements to the performance management framework including Deep Dives with directorates. Additionally, the Trust as part of its performance management review is looking at other Trusts, against which it can benchmark best practice.	
Advise	The Committee wishes to advise of the following matters: • The EPRR Annual Report was received and approved by the Committee and will be included in the Board of Directors meeting in October 2023. • The need for further discussion on transformation and how to derive financial benefits from this. • Ther Trust has responded constructively to requests from the Regional Director of Finance regarding tighter financial controls.	
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: 1. None were identified.	
Report compiled by		**Minutes available from: Nicola Raybould**

6.1.1. (b) Finance, Performance & Productivity Committee Chair’s Assurance Report September

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 October 2023**
Date(s) of Committee Meeting(s) reported	**20 September 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Integrated Performance Report • Finance Report (including Year-End Forecast) • Terms of Reference Annual Review
Alert:	The Committee wished to alert the Board of Directors on the following areas of performance and financial sustainability: • Despite the Trust's efforts around increasing WTE levels (+175 from last year), **temporary staffing** continued to increase, with a forecast £45m spend for 2023/24. • There were continued challenges related to **out of area placements**. The Committee noted the plans in place and the intention to embed locality working arrangements, bed modelling and challenging the norms around in-patient vs. home treatment. The arrangements for scrutiny and challenge within the Out of Area steering group had been reviewed; the meeting would now be chaired by the Executive Director of Operations. The **structural issues** outside of the Trust's control were also noted. • Pace of delivery and the development of a robust pipeline of **Cost Improvement** opportunities remained a challenge. • The Month 5 financial position showed an **underlying deficit**. Whilst the Committee was assured that a break-even position for the year end was achievable, this was only possible through balance sheet flexibilities. This practice would be neither sustainable nor possible in 2024/25. The Committee re-iterated the need for a **change agenda** that was truly transformational, as well as the development of a **financial culture** across the Trust.
Assurance:	The Committee was assured on the following areas of performance and financial sustainability: • Notwithstanding the areas highlighted within the Alert section, the Committee noted **improvements across some performance indicators**, (CPA with formal review in the last 12 months; IAPT seen within 6-18 weeks; CPA 7-day follow up). The Committee was also

	assured regarding broader **controls** the Trust was implementing to drive further performance improvement. • The Committee was encouraged by the fact that work was already underway to embed robust financial control processes within the organisation. This was demonstrated through the **budget setting** process for **24/25** and the **Medium-Term Plan** that would contribute to a system submission into NHSE. • **Terms of Reference** were approved, subject to the inclusion of an organogram of subgroups into the Committee, and revised language in relation to the "investment strategy" and "financial strategy". Amendments to the membership of the Committee were approved, with an increase in non-executive director representation from two to three. Assurance was sought on the references to 'research', the annual workplan and the assurance reports that would need to come to FPP.	
Advise	The Committee was advised of the developing situation at **Birmingham City Council** and was encouraged by the fact that the Trust was clear on where the risks lay (provider, commissioner, third sector).	
Risks identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair	**Minutes available from:** Nicola Raybould

6.1.2. c) Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**		
Agenda item	**6.1c**		
Paper title	Month 5 2023/24 Finance Report		
Date	04 October 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 5 2023/24 Group position year to date is a deficit of £533k. This is £533k adverse to the break-even plan as submitted to NHSE on 5.4.23 and the trend is little changed from previous months. The position comprises a £718k deficit for the Trust, £138k surplus for Summerhill Services Limited (SSL), a £104k surplus position for the Reach Out Provider Collaborative and a break-even position for the Mental Health Provider Collaborative (MHPC).

Alert:

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

- Out of area expenditure – YTD £7.8m, straight lined for the full year, would equate to £18.6m. This would result in a potential overspend of £10.6m against a plan of £8m (which allows for £5m savings target).

- Savings - £14.7m target. YTD delivery of £4m equates to a shortfall against plan of £2.1m driven by non-achievement of delivery against £5m out of area savings target.

- Given the lack of savings pipeline for 2024/25, it is proposed that a 1% savings target is set across all budgets with plans to be developed for initial review at October Sustainability Board. The Board is asked to endorse this approach.

- Temporary staffing – YTD bank and agency spend £19.3m, straight lined

for the full year, would equate to £46m. The forecast submitted to NHSE assumes a reduction in run rate for the second half of the year as a result of enhanced financial controls. YTD agency expenditure has breached the NHSE ceiling by £613k: agency spend as percentage of pay bill is 4.25% YTD compared to ceiling of 3.7%.

- The Birmingham Solihull Integrated Care System (BSOL ICS) draft month 5 financial position is a deficit of £41m (a deterioration of £11m compared to month 4). Work is ongoing across the system to introduce enhanced financial controls to support financial recovery.

- The forecast position for 2023/24 is held at break even, in line with plan. This will be partly achieved via non recurrent savings and non recurrent benefits in year and the current assessment of the underlying run rate is £13m deficit.

- We have been asked to prepare a high level medium term plan to input into a system submission to NHSE Regional team. The expectation is that all systems will demonstrate financial balance by 2024/25. The current assessment is an underlying run rate of £11m deficit and £8m deficit respectively for 2024/25 and 2025/26. The savings plans assumptions to achieve break-even are currently £20m for 2024/25 and £16m for 2025/26

Advise:
The Board is asked to note the following:

- An accrual has been made in the month 5 position for the medical pay award funding and the associated expenditure. It is anticipated that payment will be made in the September payroll, backdated to April.

- In response to the deteriorating system financial position, the Birmingham and Solihull ICS Financial Recovery Board has been introduced. Membership includes the CEO and CFO of each system partners. The Board will have oversight of financial recovery plans and key system efficiency programmes. A short-term financial recovery diagnostics project has also been undertaken, led by KPMG, with findings to be shared mid-September.

- The budget setting process for 2024/25 is shared within the report to provide an understanding of the approach to be undertaken to assess the BSMHFT internal budgetary requirements for the next financial year, including approach to savings and cost pressures.

Capital position
Month 5 2023/24 Group capital expenditure is £2.8m. This is £2.5m greater than plan due to works progressing ahead of plan, mainly related to risk assessment works including door set expenditure.

Cash position
The month 5 Group cash position is £80.9m.

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

To review month 5 financial position and 2023/24 forecast outturn position and underlying run rate.
To review the assessment of the high level medium term plan and the proposed budget setting approach for 2024/25.

The Board is asked to endorse the proposal to allocate a 1% savings target across all corporate and operational service areas to identify initial savings plans for 2024/25.

The Board is asked to approve the medium term plan assessment for submission.

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:

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 organisation." (HM Treasury – 2012).	

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2023 to 31st August 2023

Month 5
Group financial position

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Group Summary	Annual Budget	1.6% Pay Award Funding	Revised Plan	YTD Position		
				Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	566,107	10,085	576,192	240,078	237,920	(2,158)
Other Income	18,832	-	18,832	7,847	10,802	2,955
Total Income	**584,940**	**10,085**	**595,025**	**247,925**	**248,722**	**797**
Expenditure						
Pay	(270,039)	(5,943)	(275,982)	(114,996)	(112,510)	2,486
Other Non Pay Expenditure	(277,459)	(4,142)	(281,601)	(117,328)	(121,118)	(3,790)
Drugs	(6,077)	-	(6,077)	(2,532)	(3,058)	(525)
Clinical Supplies	(795)	-	(795)	(331)	(257)	75
PFI	(12,611)	-	(12,611)	(5,254)	(5,904)	(649)
EBITDA	**17,959**	**-**	**17,959**	**7,483**	**5,876**	**(1,607)**
Capital Financing						
Depreciation	(9,906)	-	(9,906)	(4,127)	(4,055)	72
PDC Dividend	(1,717)	-	(1,717)	(716)	(716)	-
Finance Lease	(5,693)	-	(5,693)	(2,372)	(2,380)	(8)
Loan Interest Payable	(1,060)	-	(1,060)	(442)	(451)	(10)
Loan Interest Receivable	797	-	797	332	1,353	1,021
Surplus / (Deficit) before taxation	**380**	**-**	**380**	**158**	**(373)**	**(532)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	(380)	-	(380)	(158)	(160)	(2)
Surplus / (Deficit)	**0**	**-**	**0**	**0**	**(533)**	**(533)**

Month 5 2023/24 Group Financial Position

The month 5 consolidated Group position is a deficit of £533k year to date. This is £533k adverse to the break-even plan as submitted to NHSE on 5.4.23.

Key run rate pressures continue with slippage on recurrent savings delivery (against £5m out of area savings target), significant out of area expenditure and staffing pressures including a significant level of temporary staffing, particularly agency in month. PFI expenditure run rate is also increasing.

In month 5, an accrual has been made for the medical pay award funding (0.7% increase to income allocations as per NHSE guidance) and the associated expenditure. It is anticipated that payment will be made in the September payroll, backdated to April. To date, budgets have not been adjusted to reflect the medical pay award.

The Group position includes a £718k deficit for the Trust, £138k surplus for the wholly owned subsidiary, Summerhill Services Limited (SSL), an £104k 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.

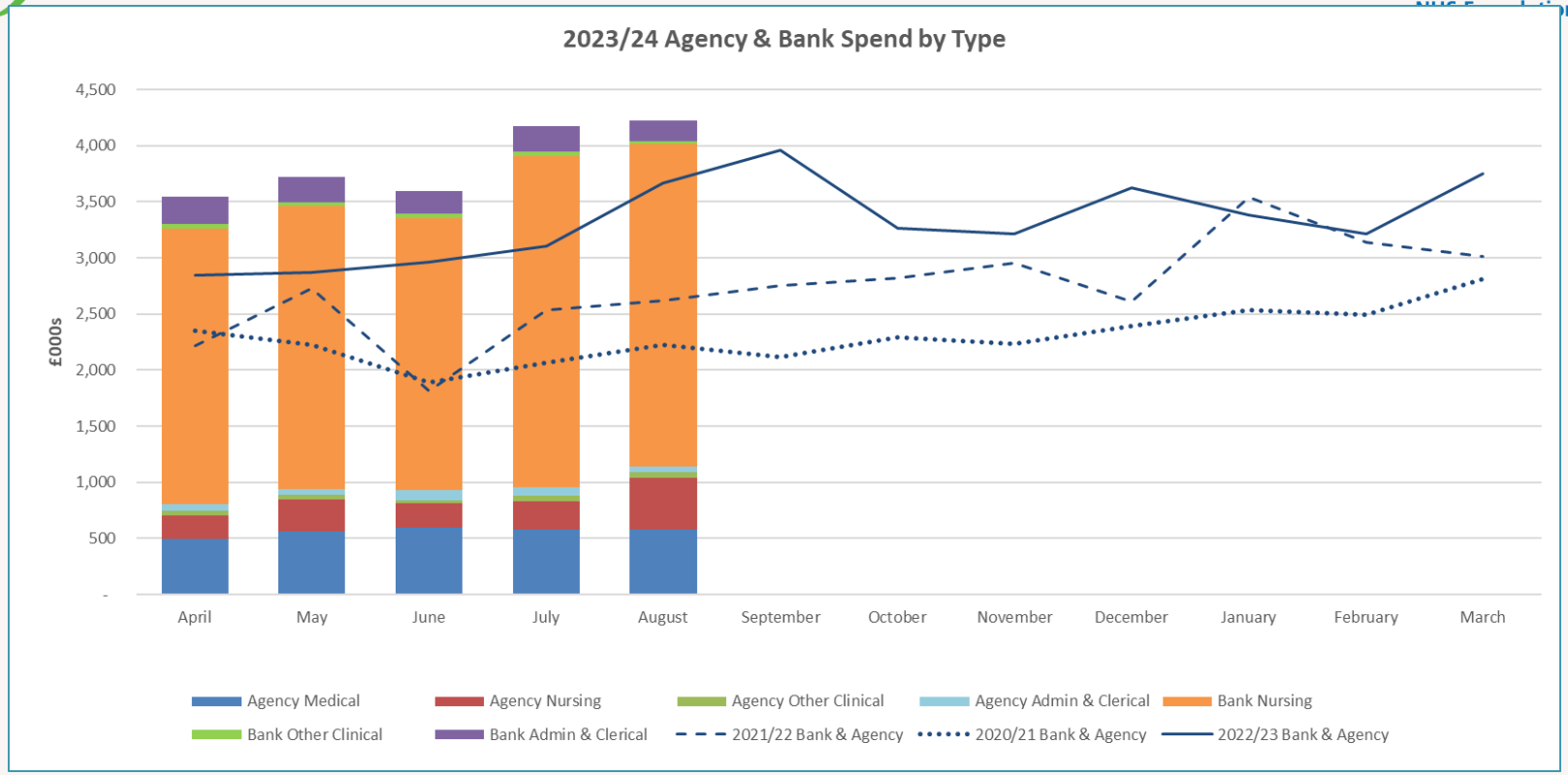
Month 5 Group position
Segmental summary

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Trust	SSL	Reach Out	MHPC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	142,741	-	60,113	154,099	(119,033)	237,920
Other Income	10,725	12,815	-	-	(12,739)	10,802
Total Income	**153,466**	**12,815**	**60,113**	**154,099**	**(131,771)**	**248,722**
Expenditure						
Pay	(105,976)	(5,460)	(650)	(539)	115	(112,510)
Other Non Pay Expenditure	(34,764)	(3,531)	(59,359)	(153,564)	130,100	(121,118)
Drugs	(3,205)	(1,243)	-	-	1,390	(3,058)
Clinical Supplies	(257)	-	-	-	-	(257)
PFI	(5,904)	-	-	-	-	(5,904)
EBITDA	**3,361**	**2,580**	**104**	**(4)**	**(166)**	**5,876**
Capital Financing						
Depreciation	(2,741)	(1,273)	-	-	(41)	(4,055)
PDC Dividend	(716)	-	-	-	-	(716)
Finance Lease	(2,374)	(159)	-	-	153	(2,380)
Loan Interest Payable	(451)	(849)	-	-	849	(451)
Loan Interest Receivable	2,203	0	-	-	(849)	1,353
Surplus / (Deficit) before Taxation	**(718)**	**298**	**104**	**(4)**	**(54)**	**(373)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(160)	-	-	-	(160)
Surplus / (Deficit)	**(718)**	**138**	**104**	**(4)**	**(54)**	**(533)**

Temporary staffing expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust



Bank

Agency

The month 5 year to date temporary staffing expenditure is £19.3m.

If the year to date average expenditure continued for the full year, this would equate to £46m (almost double the expenditure in 2019/20). It is forecast that there will be an improvement in run rate in response to the enhanced financial controls being introduced to support financial recovery, with a current forecast of £44.4m.

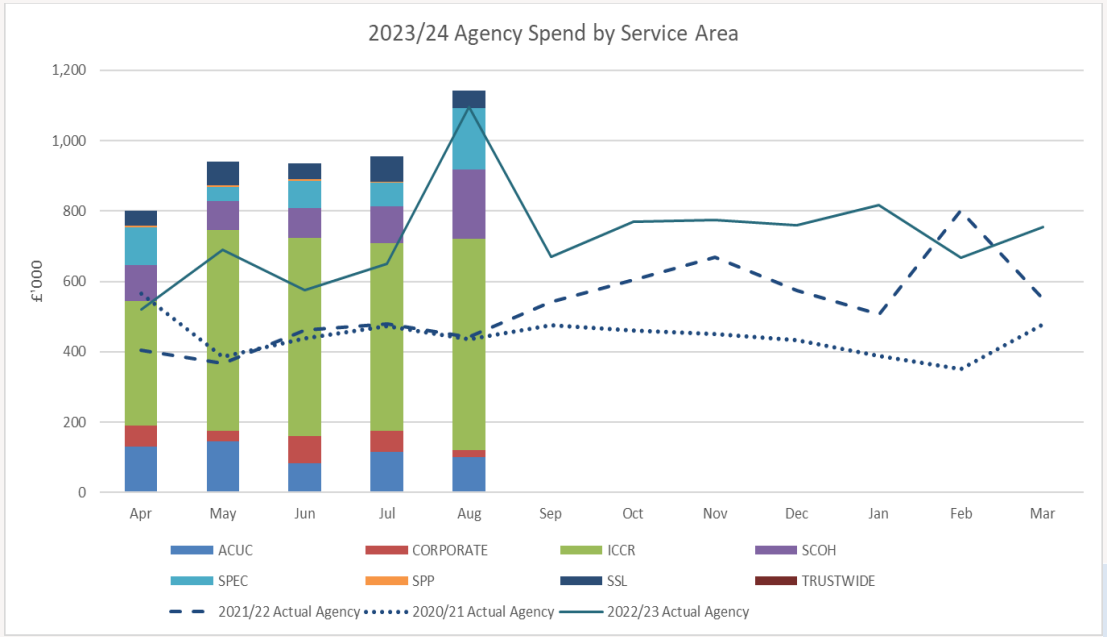
Bank expenditure £14.5m (75%) – the majority of bank expenditure relates to nursing bank shifts - £13.2m

Agency expenditure £4.8m (25%) – the majority of agency expenditure relates to medical agency - £2.8m.

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

Agency expenditure analysis

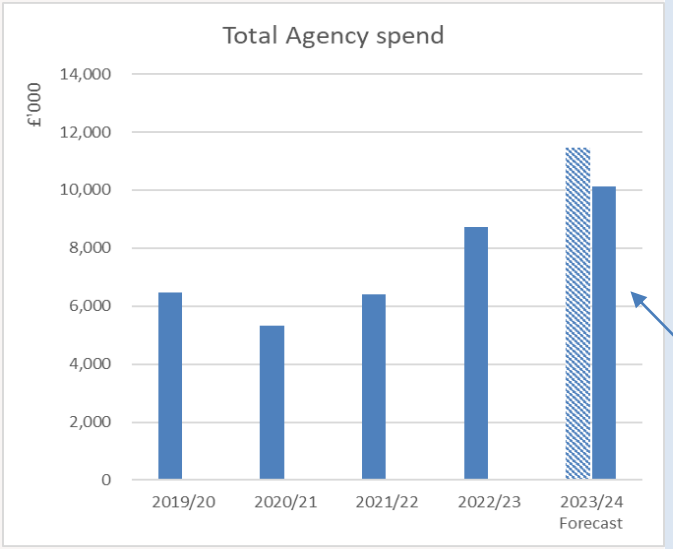
Birmingham and Solihull Mental Health NHS Foundation Trust



KPIs	Target	Aug-23
Agency framework breaches	0	0
Above price cap agency bookings	0	40
Agency spend as % of pay bill (YTD)	3.7%	4.25%

Agency spend as % of pay bill YTD	Aug-23
ACUC	2.6%
CORPORATE	1.5%
ESTATES	2.2%
ICCR	10.6%
SCOH	2.3%
SPEC	2.2%
SPP	0.7%
SSL	7.2%

	2023/24 YTD
	£'000
Agency Expenditure	4,776
NHSE Ceiling (3.7% of pay bill)	4,163
Variance to NHSE ceiling	(613)
Agency Medical	2,805
Agency Nursing (Registered)	1,170
Agency Nursing HCA	263
Agency Other Clinical	204
Agency Admin & Clerical	334
Agency Expenditure	4,776



- Agency expenditure is £4.8m year to date. This is 4.25% of the year to date pay bill, compared to the NHSE ceiling of 3.7% - total breach of £613k.

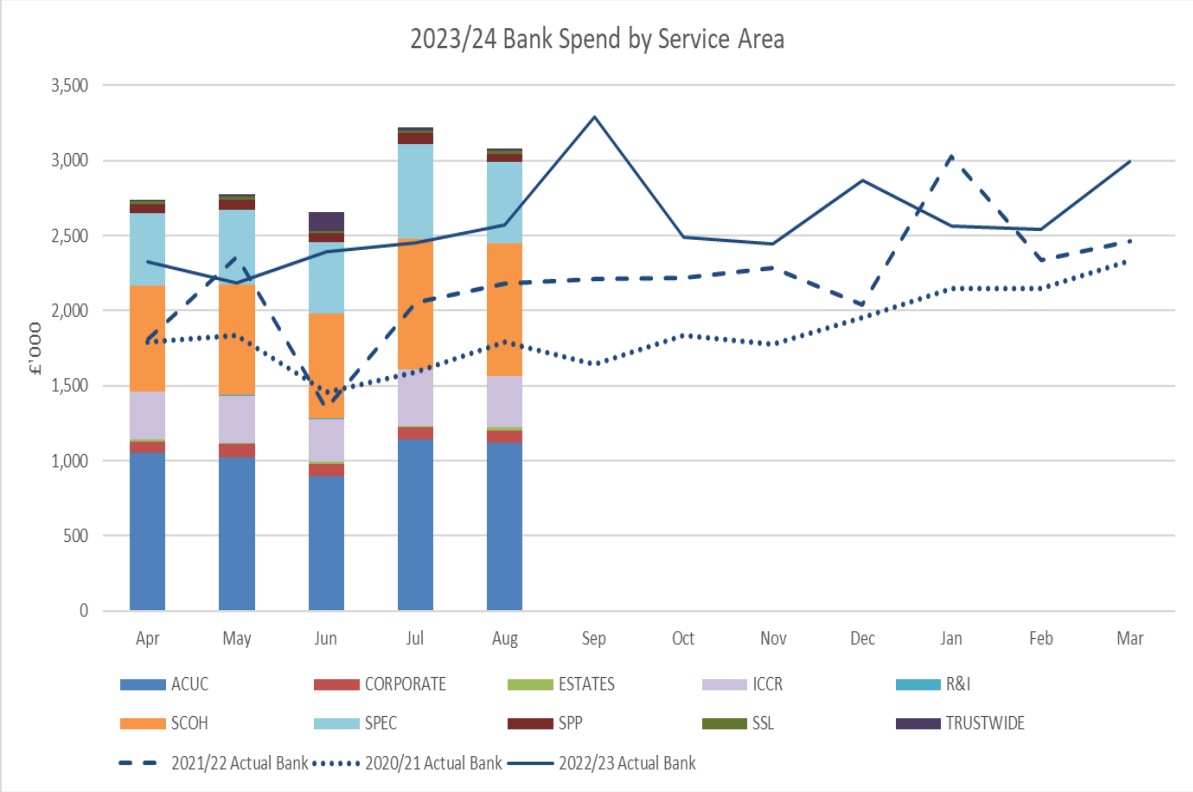
- Expenditure increased by £186k compared to July, mainly due to:
- Specialties £109k driven by Older Adults agency qualified nursing spend including year to date catch up.
- Secure and Offender Health £93k. Of this, £46k is due to special nursing observations which is under review regarding coding. £26k increase in unqualified nursing agency spend (mainly FCAMHS Pacific ward).

- A straight line forecast of year to date expenditure would give a total spend of £11.5m. The actual forecast as submitted to NHSE is £10.1m in anticipation of the impact of enhanced controls being introduced to support financial recovery.

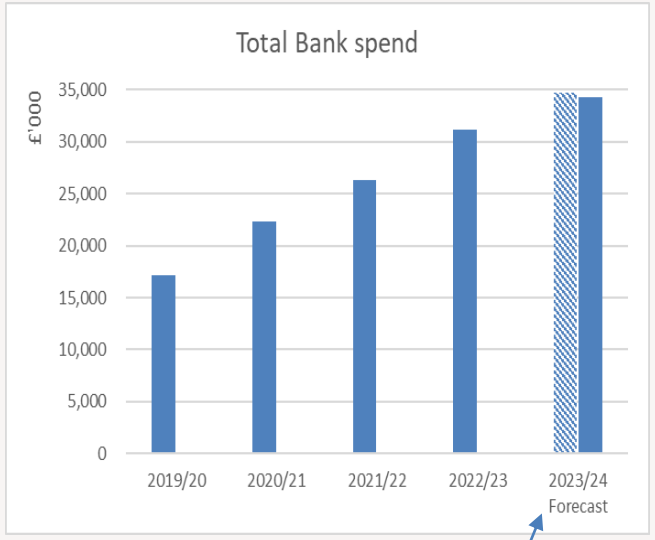
- 55% of the year to date expenditure was incurred by ICCR (11% of the ICCR pay bill year to date). 59% of total spend relates to medical agency.

Bank expenditure analysis

Birmingham and Solihull Mental Health NHS Foundation Trust



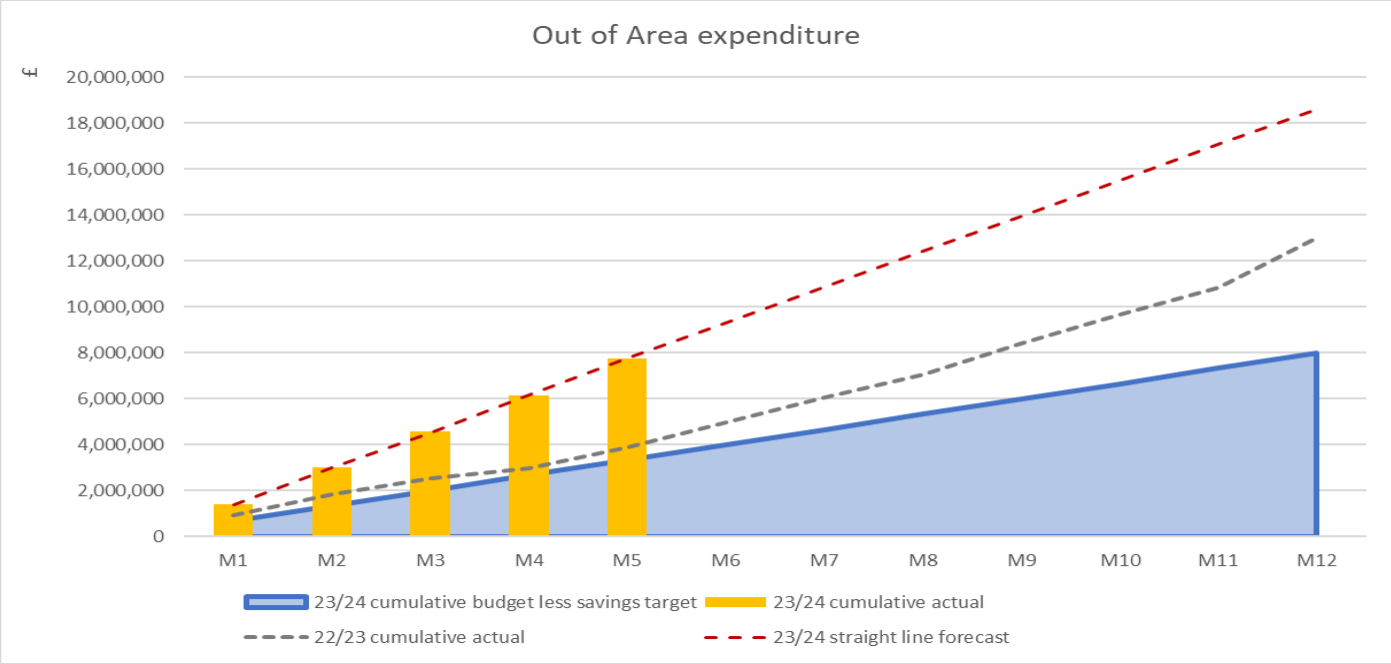
Type	YTD £'000	% of spend
Bank Nursing	13,210	91%
Bank Other Clinical	189	1%
Bank Admin & Clerical	1,083	7%
Grand Total	**14,482**	**100%**

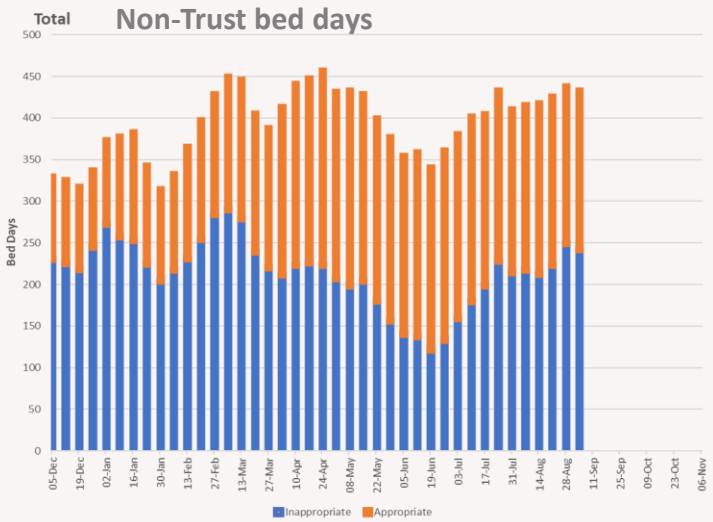


Bank expenditure

- Month 5 year to date bank expenditure is £14.5m. A straight line of year to date spend would result in £34.7m total spend. Forecast expenditure as submitted to NHSE is £34.3m, in anticipation of the impact of enhanced controls being introduced to support financial recovery.
- August bank expenditure has decreased by £134k compared to July, when spend spiked at the highest level year to date.
- Year to date bank expenditure has predominantly been incurred within the following service areas: Acute & Urgent Care £5.2m, Secure and Offender Health £3.9m and Specialities £2.6m.

Out of Area overspend





- Year to date out of area expenditure as at month 5 is £7.8m. This is double the cumulative expenditure at the same point in 2022/23.
- Total 2023/24 plan for out of area, including a £5m savings target, is £8m. Year to date overspend is £4.4m. If spend were to continue at the year to date average, total expenditure would be £18.6m; an overspend of £10.6m.
- Following the reduction in bed days in May/June, there has been an increasing trend in bed numbers throughout July and August, mainly relating to PICU beds.
- The impact of out of contract arrangements with Priory and Active Care Group is still being assessed.

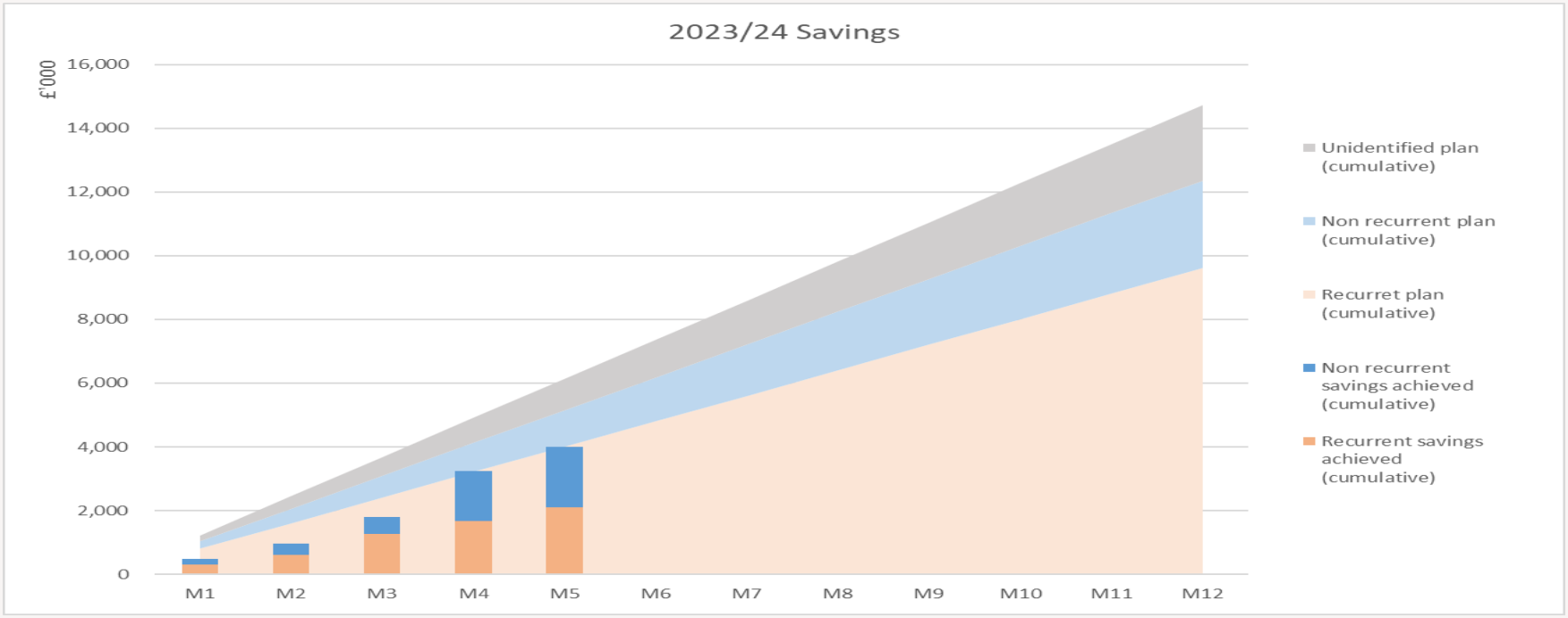
Efficiencies

The 2023/24 efficiency target is £14.7m. 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).

Savings achievement at month 5 totals £4m, a shortfall of £2.1m year to date, driven by non-delivery against the out of area savings target.

£1.2m of the total £2.4m unidentified non recurrent plan has been offset by £1m additional interest receivable year to date and £0.2m additional overhead contribution.

Recurrent/ Non-Recurre	Scheme Name	Sum of Annual Plan	Sum of YTD Plan	Sum of YTD Actual	Sum of YTD Variance	
Non-recurren	Budget setting pay review (not wte)	500	208	208	-	
	Budget setting pension review	1,400	583	583	-	
	Interest receivable (1%)	250	104	104	-	
	PFI - commercial performance settlemen	600	250	-	(250)	Expect full year delivery in M6
	Unidentified	2,358	983	-	(983)	Offset by additional OH and IR below
	Additional interest receivable	-	-	1,021	1,021	Offset against unidentified plans
Non-recurrent Total		**5,108**	**2,128**	**1,917**	**(211)**	
Recurrent	Budget setting non pay review	1,250	521	521	-	
	Budget setting pay review (not wte)	1,059	441	430	(11)	
	Estates budget for Ross House (disposal)	150	63	31	(31)	
	Interest receivable (@2.25%)	200	83	83	-	
	OH contribution	1,950	813	813	0	
	Out of Area reduction	5,000	2,083	-	(2,083)	No delivery against OOA target YTD
	Additional OH contribution		-	213	213	Offset against unidentified plans
Recurrent Total		**9,609**	**4,004**	**2,091**	**(1,913)**	
Grand Total		**14,717**	**6,132**	**4,008**	**(2,124)**	



Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-23 £m's	NHSI Plan YTD 31-Aug-23 £m's	Actual YTD 31-Aug-23 £m's	NHSI Plan Forecast 31-Mar-24 £m's
Non-Current Assets				
Property, plant and equipment	214.2	213.0	213.0	211.3
Prepayments PFI	1.3	1.3	1.8	1.3
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	0.0	-	-	-
Deferred Tax Asset	(0.1)	-	-	-
Total Non-Current Assets	215.4	214.3	214.8	212.6
Current assets				
Inventories	0.6	0.6	0.5	0.6
Trade and Other Receivables	28.2	28.2	19.6	28.2
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	59.0	58.6	80.9	56.8
Total Curent Assets	87.9	87.5	100.9	85.7
Current liabilities				
Trade and other payables	(55.9)	(56.6)	(66.5)	(55.9)
Tax payable	(5.0)	(5.0)	(5.3)	(5.0)
Loan and Borrowings	(2.6)	(2.6)	(2.5)	(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)	(45.0)	(40.4)
Total Current Liabilities	(106.5)	(107.3)	(122.0)	(106.6)
Non-current liabilities				
Deferred Tax Liability	-	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(25.1)	(24.1)	(24.1)	(23.0)
PFI lease	(45.7)	(44.9)	(44.9)	(43.8)
Finance Lease, non current	(7.9)	(7.4)	(7.4)	(6.8)
Provisions	(3.7)	(3.7)	(3.5)	(3.7)
Total non-current liabilities	(82.4)	(80.2)	(79.9)	(77.4)
Total assets employed	114.4	114.4	113.8	114.4
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)	(42.4)	(41.8)
Total taxpayers' equity	114.4	114.4	113.8	114.4

SOFP Highlights

The Group cash position at the end of August 2023 is £80.9m, 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

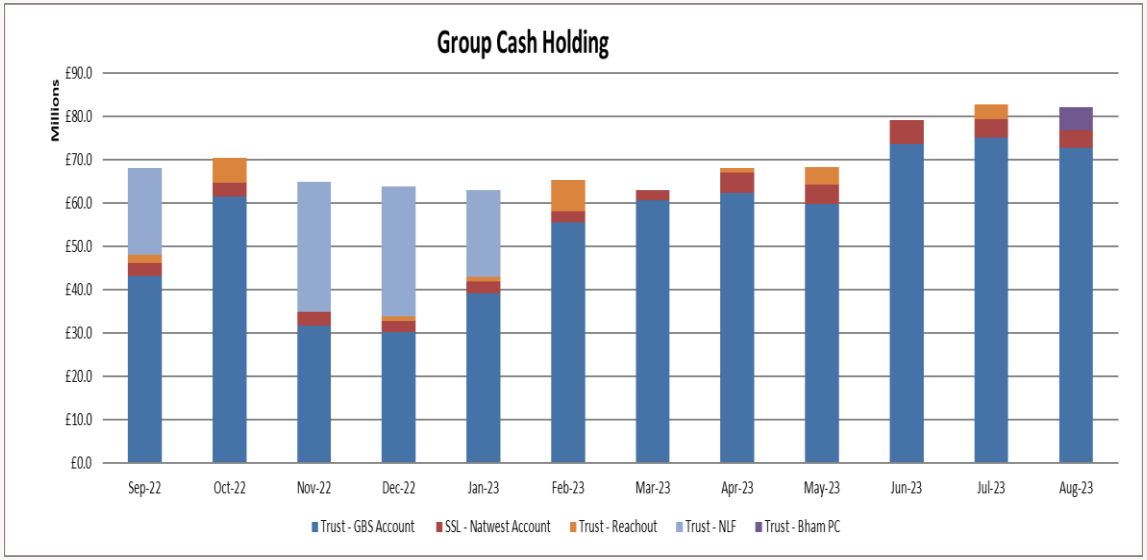
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

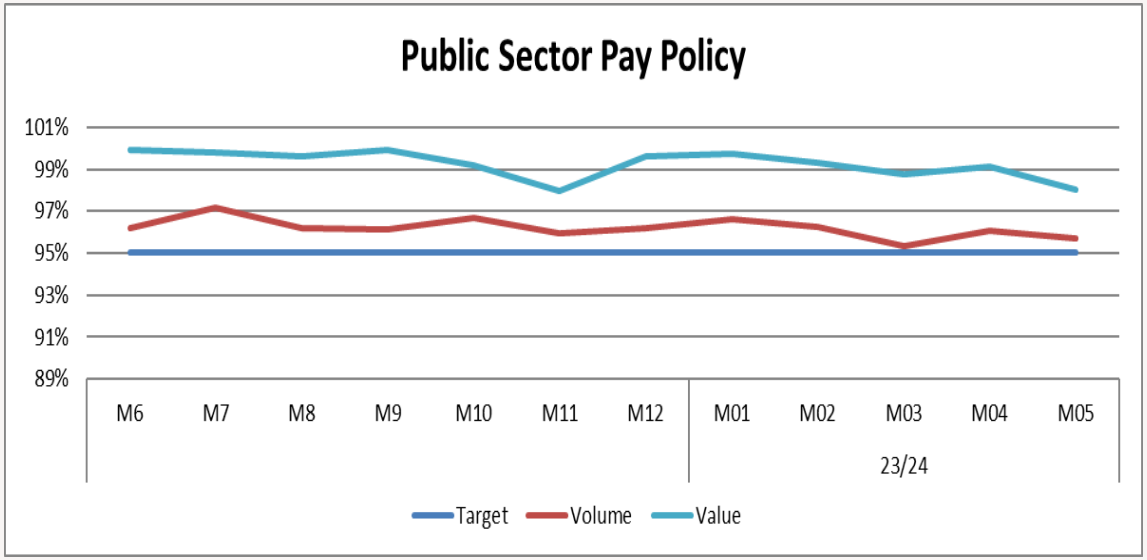
Current Ratio :	**£m's**
Current Assets	100.9
Current Liabilities	-122.0
Ratio	0.8

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of August 2023 is £80.9m.

At this present time, the National Loan Fund (NLF) is not offering a more favourable interest rate than the Government Banking Service (GBS) hence we have not placed any short-term/long-term deposits.

Better Payments

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

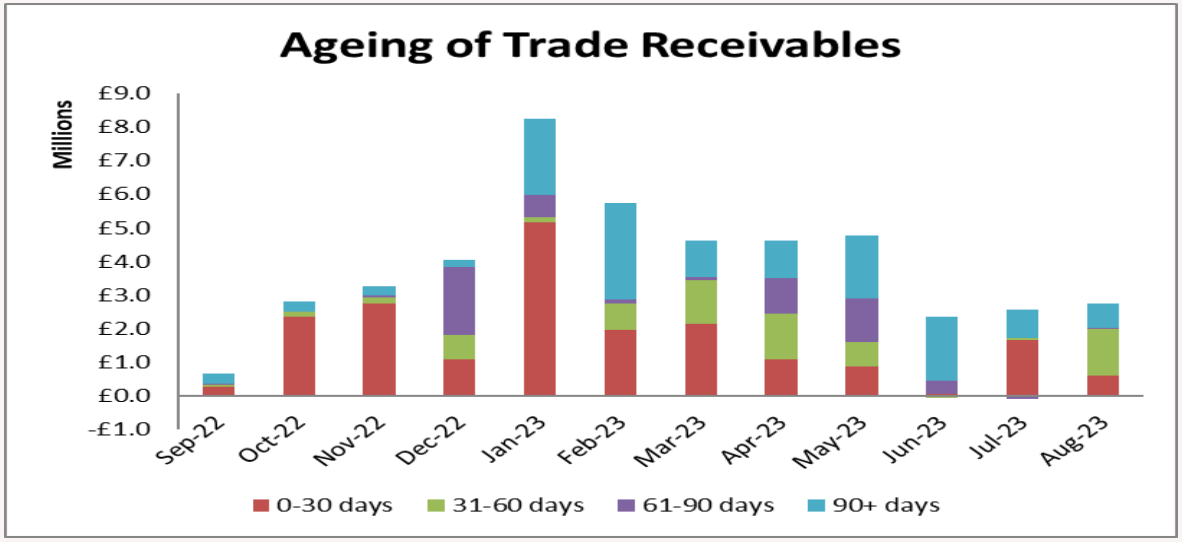
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

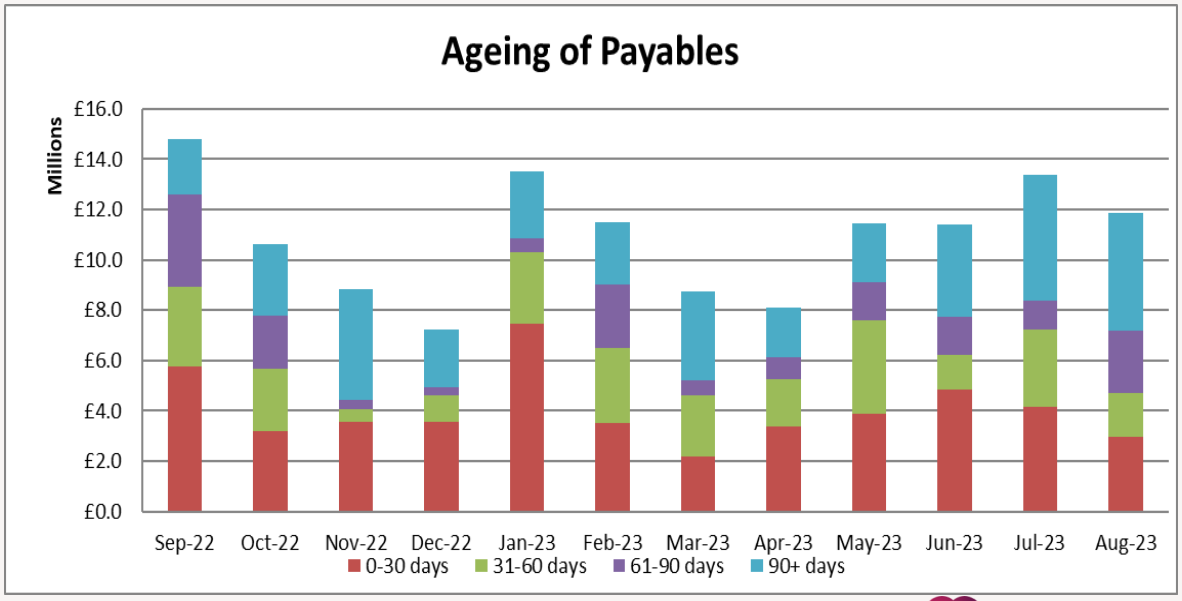
Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	97%	✓	100%	✓
Non - NHS Creditors within 30 Days	96%	✓	97%	✓

Trust Receivables and Payables

Birmingham and Solihull Mental Health NHS Foundation Trust





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 reduced in month as regular payments are being received & have been received during September 2023.
- **31-60 days-** increase in balance mainly due to UHB £937k invoices raised without contracts agreed & no purchase orders in place so anticipated delays in payment, balance relates to staff overpayments (on payment plans)
- **61-90 days-** slight increase in month relating to queries with WHSSC £84k, South Warwick £50k, SDSmyhealthcare £35k , balance mainly relates to staff overpayments (on payment plans)
- **Over 90 days –**overall balance due to queries with UHB £201k, BWC £282k awaiting approval, BUPA £62k, Nottinghamshire NHS £48k, South Warwickshire Partnership Trust £24k, DOH £57k still under review/in query , balance staff overpayments (on payment plans).

Trade Payables:

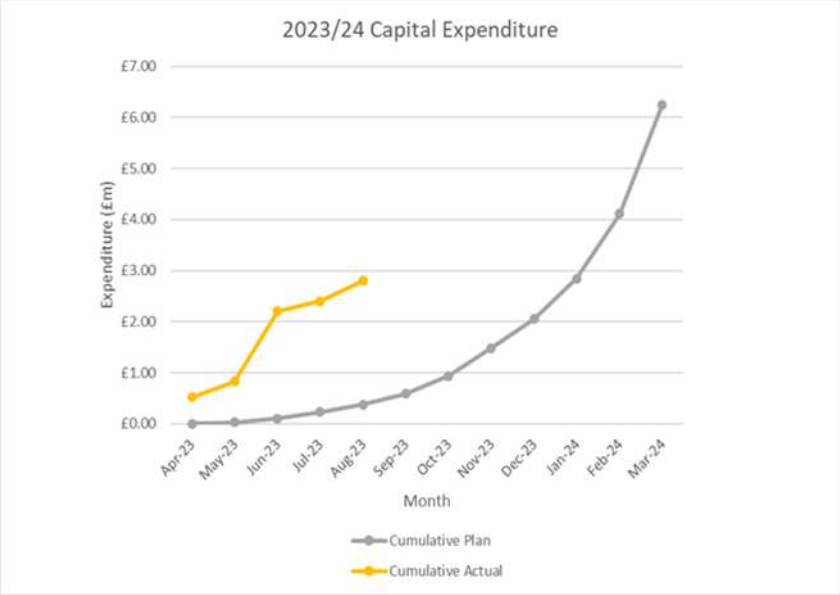
Over 90 days -

- Bham W&C £424k paid in Sept 23, Nottingham HC £416k RO in query, Mid Partnership £292k RO in query, NHS Property £263k-historic invoices
- Non-NHS Suppliers (65+) £2.6m – mainly bed fees invoices in query, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in Sept 2023.

Month 5 Capital Expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust

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**	**0.6**		**0.6**
SSBM Works	**2.0**	**0.2**	**0.3**		**0.1**
ICT Projects	**0.9**	**0.0**	**0.4**		**0.4**
Risk Assessment Works	**0.4**	**0.0**	**1.4**		**1.4**
CAMHS Seclusion Suite (PDC Funded)	**1.3**	**0.1**	**0.0**		**-0.1**
Total	**6.3**	**0.3**	**2.8**		**2.5**



Group Capital Expenditure

Group capital expenditure is £2.8m year to date. This is £2.5m adverse to the year to date plan due to works progressing ahead of plan, mainly related to risk assessment works including 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 there will be a of review strategic priorities across the system during September.

Month 5 DRAFT system position

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

At the time of writing, the month 5 financial position for Birmingham and Solihull Integrated Care System (BSOL ICS), is draft:

- The draft revenue system position is a year to date deficit of £41m. This is a deterioration of £11m compared to month 4, mainly driven by the UHB position. The system forecast currently remains at break even.
- The draft system capital position is showing expenditure at £6.8m ahead of plan, driven by BSMHFT £2.4m, UHB £3.7m and BWCH £2m.
- Agency spend for the system as a whole is 4.9% of the total pay bill (NHSE ceiling is 3.7%)

Given the deteriorating financial position of the system, work is ongoing to introduce enhanced financial controls, for further detail, see page 16.

Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							Prior Month		Movement	
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Actual YTD £000	Variance YTD £000	Actual YTD £000	Variance YTD £000
Birmingham And Solihull ICB	5,756	3,547	(2,209)		-	-	-	3,816	-2100.71	(269)	(108)
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(532)	(532)	(0.2%)	-	-	-	-442	-442.421	(89)	(89)
Birmingham Community Healthcare NHS Foundation Trust	220	(969)	(1,189)	(0.8%)	-	-	-	-1,038	-1213.72	69	25
Birmingham Women'S And Children'S NHS Foundation Trust	0	(1,067)	(1,067)	(0.4%)	0	0	0	-1,609	-1608.99	542	542
The Royal Orthopaedic Hospital NHS Foundation Trust	227	(2,664)	(2,891)	(5.5%)	(0)	-	0	-1,986	-2085.24	(677)	(805)
University Hospitals Birmingham NHS Foundation Trust	(9,400)	(39,352)	(29,952)	(3.3%)	-	0	0	-28,886	-18786.3	(10,466)	(11,166)
ICS Total	(3,197)	(41,036)	(37,839)	(0)	(0)	1	1	(30,145)	(26,237)	(10,890)	(11,601)

Agency

	Agency spend as % of total pay bill YTD	FOT
Birmingham And Solihull Mental Health NHS Foundation Trust	4.25%	3.79%
Birmingham Community Healthcare NHS Foundation Trust	6.33%	5.32%
Birmingham Women'S And Children'S NHS Foundation Trust	3.79%	3.86%
The Royal Orthopaedic Hospital NHS Foundation Trust	8.41%	7.72%
University Hospitals Birmingham NHS Foundation Trust	4.80%	4.48%
	4.86%	4.50%

Capital

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Variance YTD %	Plan Year Ending £'000	Forecast Year Ending £'000
Birmingham And Solihull Mental Health NHS Foundation Trust	375	2,805	(2,430)	-647.9%	6,977	6,977
Birmingham Community Healthcare NHS Foundation Trust	1,886	642	1,244	66.0%	6,372	6,372
Birmingham Women'S And Children'S NHS Foundation Trust	3,474	5,518	(2,044)	-58.8%	20,874	20,874
The Royal Orthopaedic Hospital NHS Foundation Trust	1,314	1,182	132	10.0%	3,909	3,909
University Hospitals Birmingham NHS Foundation Trust	12,227	15,909	(3,682)	-30.1%	37,071	37,071
Total Provider charge against allocation	19,276	26,056	(6,779)	-35.2%	75,203	75,203

Birmingham and Solihull Mental Health NHS Foundation Trust

Enhanced Financial Controls

Enhanced Financial Controls Actions

Birmingham and Solihull Mental Health NHS Foundation Trust

Given the deteriorating financial position across BSOL ICS (£30m deficit at month 4, with a draft month 5 deficit of £41m) work is ongoing regarding the introduction of enhanced financial controls to support financial recovery. The following key actions have been taken to date

Initial changes

BSMHFT:

On 14.8.23, the BSMHFT Executive Team approved the following proposals:

- Introduction of a weekly Workforce Approvals Group to review all vacancy requests – commenced w/c 21.8.23
- Introduction of a weekly investment oversight panel
- No sale of annual leave for 23/24 – communications early to ensure maximum of five days carried forward
- Revert mileage allowance back to national A4C rates
- Introduce direct engagement for medics as soon as possible

Internal communications have been made in August to inform the organisation of the financial position and the initial actions to be taken, see Appendix 1.

System wide:

- ICS Financial Recovery Board has been introduced, with the first meeting held on 1.9.23. Membership includes the CEO and CFO of all system partners. The Board will have oversight of financial recovery plans and key system efficiency programmes. For the Board terms of reference, see Appendix 2.
- KPMG Financial Recovery Diagnostics – a 6 week project lead by KPMG, due to be completed mid to late September. See Appendix 3 for the outline work plan.

Ongoing work

- In line with the NHSE financial controls letter of 9.8.23, each system organisation was asked by the ICB to:
- review compliance against each control. See Appendix 4 for BSMHFT initial assessment.
- Develop a financial recovery plan by 29.9.23.
- Submit updated efficiency plans by 29.9.23, demonstrating that 90% of 2023/24 schemes have been 'developed' and are 'in delivery'

Birmingham and Solihull Mental Health NHS Foundation Trust

Forecast Outturn 2023/24

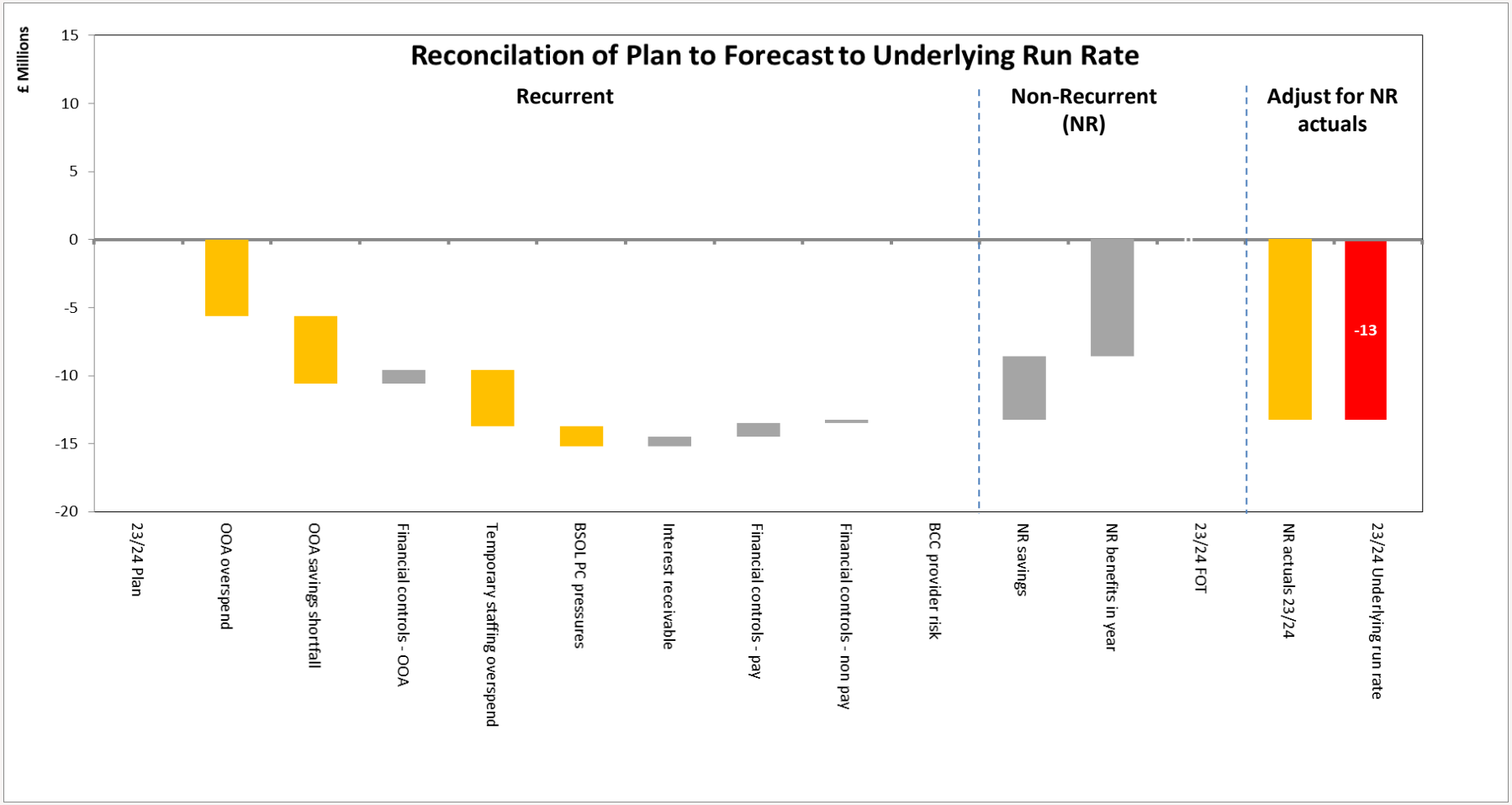
2023/24 Forecast Outturn

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	YTD Position			Full Year			Commentary
	Budget	Actual	Variance	Plan	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
Income							
Patient Care Activities	240,078	237,920	(2,158)	576,192	582,211	6,019	Additional income above plan - Reach Out non recurrent funding, medical pay award, specialling, plus deferred income release partly offset by underperformance on FCAMHS low secure, St Andrews FIRST
Other Income	7,847	10,802	2,955	18,832	24,687	5,855	Additional LDA income above plan, one off PFI settlement agreements and release of income relating to People Board and Shared Care Record deferred from prior year (offset by non pay expenditure)
Total Income	**247,925**	**248,722**	**797**	**595,025**	**606,898**	**11,873**	
Expenditure							
Pay	(114,996)	(112,510)	2,486	(275,982)	(269,406)	6,576	Forecast £2.7m overspend on bank and £1.4m overspend on agency. Substantive underspend due to ongoing vacancies, slippage against new investment and some budget realignment requirement
Other Non Pay Expenditure	(117,328)	(121,118)	(3,790)	(281,601)	(299,403)	(17,802)	Forecast overspend mainly attributable to £11m out of area - budgetary overspend and slippage against £5m savings target, £2m unidentified savings non pay offset mainly in interest receivable, £2m SSL costs (mainly pay award impact), £1m SPT
Drugs	(2,532)	(3,058)	(525)	(6,077)	(7,171)	(1,093)	
Clinical Supplies	(331)	(257)	75	(795)	(625)	170	
PFI	(5,254)	(5,904)	(649)	(12,611)	(14,614)	(2,003)	PFI water management costs
EBITDA	**7,483**	**5,876**	**(1,607)**	**17,959**	**15,679**	**(2,279)**	
Capital Financing							
Depreciation	(4,127)	(4,055)	72	(9,906)	(9,775)	130	
PDC Dividend	(716)	(716)	-	(1,717)	(1,717)	-	
Finance Lease	(2,372)	(2,380)	(8)	(5,693)	(5,693)	0	
Loan Interest Payable	(442)	(451)	(10)	(1,060)	(1,060)	(0)	
Loan Interest Receivable	332	1,353	1,021	797	2,948	2,151	Interest receivable above plan due to cash balance and increased interest rates - offset non recurrent savings targets in non pay
Surplus / (Deficit) before taxation	**158**	**(373)**	**(532)**	**380**	**382**	**2**	
Impairment	-	-	-	-		-	
Profit/ (Loss) on Disposal	-	-	-	-		-	
Taxation	(158)	(160)	(2)	(380)	(382)	(2)	
Surplus / (Deficit)	**0**	**(533)**	**(533)**	**0**	**(0)**	**(0)**	

2023/24 Forecast and Underlying Run Rate

The forecast position for 2023/24 is held at break even, in line with plan. This will be partly achieved via non recurrent savings and non recurrent benefits in year and the current assessment of the underlying run rate is £13m deficit. It is assumed that financial controls implementation will reduce run rate by £1.3m in year, mainly relating to pay controls. These workings will inform the financial recovery plan to be submitted to the ICB at the end of September.



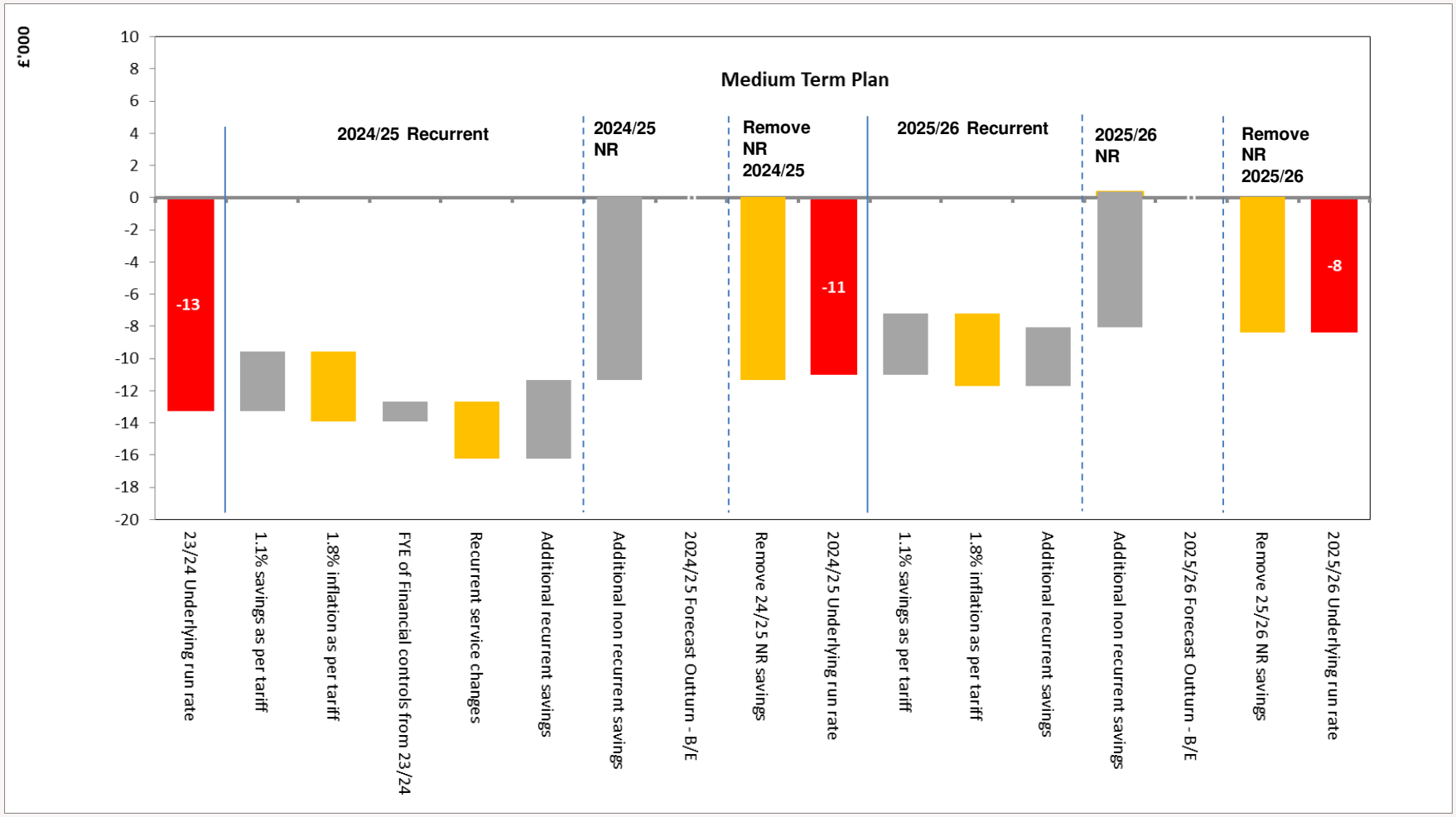
Birmingham and Solihull Mental Health NHS Foundation Trust

Medium Term Plan

Medium Term Plan

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

There has been a request by NHSE Midlands regional team to complete a medium-term financial plan. The expectation is that systems should be able to demonstrate achievement of recurrent financial balance by 2024/25. This is a high-level assessment of the expected future financial outturn, taking into account current assessment of underlying run rate, impact of financial controls and application of specified inflation and efficiency tariff assumptions. The bridge below shows a break even outturn for 2024/25 and 2025/26, however, the underlying run rate is £11m deficit and £8m deficit respectively. The savings plans assumptions to achieve break even (including 1.1% tariff efficiency target) are currently £20m for 2024/25 and £16m for 2025/26.



NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Budget Setting 2024/25

Budget Setting 2024/25

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

The budget setting process for 2024/25 is now underway, the key steps are summarised below. For completeness and to satisfy audit requirements, the budget setting process document is attached in Appendix 5.

Revenue Financial Plan:

Phase 1 - August to October 2023

- **Budget review and realignment** - Financial management teams will work with budget holders to review recurrent expenditure budgets and income targets and use financial trends and forecast data to action any necessary budget realignments within the service area budgetary envelope.

- **Cost Pressures** - All cost pressure funding requests to be completed using the appropriate business case template and submitted by the end of November, ready for review by the Executive Team at the beginning of December.

- **Savings** - It is proposed that a 1% savings target is applied to all corporate and service area budgets, with savings plans to be developed for initial review at October Sustainability Board. Detailed assessments and CQEIA to be completed during November. Final recommendation and review of savings plans at November Sustainability Board. Savings plans should be ready to deliver from 1 April 2024.
  The Committee is asked to endorse this approach to identifying initial savings plans for 2024/25.

It is anticipated that the remainder of the 2024/25 savings will be achieved via transformational plans including work that has commenced on out of area, direct engagement and KPMG financial diagnostics outcomes.

Phase 2 November 2023 to January 2024

Financial management teams will work with budget holders to ensure they have completed full establishment costings. Non pay and capital financing inflation will be calculated in line with national tariff guidance. There will be a review of savings plans progress and the outcome of cost pressure submissions will be determined by the Executive Team.

Phase 3 February to April 2024

Income contracts to be finalised and final adjustments to the plan to be completed ahead of submission to FPP and Trust Board for approval prior to submission to NHSE. Associate Directors to formally sign off their service area budgets.

Capital Financial Plan:

In line with the agreed annual cycle for capital planning and the capital prioritisation process, Capital Priority Grouping Owners to determine capital priorities for the next two financial years in preparation for review and sign off by December Capital Review Group. Once the capital envelope is known, final proposed capital plan to be submitted to FPP and Trust Board in February 2024 for approval.

Appendix 1
Financial Controls
Internal Communication

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Dear colleague,

The cost-of-living has been on our minds for some time and something as a Trust and system we have continued to monitor. I'd like to thank individuals and teams for taking local ownership over the last few months and working hard to balance expenditure with quality and safety of care.

At the end of July, however, we have reported an overspend of nearly £500,000. Across the Birmingham and Solihull (BSol) system, our partners are also reporting overspends. Over the last few years our financial position has always been good and while our current deficit is relatively small given the size of our Trust, if our finances continue on this downward trajectory, we will not achieve the requirement to break even by 31 March 2024.

As a health system we have been asked by NHS England to tighten up our financial governance and implement a number of cost-saving measures. We have taken a look at those and carefully considered how these can best be implemented and will be introducing a few changes as detailed below.

1. **From 1 September 2023 we will be reverting back to the national Agenda for Change mileage allowance of 56p/mile**

   Last year we increased the rate twice up to 64p/mile (April and October 2022) for those of us who use our cars during work time. We've kept those costs consistent for as long as we can and we're the last across the BSol system to bring them back down, in parity with other local NHS Trusts.

2. **We will be removing the option of selling back annual leave**

   Last year we were in a better financial position to offer this and recognise this was our single biggest discretionary spend at £660,000. The option to carry over five days will remain. Exceptional circumstances beyond this will need to be presented to your line manager and the appropriate considerations made.

3. **For budget managers, there will be a requirement to submit paperwork in support of any single project expenditure (not including any Estates/SSL projects) that exceeds £20,000**

   This is so that we can look at value for money, affordability and need.

4. **A vacancy panel for all vacancies across the Trust will be established**

   This will be facilitated by the Recruitment team. All requests for recruitment will be reviewed but with an assumption that Band 5 nurses will be automatically approved.

5. **Introduction of a Temporary Staffing Panel**

   This will be used to review all block booking TSS requests.

We're also doing a lot of work currently to reduce out of area placements and spend on bank staff which will continue, alongside these cost-saving measures. At this stage, this is what is required to recover the current overspend and break even by 31 March 2024 and in future financial years.

The Integrated Care Board (ICB) has set up a monthly Financial Delivery and Oversight Group that will oversee the actions all Trusts have in place, to address the BSol system's financial challenges.

We also welcome any other ideas you may have that can help us to save money, without compromising the care we provide. If so, please email bsmhft.costsavings@nhs.net.

On behalf of the Trust Board, I'd like to thank you in advance for your support while we take these necessary steps. We will continue to keep you updated with our progress over the coming weeks and months.

Best wishes

Patrick Nyarumbu
Deputy Chief Executive

Appendix 2
Financial Recovery Board
Terms of Reference

Birmingham and Solihull Integrated Care System

Financial Recovery Board

Terms of Reference

1. Context & Authority

The Financial Recovery Board is constituted as an officer-led committee of NHS Birmingham and Solihull ICB, reporting into the ICB Finance and Performance Committee, however it's function is to oversee financial recovery across the whole Integrated Care System (ICS).

These Terms of Reference (ToR) set out the membership, the remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

The role of the Board is to oversee the development and delivery of Birmingham and Solihull's Financial Recovery Plan, both at a system and at an individual organisation level.

The Board will ensure all partners are committed to the actions required to deliver on the statutory financial duty of each organisation to deliver services within the funding set out in annual plans, both at an organisation and system level.

3. Membership and Attendance

Membership

The Board will consist of the 6 Chief Executives and 6 Chief Finance Officers of each NHS organisation that collectively makes up the financial performance of the ICS.

Clinical Representation - TBC

Where members are unable to attend, it is expected that a suitable deputy will be nominated to attend in their place.

Chair and Vice Chair

The Board will be chaired by the Chief Executive Officer for NHS Birmingham and Solihull ICB. The Vice Chair will be the Chief Finance Officer for NHS Birmingham and Solihull ICB.

Attendees

In addition to the members set out above, the following individuals will also be invited to attend:

- Chief Executive Officer of Sandwell & West Birmingham NHSFT
- System SROs for key efficiency programmes

4. Meetings Quoracy and Decisions

The Financial Recovery Board will usually meet monthly but may be called at any other such time as the Committee Chair may required.

Quorum

For a meeting to be quorate, there should be a minimum of one member in attendance from each of the 6 NHS organisations that collectively makes up the financial performance of the ICS, including the Chair or Vice Chair. This can include a nominated deputy for any of the named members.

Decision making

The committee will have no formal decision making powers, however it is expected that members will use the delegated authority that sits with them from their own organisations to agree and implement organisational and system decisions that support overall financial delivery.

5. Roles & Responsibilities

The Board's duties may be categorised as follows, although will be reviewed by the Board on a periodic basis:

Oversight of Financial Recovery Plans

- To oversee the approval and delivery of the system financial recovery plan, and the organisational recovery plans that form part of this.
- To monitor the risks of delivery and ensure appropriate mitigations are in place
- Where the plan is off-track, agree collective system actions to address this and bring performance back in line with the plan.
- Ensure that decisions are taken that support both in-year financial delivery and medium term plans to bring the system back into underlying financial balance.

Oversight of key system efficiency programmes

The Board will ensure that key system efficiency programmes are on track, and agree mitigating actions to address any underperformance as appropriate. The initial set of programmes are set out below, however it is expected that these will develop further during 2023/24:

- Agency reduction programme
- Corporate Services redesign
- KPMG system efficiency diagnostic

Enhance and embed a system-first approach to financial delivery and sustainability

- Ensuring a collective approach to financial leadership with clear organisational responsibilities within a system framework to ensure the best possible use of resources for the local population.
- Ensure consistency of approach where this will have a positive impact on the overall delivery of financial statutory duties. This should include, where possible, collective agreement on a consistent system approach to financial controls, pay rates, pay incentives etc.
- To accelerate strategic transformation to support financial delivery, whilst retaining a focus on quality and safety, strengthening workforce resilience and removing cost duplication

Appendix 2 continued Financial Recovery Board Terms of Reference

6. Accountability and reporting

The Committee is accountable to the ICB Finance & Performance Committee and shall report to the committee on how it discharges its responsibilities.

Members are accountable for the delivery of their individual organisation's statutory financial duties, at both an organisation and system level.

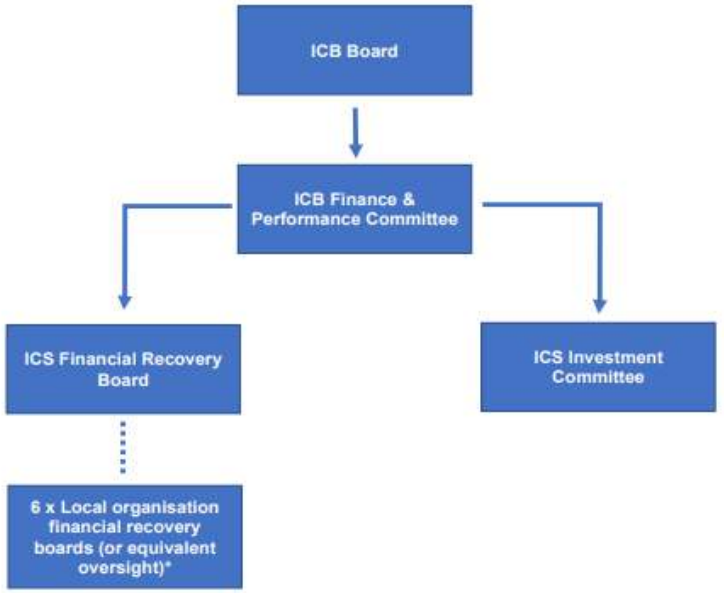
7. Secretariat and Administration

Secretariat support will be provided by the ICB

8. Review

The Committee will review its Terms of Reference and overall effectiveness after it's first quarter to ensure that it is fit for purpose in supporting system financial delivery.

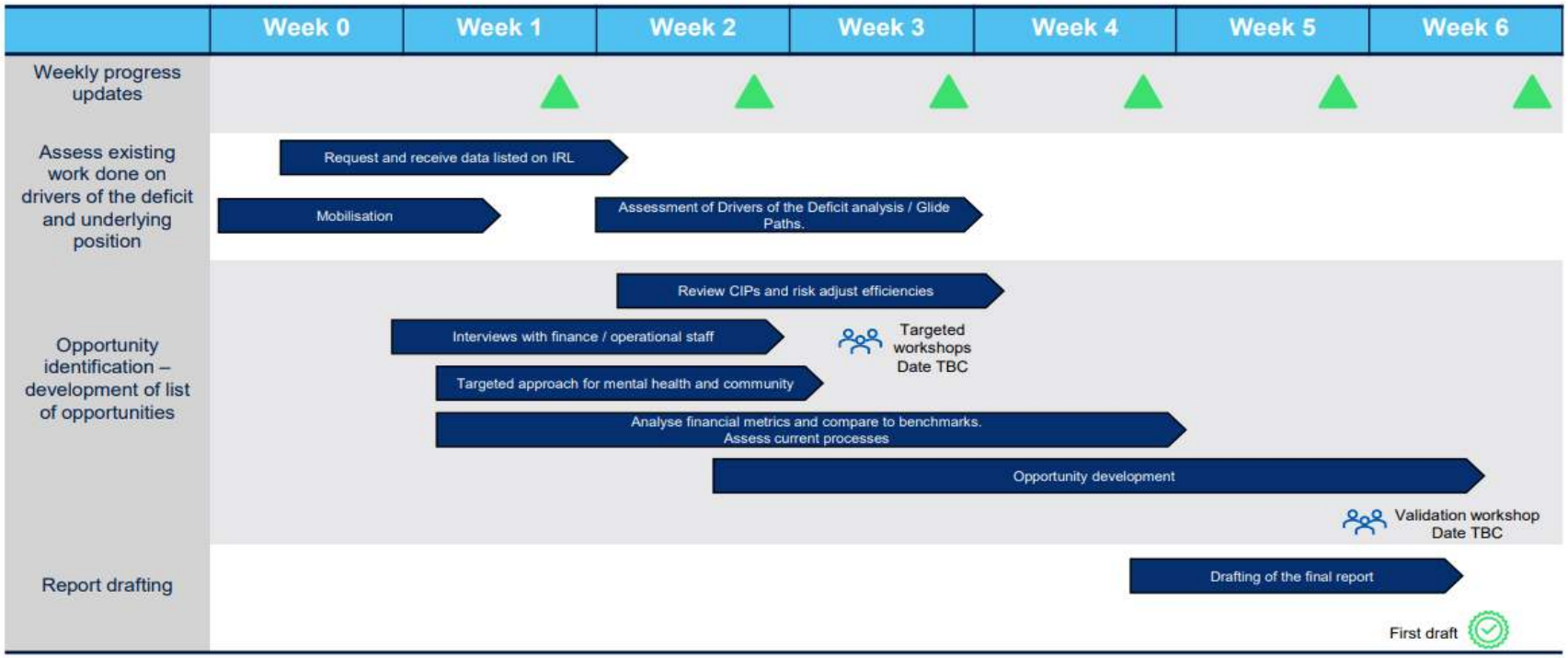
Governance Structure



**Local oversight dependent upon each organisation's specific financial position*

Appendix 3
KPMG Financial Diagnostics work plan

- 6-8 week diagnostic
- High-level review of underlying deficit
- Focus on opportunities for financial recovery



Appendix 4
NHSE Financial Controls status

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
1 a)	**Workforce and Pay - Recruitment Process and Review of Vacancies**			
1 a)	**Challenge & review establishment growth since 2019/20**: Prepare a full reconciliation of staff increases since 19/20 with full justification for posts based on outcomes / safety /quality / new service models. Where posts are not justifiable, a plan to remove needs to be in place.		01/08/2023	Ongoing reviews - analysis done in various ways including 19/20 v 22/23 bank v substantive spend at individual ward level, assessment of new SDF and MHIS investment and analysis of particular corporate teams comparing pre covid levels
1 a)	**Vacancy freeze**: • Review all current open vacancies with a view to remove or freeze posts. Focus on long term/6-month vacant posts initially with an assumption that these should be removed or re-engineered. Bank and agency back fill not permitted. • Implement non-clinical recruitment freeze unless it can be evidenced by exception that role is business critical or key for financial / quality management.			BSMHFT have indicated that they will not be implementing a vacancy freeze - all vacancies will be reviwed through the Vacancy Control Panel overseen by the Deputy CEO/Exec Director with responsibility for People
1 a)	**Vacancy control panel**: Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. Ensure that approval is at an Executive level.		14/08/2023	overseen by Deputy CEO/Exec Director with responsibility for people. Analysis shows new or replacement post etc and panel query whether post should proceed or whether alternative (inc FTC) might be more appropriate
1 a)	**Review of external funding**: Review the establishment to remove partial posts not required and identify unfunded posts which should be removed, or matching funding confirmed with 3rd parties.		01/08/2023	Establishments continue to be reviewed - major ward based establishment review using MHOST - to be reported to committees in Autumn 23
1 a)	**Review pay spend approval profiles**: Review current governance arrangements for recruitment and temporary staffing (panels and sign off at all levels of the organisation including groups, Terms of Reference, SFIs and sign off rights).		Ongoing	SFIs and SOD were reviwed and amended following introduction of commissioning responsibility - May 23. Some services areas have raised approval levels for spend and vacancy approvals
1 a)	**Workforce plans**: Ensure workforce plans are in place and that these are in a granular level of detail (e.g. by service, workforce type and substantive / temporary) and align to approved establishment levels and budget.		01/05/2023	Detailed workforce planning round completed as part of annual planning round but continued into 23/24 - reported through People Ctte but also preparation for 24/25

Appendix 4 continued
NHSE Financial Controls status

Birmingham and Solihull Mental Health NHS Foundation Trust

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
1 b)	**Workforce and Pay - Rostering**			
1 b)	Nursing and medical rotas to be reviewed weekly and temporary cover reviewed		Ongoing	
1 b)	Reconciliation of rosters for nursing and medical to financial budgeted establishment.		Ongoing	
1 b)	Review specialing policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity		Ongoing	
1 b)	Review compliance with / introduce CNS and AHP job planning process to identify opportunities for greater productivity.		Ongoing	
1 b)	Roll out e-rostering with 6-8 week forecasts and approval, and minimal changes to rosters once approved, for all staff grades (linked to patient acuity)		Ongoing	
1 b)	Assure the process for the correct accounting for breaks and hours claimed within e roster is correct and in accordance with AfC T&Cs.		Ongoing	
1 b)	Ensure all staff are working their contracted hours and that hours owed and owing is correctly reflected into rotas.		Ongoing	
1 b)	Set up weekly monitoring for shift requests vs. shift fill rate vs. planned capped trajectory and any associated care and safety issues		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 b)	Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high PA staff)		Ongoing	Medical Director and deputy MDs continually review job planning process and where additional Pas are paid
1 b)	Support Medical Director leadership and consultant champions (e.g. Junior Doctors); consider use of dashboards to track medical productivity including job plan delivery (individual and then team job plans).		Ongoing	Need to ensure focus on mental health elements
1 b)	Benchmark WLI rate against local organisations. Enhance authorisation process for WLIs, ensuring WLIs offer financial benefit or are operationally critical before approving	N/A		
1 b)	Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning		Ongoing	Clinical Directors have continued practice implemented through covid pandemic of effective holiday planning
1 b)	Review on-call run rate for utilisation trends	N/A		

Appendix 4 continued
NHSE Financial Controls status

Birmingham and Solihull Mental Health NHS Foundation Trust

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
1 c)	**Workforce and Pay - Temporary staffing/bank/agency controls**			
1 c)	Ban on usage of non-clinical agency staff, with exceptions authorised by an executive director and then requiring onward double / triple lock approval.		01/05/2023	
1 c)	Review nursing agency use before, during and after school holiday periods (tests the strength of rota planning) and provide constructive challenge to heads of nursing on agency use		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Establish governance process to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate), with updates from key areas set out to drive action.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Implement prior approval for overtime and enhanced payments, with a clarity on senior sign off for these costs. A week by week trajectory, with reduction over time, should be set for these payments with choices then made by senior management within these reducing capped levels		01/05/2023	Any enhanced payments need 2 execs to approve - none approved so far in 23/24
1 c)	Perform a monthly 'audit' of the top 10 highest overtime earners by central team with specific actions for reduction		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Impose greater controls over agency usage – this should include a specific cap on agency spend per week – with a week by week and month by month plan to reduce this cap over time.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Hold weekly agency meetings across all staffing groups attended by finance and key stakeholders, to review and control agency spend in line with weekly capped levels.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Track number of interims, termination dates, delivery of objectives, and daily rates. Within capped limits confirm a trajectory for reduction of these costs.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Track number of secondments, termination dates		Ongoing	temporary staffing approvals and challenge high use wards
1 c)	Promote, or establish then promote, the use of the Trust internal bank among Trust staff as an alternative to agency.		01/05/2023	65% of agency usage is medical - relatively limited usage compared to bank
1 c)	Agree an implementation date for a ban on recruitment of non-framework agency staff with an associated organisation-wide temporary staffing policy		01/04/2023	Non framework providers never used
1 c)	Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address		01/04/2023	Ongoing piece of work to explore bespoke packages to attract high cost agency medics to move to locum arrangements
1 c)	Seek local agreement of agency pay rates with surrounding Trusts / explore use of a system collaborative bank.		Ongoing	Discussions with other local mental health trusts around usage - compared with Black Country relatively low levels of nursing agency
1 c)	Assure the process for the correct accounting for breaks and hours claimed in timesheets (i.e. agency workers are only paid for time worked, in accordance with Trust policies).		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Limit the authorisation of agency staff to Executives or named senior managers; follow up on all short notice use.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards
1 c)	Weekly dashboard to be widely shared summarising temporary staff usage v planned trajectory, cost and trends.		Ongoing	Part B element of new Workforce Approvals Group to review temporary staffing approvals and challenge high use wards

Appendix 4 continued
NHSE Financial Controls status

Birmingham and Solihull Mental Health NHS Foundation Trust

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
1 d)	**Workforce and Pay - Other Pay Controls**			
1 d)	**Sickness / absence management**: • Ensure that rigorous illness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting). Long term sickness cover to be planned. • Set a % target for staff off sick at any time and measure performance against this. Consider increasing sign off levels for sick leave to ensure transparency. • Set % target for staff on leave at any time and measure performance against this. Build into rotas - medical and nursing. • Review and relaunch of annual and study leave policies with tighter controls and approvals.		Ongoing	People Ctte receved regular updates on all of these elements including areas of concern and good practice
1 d)	**Retention maximisation**: Retention variables reviewed – exit interviews, flexible working options, retentions schemes.		Ongoing	Key focus of People strategy this year as reporting into People Ctte
1 d)	Controls around leavers to ensure no overpayments. Pay listings to be signed off monthly.		01/04/2023	Continued focus of Audit Committee
1 d)	WTE tracker: Implement a comprehensive and regular head count tracker (temporary and substantive).		Ongoing	To become part of workforce approvals group and other trackers as part of KPI reporting into People Committee
1 d)	Closure of escalation wards	Not relevant		
1 d)	Reduce usage of adult RMNs in the emergency department setting.		Ongoing	Work with system to manage all relevant patients in ED with BSMHFT continuing to honour contractial obligations through the Psych Liaison Teams

Appendix 4 continued
NHSE Financial Controls status

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
2	**Procurement / non-pay – discretionary spend**			
2	Ensure a robust purchase ordering (PO) system in place to enable the implementation of a 'no PO no payment' rule and no retrospective POs, to be monitored weekly.		01/04/2023	Trust has now joined the BSOL procurement collaborative
2	Ensure Oracle approvals are actioned in a timely manner to ensure late payment interest is avoided and BPPC target is achieved.		Ongoing	Trust received letter from Julian Kelly re continued over achievement on BPPC targets
2	Review all areas for non-committed spend with a view to reduction/removal		Ongoing	Through investment oversight group
2	Ensure all contracts subject to scrutiny and penalty clauses are actioned as appropriate.		01/04/2023	Trust has now joined the BSOL procurement collaborative
2	Ensure all contracts are subject to market testing/tendering processes		01/04/2023	Trust has now joined the BSOL procurement collaborative
2	All requests for the use of consultancy services to be reviewed and approved by the Director of Finance and subject to national NHSE rules.		01/04/2023	
2	Implementation and Enforcement of Trust Reps Policy. Booking processes to be followed and logged in all cases.	Not relevant		
2	Acute medicines formulary group to look at 'influenceable' prescribing on high cost drugs and adopt a system-level consistency on these specific areas identified. The benefit of bringing hospitals together is that clinical peer challenge is the most effective way of having these discussions, and we can be confident that we do not have variation by provider for our patients.	Not relevant		
2	Procurement - Category management opportunities to reduce unwarranted usage and supply costs. A significant portion of in-system contracting is with the same provider.		Ongoing	Working with BSOL Procurement collaborative to manage all spend - they will be key part of investment oversight group
2	Working with acute pathology services to identify unwarranted variation in GP pathology requests, clarify the clinical order sets based on the evidence base, and work with primary care to address this variation. The aim is to reduce low value testing to reduce pathology costs to the acutes / system	Not relevant		
2	System led review of s75 and Better Care Fund.	System to respond		
2	Drug expenditure reviews being completed		Aug-23	Work with Director of Pharmacy to explore opportunities - in particular national queries around Paliperidone implemented

Appendix 4 continued
NHSE Financial Controls status

Birmingham and Solihull Mental Health NHS Foundation Trust

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
3	**Income**			
3	Ensure that all income due is identified early and invoiced immediately. Ensure all evidence available to support recovery of funds to ensure payment. Ensure all debts are subject to proactive collection processes		Ongoing	
3	Review income contracts with commissioners to highlight any opportunities to maximise income and to reduce penalties. Ensure all activity is captured and coded to ensure full recovery of ERF		01/04/2023	Focus now on working with provider collaboratives in particular to explore opportunities for income
3	Ensure all other income, such as car parking has been reinstated to the levels in the plan		22/23	
3	Ensure maximisation of invoicing for Trust owned sites occupied by other organisations.		Ongoing	Not relevant
4	**Other**			
4	Financial Improvement Communications plan. Examples could include: - Implement a regular drum beat of comms about the financial improvement (e.g. as standard item within Divisional / Service team meetings, Exec videos, newsletters, staff feedback). - Establish regular targeted contact with key internal and external stakeholders inc. case for change and expected impacts. - Seek ways of empowering staff to develop and deliver savings and / or drive transformational change through the organisation.		Aug-23	Trustwide comms issued, new cost savings mailbox created for staff to email in with new ideas, proposal to use one of the trustwide listen up live sessions for finance
4	Review income contracts with commissioners to highlight any opportunities to maximise income and to reduce penalties. Ensure all activity is captured and coded to ensure full recovery of ERF		01/04/2023	Focus now on working with provider collaboratives in particular to explore opportunities for income
4	Ensure all other income, such as car parking has been reinstated to the levels in the plan		22/23	
4	Ensure maximisation of invoicing for Trust owned sites occupied by other organisations.		Ongoing	Not relevant

Appendix 4 continued
NHSE Financial Controls status

Birmingham and Solihull Mental Health NHS Foundation Trust

	Enhanced Control	B'ham and Solihull MH FT		
		Status RAG	Date Implemented	Local specification (if local circumstances dictate a nuanced or alternative approach)
5	**Financial Governance**			
	Review all budget holders and reset to elevate responsibility if required. Ensure that all those charged with budget management adhere to SFIs, Scheme of Delegation and internal budget responsibilities. Ensure rules are followed e.g. approval of exit packages and consultancy over £50k		01/04/2023	
	Budget holders: • Ensure all budgets have physical sign off down to ward budget level • Monthly meetings take place between finance and budget holders • Budget holders have a PDP task regarding financial management and control • Ensure all have read and understood SFIs and Scheme of Delegation • Appropriate training (HFMA finance for managers training) • Enhanced expectations for senior Budget Holders including assessment of financial risk and holding to account for delivery		Ongoing	Many of these elements included in new Trust wide objective around finance training - licences purchased for HFMA on line training, and finance agreed will be part of new first manager training programme
	Extensive expenditure run rate analysis and targeted intervention.		Jul-23	
	Review meeting structures to ensure that key financial data is presented and addressed appropriately, both in terms of regularity and depth of coverage.		01/04/2023	
	Implement a 3 year financial planning cycle at Trust / system level		Autumn 23	To be developed as part of national medium term financial plan and 24/25 planning round
	Ensure a process is in place for any investments over the agreed double / triple lock threshold.		Ongoing	Process for investment oversight group being developed - business cases have been going via exec team so controls currently in place - plan to enhance
	Ensure there is a governance structure in place to guide and progress deficit control regime actions.		01/04/2023	Trustwide sustainability board, reporting into Trust FPP
	Ensure the Financial Recovery Plan has sufficient visibility with employees at all levels in the Trust / ICB / system.		Aug-23	Trust wide comms re financial position and new controls
	NHSE grip and control checklist review.		01/04/2023	Continual review via Trustwide Sustainability Board / reviewed as part of opportunities for 23/24 savings programme
	Back to basics: agreed benchmarking exercise to determine organisations capacity to deliver CIP – Internal Audit, HFMA checklist, Board and Exec engagement, Team capacity.		01/02/2023	Update to Audit Ctte re HFMA checklist - appreciated honest assessment
	Standardising the in-year reporting of underlying financial position.		01/04/2023	
	Enhanced Role for the Finance Committee – changed ToR to allow for recommendations to ICB for remedial actions if necessary and increase the Trust NED representation.		Sep-23	Will take new ICB Finance Recovery Board to Trust FPP during September 23. August 23 FPP received update on additional controls
	Regular self-assessment / RAG rating against an agreed matrix of controls covering financial governance and recovery		Ongoing	Continual review via Trustwide Sustainability Board

Appendix 5
Budget Setting process

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Budget Setting Process

Abstract: This document details the budget setting process for Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).

Version Control

Version	Date	Author	Issued To	Comments
V 1.0	August 2022	Emma Ellis	Richard Sollars	Initial Draft
V 2.0	August 2023	Jonathan Scott	Emma Ellis	Update for new year

Approvals

This document requires the following approvals;

Name	Signature	Title	Date of Issue	Version
Richard Sollars		Deputy Director of Finance		
David Tomlinson		Executive Director of Finance		

Glossary of Acronyms and Terms

Acronyms	Description
AD	Associate Director
PMO	Programme Management Office
SRO	Senior Responsible Owner
CQE (IA)	Clinical, Quality and Equality (Impact Assessment)
FYE	Full Year Effect
FPP	Finance, Performance and Productivity (Committee meeting)
CIP	Cost Improvement Programme
Terms	**Description**
Pay	Relating to staff pay
Non Pay	Relating to goods and services
Income	Relating to money/Funding provided or generated for services
Recurrent	Occurring over ongoing years
Rollover	Startpoint for next financial year budget
Non-Recurrent	One off / in-year only
Expenditure	Amount of money spent by the Trust
Surplus	Amount of money made in excess of a target
Shortfall	Amount of money required to meet a target
Slippage	Relating to how much a timescale is delayed by/target is missed

Appendix 5 continued
Budget Setting process

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Contents

1. Purpose of this document

Every NHS organisation has a specific statutory duty to make 'proper arrangements for securing economy, efficiency and effectiveness in its use of resources'. To be able to meet this requirement, each organisation needs to plan the activities it will deliver and establish the associated resources. Financial planning and budgeting take place in two areas – revenue and capital, these are then brought together in an overall plan. To assess the financial position accurately, the budget must cover all expected sources of income and expenditure across the full range of activities for which the organisation is responsible and take account of other non-financial information, such as activity levels, savings schemes and staffing requirements.

The purpose of this document is to outline the financial planning process for Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). The process aims to ensure that the financial plan is set in a robust way with due consideration of financial sustainability and that financial performance against plan can be managed, monitored, reported, reviewed and communicated to the Finance, Performance and Productivity Committee (FPP) and Trust Board to enable strategic decision making.

2. Scope

This process sets out the budget setting framework for all BSMHFT Operational and Corporate budgets. It excludes the impact of commissioning budgets for any provider collaboratives.

3. Process

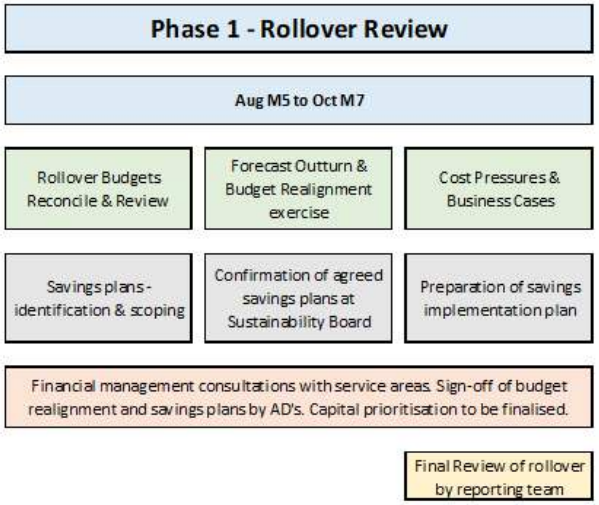
The current NHS financial arrangements support a system-based approach to planning. NHS England (NHSE) issue system revenue and capital allocations and publish a timetable for system planning submission deadlines on an annual basis. Once system allocations have been received, it is then necessary for system partners to work collaboratively to develop an overall system financial plan within the allocated envelope. In order to meet the NHSE financial plan submission deadlines and the subsequent system internal planning timetable, it is essential that the BSMHFT plan requirements are clear so that we can effectively engage in system planning discussions. The Trust financial planning process outlined in this document aims to facilitate this and will be scheduled over three phases as follows (the timetable and planning requirements are subject to change in line with any changes in directive from NHSE):

- **Phase 1** – Rollover Review
- **Phase 2** – Draft Plans
- **Phase 3** – Final Plans

Appendix 5 continued
Budget Setting process

3.1. Phase 1 – Rollover Review

This phase will be carried out between August and October. It will be lead by financial management teams, working in partnership with Budget Managers, Budget Holders and Accountable Directors:



- **Rollover Budgets - Reconcile and Review** – this is an exercise to ensure that the next year (rollover) financial budgets accurately reflect any agreed adjustments that have been made in the current financial year.

- **Forecast Outturn exercise and budget realignment** – this is an exercise to review validity of rollover budgets on a line by line basis. Current financial forecast and trends plus service area knowledge of future plans, should be used to determine which budget lines spend will actually occur against in the next financial year. Income targets must also be reviewed and adjusted where appropriate. Income targets must not remain where there is no identified income stream, with an offsetting adjustment to the expenditure budget reflecting the relevant cost reduction. Income targets should be created where there is an expected income stream, with an appropriate expenditure budget.
  The rollover budget should be realigned within the confines of the service area budget envelope and any changes should be signed off by the appropriate Associate Director. A final review and reconciliation of any budget realignment will be undertaken by the financial reporting team, with confirm and challenge meetings to take place as necessary.

- **Cost Pressures** – Operational and Corporate areas should identify any material cost pressures and document them using the Trust funding request approval process:
  Cost pressures below £5k – funding to be identified from existing budgets as part of the budget setting process.
  Cost pressures £5k - £50k - to be supported by a completed short form business case template.
  Cost pressures above £50k to be supported by a completed standard business case template.
  All cost pressure funding requests to be completed by the end of November, ready for review by the Executive Team at the beginning of December.

- **Business Cases** – A review of business cases approved in the current financial year and the Full Year Effect (FYE) of those not fully funded should be undertaken. Any planned business cases for the next financial year should be flagged by financial management teams to the financial reporting team.

- **Savings Plans** – In line with the Trust savings policy, service areas to develop recurrent savings plans for the next financial year for initial review at October Sustainability Board. Detailed assessments and CQEIA to be completed during November. Final recommendation and review of savings plans at November Sustainability Board. Once confirmation of recommended plans is communicated, service areas should develop plans to implement their savings schemes with delivery to be achieved from the beginning of the financial year (1 April).

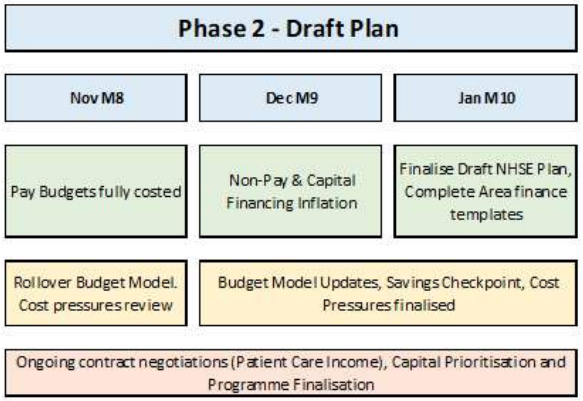
- **Capital Prioritisation** - In line with the agreed annual cycle for capital planning and the capital prioritisation process, Capital Priority Grouping Owners to determine capital priorities for the next two financial years in preparation for review and sign off by December Capital Review Group:
  Priority 1 – Risk Assessments – Owner: Executive Director responsible for Health & Safety (Director of Nursing)
  Priority 2 – Statutory Standards and Backlog Maintenance (SSBM) – Owner: Executive Director responsible for compliance with statutory buildings standards (Director of Finance)
  Priority 3 – Discretionary schemes – Owners: (A) Director of Operations (work on buildings) and (B) Director of Finance (technology requirements)

[No Title]

Appendix 5 continued
Budget Setting process

3.2. Phase 2 – Draft Plans

Following the realignment exercise to determine baseline budgets in phase 1, more detailed work will commence in Phase 2, to develop draft financial plans



- **Pay Budgets** – Service areas and financial management teams will need to ensure they have completed full establishment costings. The exercise is to include a full check and confirmation of budgeted whole time equivalents (wte) – there should be agreement on the authorised establishment including any proposed changes due to cost pressures or development/productivity plans. Work should be completed in collaboration with the workforce team. In line with recent previous years, pay budgets up to band 7 will be costed at midpoint, with all vacancies also costed at midpoint. The pay budgets must be set with due consideration of the outcome of the safer staffing/establishment review.

- **Non Pay & Capital Financing Inflation** – to be centrally calculated by the financial reporting team following national tariff guidance and allocated to service area budgets as appropriate.

- **Area Finance templates** – In January, all Operational and Corporate service areas to complete area finance templates (Budget Books) to summarise draft financial plans. This will provide a detailed bridge from rollover plan and underlying run rate to draft plan. This should help to ensure all areas have assessed material impacts on their financial plans in a consistent and comparable format. This will include budget realignments, cost pressures, service developments, savings plans and final business case assumptions. A brief financial narrative should accompany the templates to outline key issues, assumptions and risks to delivery of the draft financial plan. These should be discussed and signed off by the relevant AD or accountable officer.

- **Savings checkpoint** – ADs to present progress on savings delivery plans at Sustainability Board. If there are any risks to delivery from 1 April, alternative plans should be identified to bridge any potential savings gap.

- **Budget model update** – financial reporting team to update the master budget model to reflect agreed rollover budgets, pay and non pay inflation and other budgets updates as required in line with the draft plan. To ensure that the budget model is fully reconciled to service area draft plans.

- **Cost Pressures** – As described in phase 1, it is expected that as far as possible, all known cost pressures will be identified by the end of November, ready for review by the Executive Team at the beginning of December. There will be a further review as necessary in January for any new cost pressures identified, allowing all cost pressure funding to be finalised by February ready for inclusion in the draft plan.

- **Budget phasing** – as part of the budget model update above, a review of phasing should take place to ensure that budgets are profiled to reflect the expected pattern of monthly expenditure. Traditionally, budgets are set in 12ths but to allow more meaningful variance analysis, larger budgets should be profiled to reflect expected spend/income over the financial year as appropriate.

- **Capital Planning** – Following the capital prioritisation in phase 1, Capital Review Group to sign off capital priorities for the next two financial years by December.
  In January, finance team to confirm agreed/expected available capital envelope for the next two financial years (this will be the BSMHFT share of the total system capital envelope that will be issued by NHSE). In February, proposed capital plan (based on prioritised schemes and available capital funding envelope) to be submitted to FPP and then Trust Board for approval of next year programme and approval in principle for year 2.

Appendix 5 continued Budget Setting process

3.3. Phase 3 – Final Plans

Phase 3 - Final Plan	
Feb M11 & Mar M12	Apr M1
Finalise Commissioner Contracts	Budget upload
Board Approval of final plan	Final sign off by AD's
Submit final plan to NHSE	Final Reconciliation of upload by reporting team

- **Finalise Income contracts –** it is anticipated that Commissioner contracts will be finalised in March and subsequently final adjustments to the plan will be confirmed once completed.
- **Final Plan approval by Board –** the final plan will be submitted to Finance, Performance and Productivity (FPP) Committee and then to Trust Board for approval prior to submission of the prescribed planning templates to NHSE.
- **Budget Upload -** Recurrent budgets and agreed funding for cost pressures and developments will be uploaded to financial ledgers in April, with a final reconciliation completed by the financial reporting team.
- **Budget sign off -** Associate Directors will be provided with letters confirming final budgets to be signed off in April.

4. Budget Setting Framework

Where possible, financial budgets should reflect the expenditure required to deliver the agreed level of activity. Budgets are an essential component of planning, control, coordination, communication and performance evaluation and the Board of Directors are responsible for formulating the Trust's financial strategy and approving the annual financial plan.
Teams will need to carefully plan to ensure:

- Key staffing resources are available to complete the process to the prescribed timetable.
- Systems and working papers are set up and organised in advance.
- All budget holders are effectively engaged through formal budget setting meetings which are minuted and retained for Internal Audit purposes.
- Key risks and issues are highlighted and best practice shared across all teams.
- Sign off of plans is achieved in a timely manner.

6.2. Integrated Performance Report - Front sheet

Enclosure 1: Integrated Performance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**All Committees and Board**
Agenda item	**Item 6.2**
Paper title	**Integrated Performance Report**
Date	4 October 23
Author	Richard Sollars, Deputy Director of Finance Gill Mordain, Associate Director of Clinical Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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

- FPP
  - CPA with formal review in last 12 months (** now significantly improved **)
  - IAPT seen within 6 and 18 weeks (** now significantly improved **)
  - Out of area bed days
  - CPA 7-day follow up (* improving *)
  - Referrals over 3 months with no contact
  - CIP delivery
  - Temporary staffing
- People
  - Bank and agency fill rate
  - Appraisals
  - 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. These are included as Appendix I.

The Committee asked for more assurance to be provided on whether we are on track with the improvement plans and/or what we can do to address ongoing issues. This is an ongoing development and we will seek to refine the report to ensure it provides the necessary assurance.

The Trust's Performance Management Framework has been reviewed and a number of improvements are being made, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement
- Bringing all performance management matters (People, Quality, Performance, Finance) through a single set of forums

Further details are provided in Appendices II, III and IV which provide an outline of discussions and progress at PDG and Deep Dives

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
- Talking Therapies – service users seen within 6 and 18 weeks (** now significantly improved **)
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months (** now significantly improved **)
- CPA 7 day follow up (* improving *)
- People metrics – Vacancies, Sickness absence (** now significantly improved **), 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. Appendix 1 provides an update against improvement trajectories for these metrics.

Performance in August 2023

The key performance issues facing us as a Trust have changed little over the last 2 years:

- **Out of Area Bed Use** – Some process improvements have helped us address underlying issues, but the level of demand has significantly impaired our ability to eliminate use of out of area beds. August's average figure is 31.6 patients
- **Talking Therapies waits** – Improving significantly
- **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. The divergence between individual areas is of concern
- **YTD financial position** is a deficit of £0.5m against a planned breakeven, chiefly because pressures on temporary staffing and out of area beds. We expect to achieve breakeven for the year as a whole

Quality

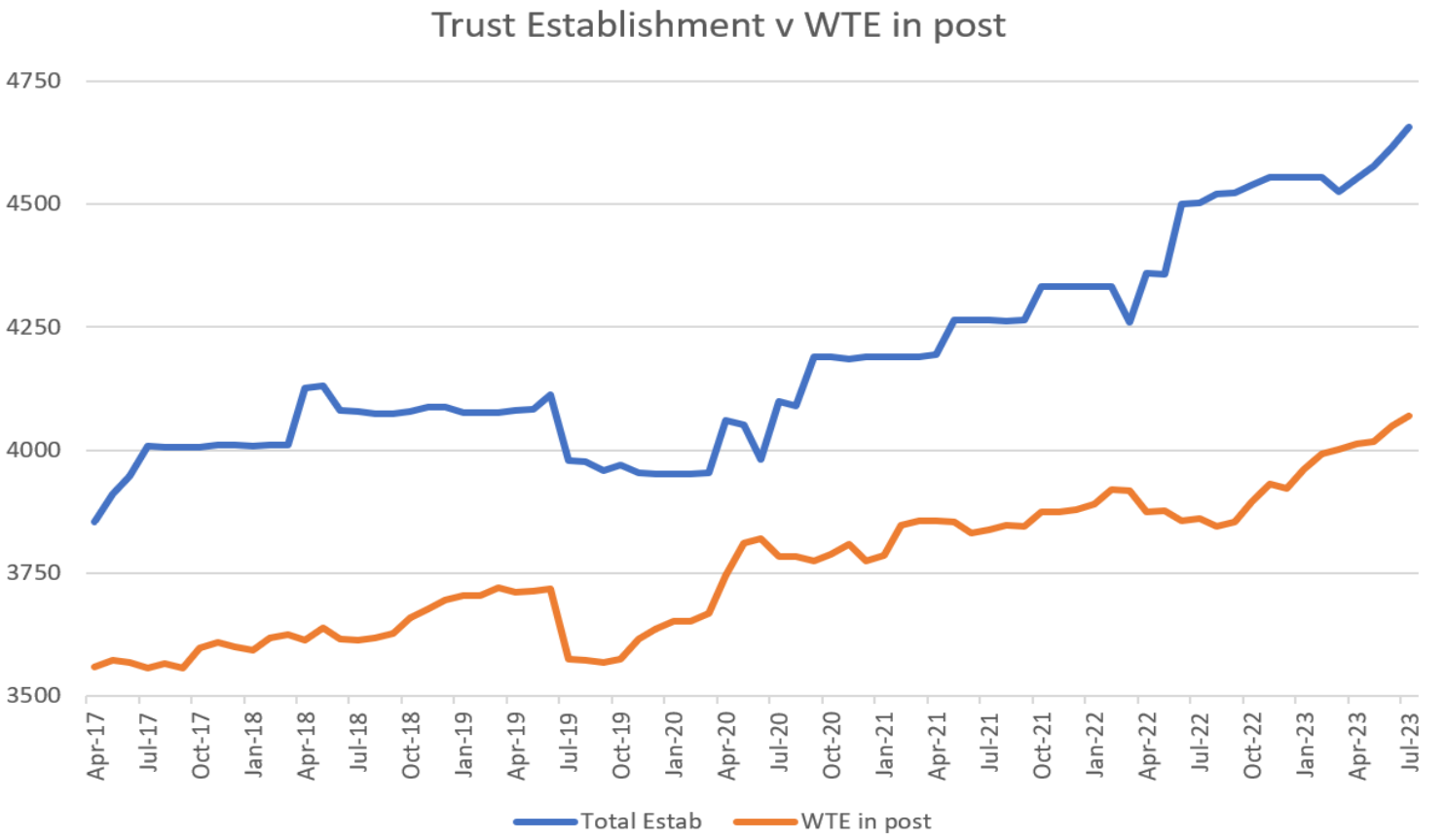
- Assaults on staff fell from 140 in May-23 to 94 (the lowest level since Jun-22) last month, but are a little higher at 101 in August
- **Key concerns: Staff assaults**

Performance

- The level of inappropriate Out of Area Patients remains a concern. The figure rose to 980 (31.6 patients per day). There have been increases for each of the last two months since June, which was the lowest level since Jun-22 (679 occupied bed days, 22.6 patients per day and represents a significant cost pressure
- CPA 7-day follow up is up to 90.0% the highest level since Feb-23
- CPA with formal review in last 12 months up to 93.7% (highest in 4 years and close to target)
- Delayed transfers of care are up to 7.7% (1,2228 occupied bed days), but remain above historic norms
- Talking Therapies wait times have improved. Services users seen within 6 weeks of referral has improved significantly to 43.4%, the highest level since Mar-21. Performance for within 18 weeks is up to 83.1%, the highest level since Sep-21
- New referrals not seen within 3 months are little changed at 3,393. Of this, Neuropsychiatry represents the most significant issue
- **Key concerns: Out of Area, CPA 7-day follow up, Talking Therapies waiting times and new referrals not seen in 3 months**

People

- Scores are of concern across the board
- Vacancy levels are 12.6% in July, significantly down on 14.9% in Aug-22 but at the highest level since Jan-23. This is driven by changes to establishment and staff in post. 4,070.3 WTE in post is the highest number ever and is up by 174.9 since Oct-22. Vacancies total 586.7 WTE and the vacancy rate varies by area. Specialties has the highest vacancy rate of the service directorates at 18.3% (161.8 WTE)



- Staff appraisals at 76.9%, highest figure since Oct-22 but well down on target of 90%
- Bank and Agency fill rate little changed at 87.2%
- **Key concerns: Vacancies, appraisals, bank and agency fill rate**

Sustainability

- Financial position for the first 5 months is a deficit of £0.5m against a planned breakeven, chiefly because of pressures on temporary staffing, out of area beds and unachieved efficiencies. We expect to achieve breakeven for the year as a whole, although the pressures above are of concern
- Capital expenditure for the first 5 months is £2.7m, which is £2.2m ahead of plan, mainly driven by expenditure which was in train at year end. The delay in agreeing the capital programme has resulted in a back-ended programme for the year
- Although we are able to generate some efficiencies for the year, there is no pipeline of savings schemes and transformative change is required to address the underlying financial position
- Monthly agency expenditure continues to rise month by month and remains higher than NHSE target, with key issues in medical staffing in ICCR
- **Key concerns: CIP, temporary staffing**

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

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

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

August 2023

Performance

CPA 7 day FU	90.0%	↓
CPA with Formal Review last 12 mths	93.7%	↓
Data Quality Maturity Index (DQMI)	97.4%	↑
Delayed Transfer Bed Days	1228	↓
Delayed Transfer, percent of bed days	7.7%	↓
Eating disorders routine	100.0%	
Eating disorders urgent	100.0%	
First episode psychosis	100.0%	↑
IAPT into recovery	42.1%	↓
IAPT seen in 18 weeks	83.1%	↓
IAPT seen in 6 weeks	43.4%	↓
Out of Area Bed Days	980	
Referrals over 3 mths with no contact	3393	↓

People

Bank & Agency Fill Rate	87.2%	
Fundamental Training	92.8%	↓
Rolling 12m Turnover	8.8%	↑
Staff Appraisals	76.9%	↓
Staff Sickness	5.4%	

Quality

Absconsions from inpatient units	2	
Commissioner reportable incidents	1	
Community confirmed suicides	0	
Community suspected suicides	0	
Failure to return	5	↑
Incidents of self harm	186	
Incidents resulting in harm (other)	14.6 %	↑
Incidents resulting in harm (patients)	16.0 %	↑
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	20	↑
Ligature with anchor point	0	
Patient assaults	49	

Sustainability

CAP Ex	£402k	
Cash	£80,904k	↑
CIP	£759k	
Info Governance	95.0%	
Monthly Agency	£1,143k	↓
Operating Surplus	£90k	↓
SOF rating	3	↑

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

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Integrated Performance Dashboard

Board of Director Part 1

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Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

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

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Division: A: All

A: All

August 2023

Performance

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Out of Area Bed Days	980
Referrals over 3 mths with no contact	3393 ↓

People

Bank & Agency Fill Rate	87.2%
Fundamental Training	92.8% ↓
Rolling 12m Turnover	8.8% ↑
Staff Appraisals	76.9% ↓
Staff Sickness	5.4%

Quality

Incidents resulting in harm (patients)	16.0 % ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	20 ↑
Ligature with anchor point	0
Patient assaults	49
Patient ssaults / 1000 OBD	2.6
Physical restraints	250
Physical restraints/ 1000 OBD	13.1
Prone restraints	71
Prone restraints/ 1000 OBD	3.7
Reported incidents	2225 ↑
Staff assaults	101
Staff assaults / 1000 OBD	5.3 ↓

Sustainability

CAP Ex	£402k
Cash	£80,904k ↑
CIP	£759k
Info Governance	95.0%
Monthly Agency	£1,143k ↓
Operating Surplus	£90k ↓
SOF rating	3 ↑

	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
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Integrated Performance Dashboard

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	
CPA 7 day FU	95.00	89.2%	87.9%	88.9%	84.5%	89.6%	90.0%	↓
CPA with Formal Review last 12 mths	95.00	88.8%	88.5%	88.7%	90.7%	91.6%	93.7%	↓
Data Quality Maturity Index (DQMI)	95.00	96.6%	97.5%	96.9%	97.3%	97.4%	97.4%	↑
Delayed Transfer Bed Days		937	991	1068	1237	1184	1228	↓
Delayed Transfer, percent of bed days		6.0%	6.6%	6.8%	8.0%	7.4%	7.7%	↓
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Eating disorders urgent	95.00	100.0%	100.0%	100.0%		100.0%	100.0%	
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↑
IAPT into recovery	50.00	50.5%	51.8%	47.8%	48.7%	47.1%	42.1%	↓
IAPT seen in 18 weeks	95.00	74.2%	71.2%	79.9%	79.6%	76.3%	83.1%	↓
IAPT seen in 6 weeks	75.00	40.8%	33.0%	41.1%	42.5%	34.4%	43.4%	↓
Out of Area Bed Days	855.00	1222	939	863	575	872	980	
Referrals over 3 mths with no contact		3201	3409	3414	3359	3378	3393	↓

Top Line Commentary (Trust level)

KEY CONCERN:

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

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	
Staff Vacancies		11.5%	11.8%	12.2%	12.2%	12.6%		
Staff Sickness	4.28	5.2%	4.8%	5.0%	4.3%	4.6%	5.4%	
Staff Appraisals	90.00	69.0%	68.8%	70.7%	72.9%	76.0%	76.9%	↓
Rolling 12m Turnover		9.9%	9.7%	9.7%	9.6%	9.1%	8.8%	↑
Fundamental Training	95.00	90.2%	91.4%	91.5%	91.1%	92.5%	92.8%	↓
Bank & Agency Fill Rate		84.6%	84.1%	89.0%	85.5%	87.3%	87.2%	

Top Line Commentary (Trust level)

KEY CONCERNS

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

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

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Integrated Performance Dashboard

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Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	
Absconsions from inpatient units		4	6	2	7	5	2	
Commissioner reportable incidents		12	4	7	5	6	1	
Community confirmed suicides		1	0	0	0	0	0	
Community suspected suicides		2	1	3	2	2	0	
Failure to return		18	10	16	16	15	5	↑
Incidents of self harm		165	169	173	134	200	186	
Incidents resulting in harm (other)		13.9%	12.8%	13.1%	13.9%	13.8%	14.6%	↑
Incidents resulting in harm (patients)		14.2%	16.2%	13.3%	12.6%	14.1%	16.0%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	0	
Ligature no anchor point		14	29	18	18	29	20	↑
Ligature with anchor point		1	1	0	4	3	0	
Patient assaults		42	45	59	66	58	49	
Patient ssaults / 1000 OBD		2.2	2.5	3.1	3.6	3.0	2.6	
Physical restraints		297	285	294	241	214	250	
Physical restraints / 1000 OBD		15.0	15.8	15.7	13.1	11.2	13.1	

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

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Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Incidents of self harm		165	169	173	134	200	186
Incidents resulting in harm (other)		13.9%	12.8%	13.1%	13.9%	13.8%	14.6% ↑
Incidents resulting in harm (patients)		14.2%	16.2%	13.3%	12.6%	14.1%	16.0% ↑
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		14	29	18	18	29	20 ↑
Ligature with anchor point		1	1	0	4	3	0
Patient assaults		42	45	59	66	58	49
Patient ssaults / 1000 OBD		2.2	2.5	3.1	3.6	3.0	2.6
Physical restraints		297	285	294	241	214	250
Physical restraints/ 1000 OBD		15.9	15.8	15.7	13.1	11.2	13.1
Prone restraints		69	84	86	68	56	71
Prone restraints/ 1000 OBD		3.7	4.7	4.6	3.7	2.9	3.7
Reported incidents		2477	2203	2474	2442	2407	2225 ↑
Staff assaults		121	100	140	137	94	101
Staff assaults / 1000 OBD		6.5	5.5	7.5	7.5	4.9	5.3 ↓

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	
CAP Ex		£1,748k	£517k	£308k	£1,378k	£200k	£402k	
Cash		£59,020k	£68,159k	£68,246k	£78,199k	£82,736k	£80,904k	↑
CIP		£3,662k	£483k	£483k	£825k	£1,457k	£759k	
Info Governance		94.9%	83.9%	94.6%	96.0%	92.6%	95.0%	
Monthly Agency		£755k	£801k	£941k	£935k	£956k	£1,143k	↓
Operating Surplus		-£2,873k	£59k	£352k	-£122k	£156k	£90k	↓
SOF rating		3	3	3	3	3	3	↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

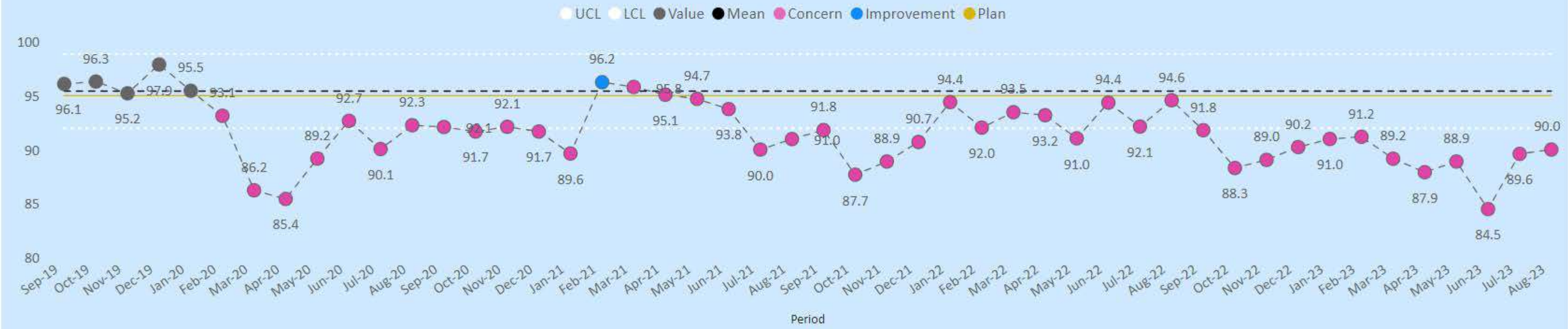
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	89.2%	87.9%	88.9%	84.5%	89.6%	90.0%
B: Acute and Urgent Care	89.6%	90.7%	90.8%	87.3%	91.9%	92.8%
C: ICCR	62.5%	60.0%	81.3%	76.5%	92.9%	83.3%
D: Secure Serv & Offender Health	100.0%	50.0%	75.0%	83.3%	66.7%	66.7%
E: Specialties	95.2%	95.0%	90.9%	76.9%	81.8%	92.3%

Commentary

National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 89.6% for July2023.
July 2023 performance is below the target of 95%. This relates to 13 outstanding follow ups from 125 discharges in June of which, 1 patient was admitted to a care home and contact was with staff only 2 patients were discharged to another mental health trust, attempts were made to see 2 patients but were unsuccessful, 1 patient was discharged to prison, 4 patients were seen outside 7 days, and 3 cases will be a pass when data entry has been completed. Of the 13 exceptions 7 were adult acute and 1 in ICCR, 4 in Specialties and 1 in secure services. When Rio data entry has been completed this will increase compliance to 92%.

CPA 7 day FU

August 2023

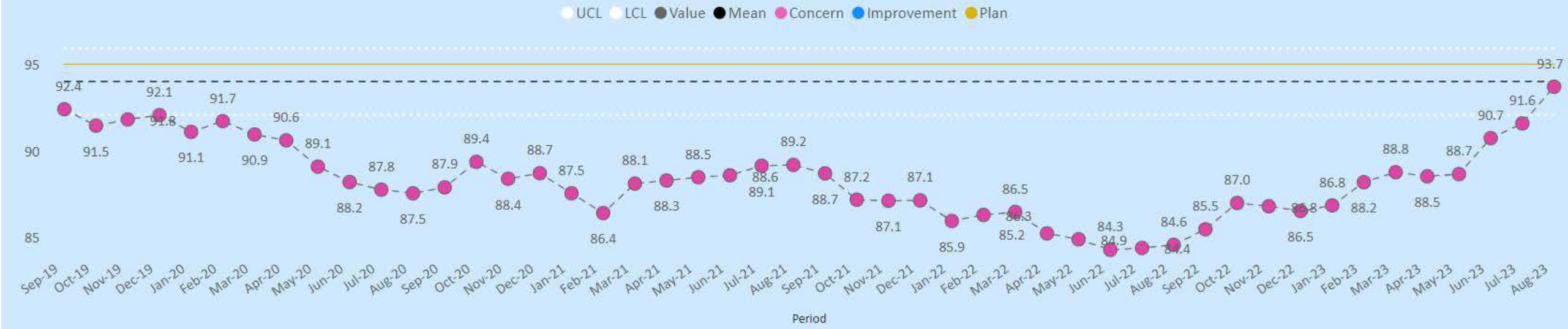
Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 89.6% for July2023. July 2023 performance is below the target of 95%. This relates to 13 outstanding follow ups from 125 discharges in June of which, 1 patient was admitted to a care home and contact was with staff only 2 patients were discharged to another mental health trust, attempts were made to see 2 patients but were unsuccessful, 1 patient was discharged to prison, 4 patients were seen outside 7 days, and 3 cases will be a pass when data entry has been completed. Of the 13 exceptions 7 were adult acute and 1 in ICCR, 4 in Specialties and 1 in secure services. When Rio data entry has been completed this will increase compliance to 92%.
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 2/13 patients were discharged to 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. There were 3 follow ups which are awaiting data entry in July.
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

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	88.8%	88.5%	88.7%	90.7%	91.6%	93.7%
B: Acute and Urgent Care	100.0%	66.7%		100.0%		
C: ICCR	88.5%	87.8%	88.5%	90.7%	91.4%	93.8%
D: Secure Serv & Offender Health	97.8%	97.8%	98.0%	97.8%	97.8%	98.0%
E: Specialties	82.6%	85.7%	76.6%	77.8%	82.9%	87.1%

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 July 2023 increasing to 91.58%. Within divisions and teams there is variation in performance with between 1-27 reviews outstanding. Adult CMHTs now have only 1 team with above 20 outstanding reviews which is an improvement from last month. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 24 outstanding and Adult CMHTs have 145 outstanding . Adult CMHT account for 49%, older adult CMHT for 4%, Secure for 16% and AOT for 25% of the total outstanding.

Detailed Commentary

CPA with Formal Review last 12 mths

August 2023

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 July 2023 increasing to 91.58%. Within divisions and teams there is variation in performance with between 1-27 reviews outstanding. Adult CMHTs now have only 1 team with above 20 outstanding reviews which is an improvement from last month. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 24 outstanding and Adult CMHTs have 145 outstanding . Adult CMHT account for 49%, older adult CMHT for 4%, 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. A proportion of CPA reviews become due each month and this is in addition to those already outstanding. 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. 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 A review of the outstanding CPA reviews has taken place to see if they still require to be on CPA or can be stepped down. As part of the wider transformation work caseloads are also be reviewed. There is 1 CMHT which has a number of vacancies and this is unlikely to improve before September 2023. There are regular meetings to review progress. Specialties: Team managers have been asked to review the outstanding CPA reviews in caseload supervision to ensure that the service user is on the correct level of care. There are significant staffing challenges within Solihull HUB and a number of agency staff have commenced and are in the process of taking over the caseloads.
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, although this will be challenging as it requires CPA reviews to be undertaken which are due that month but also to undertake those who are overdue.

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths

August 2023

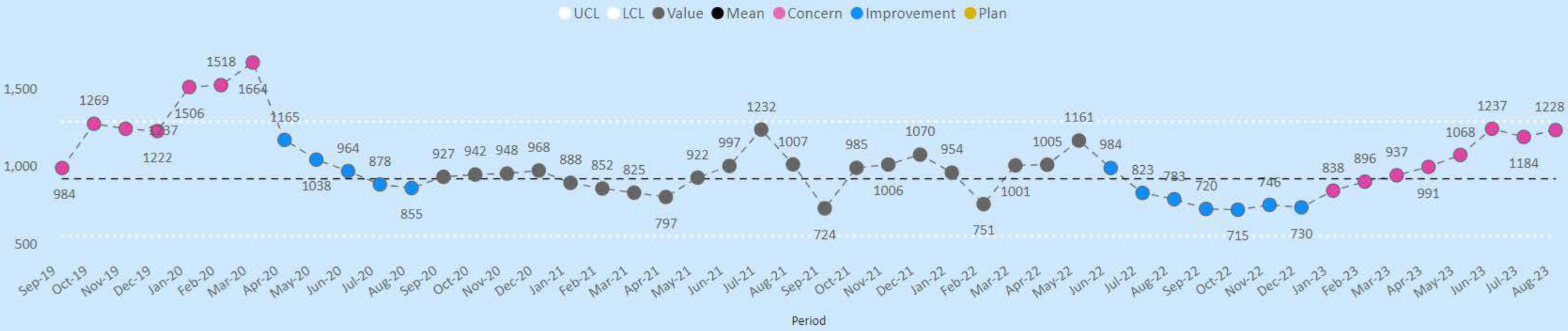
Question	Answers
	increase with July 2023 increasing to 91.58%. Within divisions and teams there is variation in performance with between 1-27 reviews outstanding. Adult CMHTs now have only 1 team with above 20 outstanding reviews which is an improvement from last month. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 24 outstanding and Adult CMHTs have 145 outstanding . Adult CMHT account for 49%, older adult CMHT for 4%, 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. A proportion of CPA reviews become due each month and this is in addition to those already outstanding. 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. 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 A review of the outstanding CPA reviews has taken place to see if they still require to be on CPA or can be stepped down. As part of the wider transformation work caseloads are also be reviewed. There is 1 CMHT which has a number of vacancies and this is unlikely to improve before September 2023. There are regular meetings to review progress. Specialties: Team managers have been asked to review the outstanding CPA reviews in caseload supervision to ensure that the service user is on the correct level of care. There are significant staffing challenges within Solihull HUB and a number of agency staff have commenced and are in the process of taking over the caseloads.
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, although this will be challenging as it requires CPA reviews to be undertaken which are due that month but also to undertake those who are overdue.
F: How will we know when we have addressed issues?	When reviews are undertaken in a systematic way and performance increases and is maintained although it is noted that the system will change and is part of a wider strategic review

Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer Bed Days

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	937	991	1068	1237	1184	1228
B: Acute and Urgent Care	532	557	485	562	633	757
D: Secure Serv & Offender Health	279	232	248	229	201	162
E: Specialties	126	202	335	446	350	309

Commentary

September 2021 had the lowest level of DTOC bed days in the previous 12 months at 724. The number of days has then fluctuated with an increase in May 2022, reaching a peak of 1161 days. June 2022 onwards has shown a reduction until January 2023 onwards when the numbers of delayed days increased until July which has seen a small reduction to 1184 days. This is due to an increase in both adults and older adults. Adult delays are due to lack of social care support and older adults are waiting for nursing home placement (which also relies on social care support).

Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer, percent of bed days

Divisions

Statistical Process Control (SPC)

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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	6.0%	6.6%	6.8%	8.0%	7.4%	7.7%
B: Acute and Urgent Care	7.8%	8.5%	7.3%	8.6%	9.2%	11.0%
D: Secure Serv & Offender Health	4.5%	3.9%	3.9%	3.7%	3.1%	2.5%
E: Specialties	4.7%	8.1%	12.3%	16.3%	12.5%	11.6%

Commentary

September 2021 had the lowest DTOC rate for the previous 12 months at 4.7%. The rate has then fluctuated with a reduction between June 2022 and December 2022. The percentage of bed days has increased until June with a slight fall in July to 7.36%. Adults moved from 8.6% in June to 9.2% in July which related to 36 patients with a main DTOC attribution of NHS. Older adults moved from 19.8% in June to 15.2% in July which related to 19 patients and a main DTOC attribution of both health and social care. Secure care moved from 3.7% in June to 3.1% in July which related to 8 patients and specialties moved from 4.7% in June to 4.3% in July 2023. This related to 1 patient in eating disorders. Production boards are available in acute wards providing an update on each patient's delay, identifying progress and tasks required to support discharge, thus allowing an opportunity for early intervention to reduce delayed discharges. This is supported in adult acute by 2 discharge co-ordinators.

Delayed Transfer Bed Days

August 2023

Question	Answers
A: What has happened?	September 2021 had the lowest level of DTOC bed days in the previous 12 months at 724. The number of days has then fluctuated with an increase in May 2022, reaching a peak of 1161 days. June 2022 onwards has shown a reduction until January 2023 onwards when the numbers of delayed days increased until July which has seen a small reduction to 1184 days. This is due to an increase in both adults and older adults. Adult delays are due to lack of social care support and older adults are waiting for nursing home placement (which also relies on social care support).
B: Why has it happened?	There has been continued work to reduce delayed transfers of care by services with regular calls to care homes and commissioners to support timely discharge. Within adult acute services 2 discharge coordinators are in place to support and put in place arrangements required to enable timely discharge of patients. Within older adults there were 2 social work posts dedicated older adult wards, but these are currently vacant so requests for social workers are directed to localities which results in a wait for social work input. The majority of the DTOCS are awaiting nursing home placements and requires social services input to facilitate this process.
C: What are the implications and consequences?	Failure to discharge patients in a timely way reduces the flow within in-patients, contributing to out of area placements and leads to an increased waiting time for beds and impacts on patient experience.
D: What are we doing about it?	Reviewing patient flow and activities as part of strategic management of demand and capacity with a focus on discharge plans ensuring robust management of actions to aid discharge. A multi-agency bed management meeting has been introduced to support improved bed flow across inpatient services. Delayed transfers of care within Older adults were discussed in a deep dive meeting with Specialties in June 2023 and a number of options were identified for further exploration. Discussions have taken place with Birmingham City Council who have agreed to advertise dedicated social worker posts. As an alternative the service have asked if it would be possible to employ our own social workers. Adult acute have identified a workstream to take forward improvements but this needs to be resourced.
E: What do we expect to happen?	Utilising data to help inform review of patient demand, patient flow, acuity to enable provision of care aligned to service users needs.
F: How will we know when we have addressed issues?	Currently part of ongoing strategic service review discussions.

Delayed Transfer, percent of bed days

August 2023

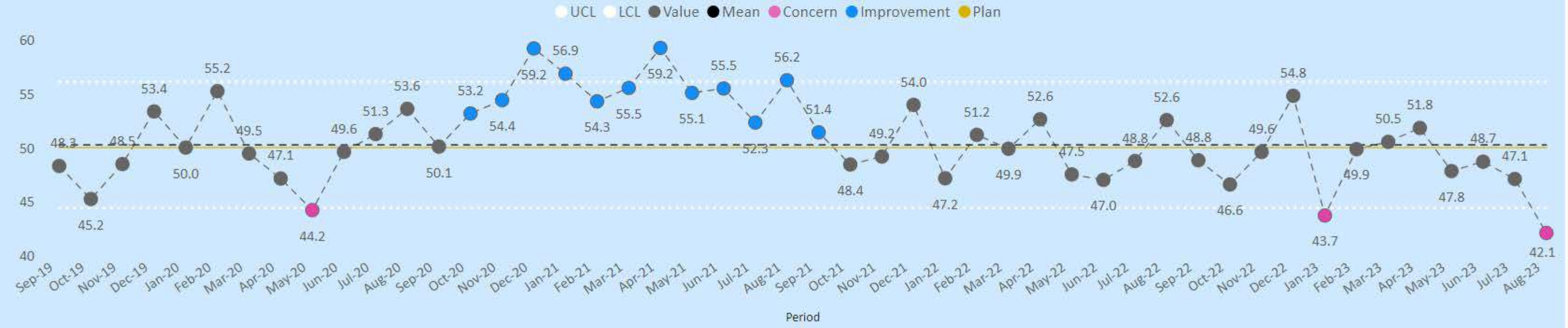
Question	Answers
A: What has happened?	September 2021 had the lowest DTOC rate for the previous 12 months at 4.7%. The rate has then fluctuated with a reduction between June 2022 and December 2022. The percentage of bed days has increased until June with a slight fall in July to 7.36%. Adults moved from 8.6% in June to 9.2% in July which related to 36 patients with a main DTOC attribution of NHS. Older adults moved from 19.8% in June to 15.2% in July which related to 19 patients and a main DTOC attribution of both health and social care. Secure care moved from 3.7% in June to 3.1% in July which related to 8 patients and specialties moved from 4.7% in June to 4.3% in July 2023. This related to 1 patient in eating disorders. Production boards are available in acute wards providing an update on each patient's delay, identifying progress and tasks required to support discharge, thus allowing an opportunity for early intervention to reduce delayed discharges. This is supported in adult acute by 2 discharge co-ordinators.
B: Why has it happened?	There has been continued work to reduce delayed transfers of care by services with regular calls to care homes and commissioners to support timely discharge. Within adult acute services 2 discharge coordinators are in place to support and put in place arrangements required to enable timely discharge of patients. Within older adults there were 2 social work posts dedicated older adult wards, but these are currently vacant so requests for social workers are directed to the social services localities which results in a wait for social work input. The majority of the DTOCS are awaiting nursing home placements and requires social services input to facilitate this process.
C: What are the implications and consequences?	Failure to discharge patients in a timely way reduces the flow within in-patients, contributing to out of area placements and leads to an increased waiting time for beds and impacts on patient experience.
D: What are we doing about it?	Reviewing patient flow and activities as part of strategic management of demand and capacity with a focus on discharge plans ensuring robust management of actions to aid discharge. A multi-agency bed management meeting has been introduced to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. Delayed transfers of care within Older adults were discussed in a deep dive meeting with Specialties in June 2023 and a number of options were identified for further exploration. Discussions have taken place with Birmingham City Council who have agreed to advertise dedicated social worker posts. As an alternative the service have asked if it would be possible to employ our own social workers. Adult acute have identified a workstream to take forward improvements but this needs to be resourced.
E: What do we expect to happen?	Utilising data to help inform review of patient demand, patient flow, acuity to enable provision of care aligned to service users needs.
F: How will we know when we have addressed issues?	Currently part of ongoing strategic service review discussions.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT into recovery

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	50.5%	51.8%	47.8%	48.7%	47.1%	42.1%
E: Specialties	50.5%	51.8%	47.8%	48.7%	47.1%	42.1%

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. August 2023 position below the 50% target at 42.08%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT into recovery

August 2023

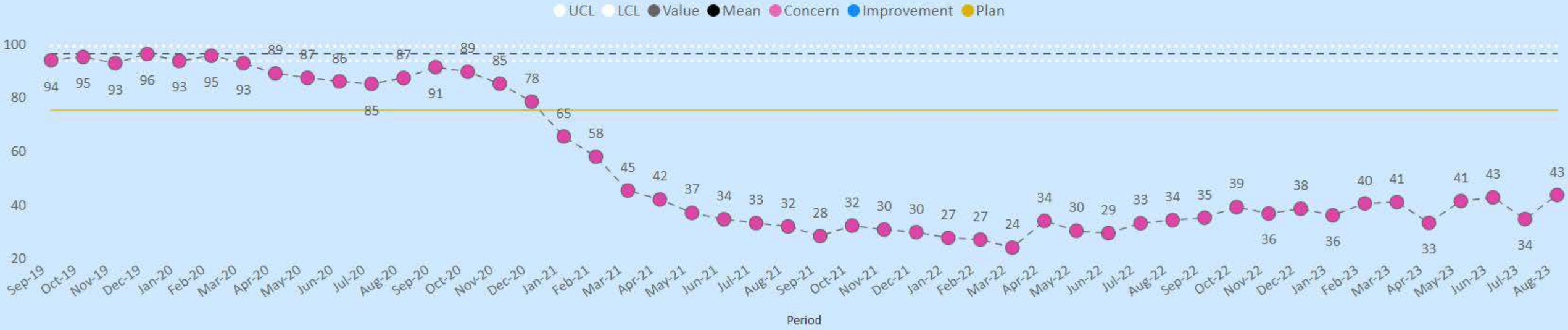
Question	Answers
A: What has happened?	The MTR rate has fluctuated and largely meets the 50% national target. MTR is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. August 2023 position below the 50% target at 42.08%.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	40.8%	33.0%	41.1%	42.5%	34.4%	43.4%
E: Specialties	40.8%	33.0%	41.1%	42.5%	34.4%	43.4%

Commentary

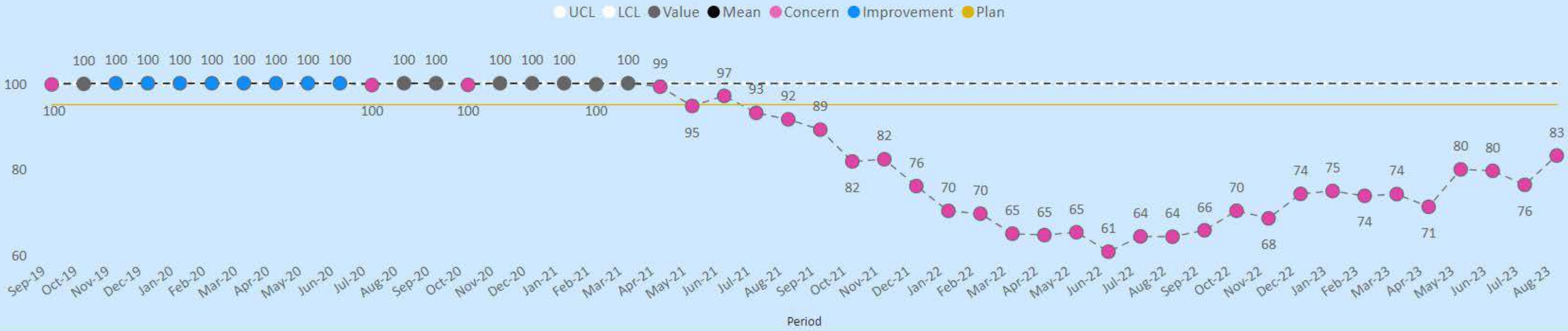
Performance has been on a reducing trend since March 2020 below the 75% target. July 2022 onwards has shown a steady increase with the exception of April 2023 which saw a decrease to 33%. Augst has increased to 43.49%.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 18 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	74.2%	71.2%	79.9%	79.6%	76.3%	83.1%
E: Specialties	74.2%	71.2%	79.9%	79.6%	76.3%	83.1%

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 an i8ncrease in August 2023 to 83.17%.

Detailed Commentary

IAPT seen in 6 weeks

August 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 with the exception of April 2023 which saw a decrease to 33%. Augst has increased to 43.49%.
B: Why has it happened?	The ability to see patients face to face was impacted by Covid as access to GP surgeries and access to community facilities stopped. Face to face groups also stopped and, whilst these have now increased in BHM premises since easing of restrictions, they have needed to be undertaken in a COVID secure way and capacity is therefore reduced in the number of participants per group. The iAPT model relies on large group interventions to see the majority of patients at Step 2, with smaller numbers then requiring Step 3 - 1:1 intervention. The service also has a large number of vacancies following staff retirements and leavers. Over the past 5 years significant challenges have been faced around retention of staff who have left to take up further training, work outside of the NHS or move to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. 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. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. A small number of staff have started since April and there are further staff will be commencing in the next couple of months and 9 higher intensity trainees will be offered placements in teams in 2023/24. The staff being recruited are to a range of posts including Counsellors, Psychological wellbeing practitioners, Employment advisors, psychological therapists and High Intensity therapists. Additional capacity (150) for assessment and treatement has been sourced through Xyla (digital Service)and letters are currently being sent out to service users to see if they would like to be seen by the service. A clinical development lead is commencing soon who will support the CSM and the team managers to screen referrals and identify barriers to recovery plan and develop existing relationships with neighbourhood mental health teams. A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff. In addition to this they have been working with the NHS Talking Therapies lead for Commissioning who has proposed a change to the way that our data is recorded which is aligned to recording utilised by other services within BSOL. The effect of this change will: - Improve the waiting times bringing them closer to the national targets

Detailed Commentary

IAPT seen in 6 weeks

August 2023

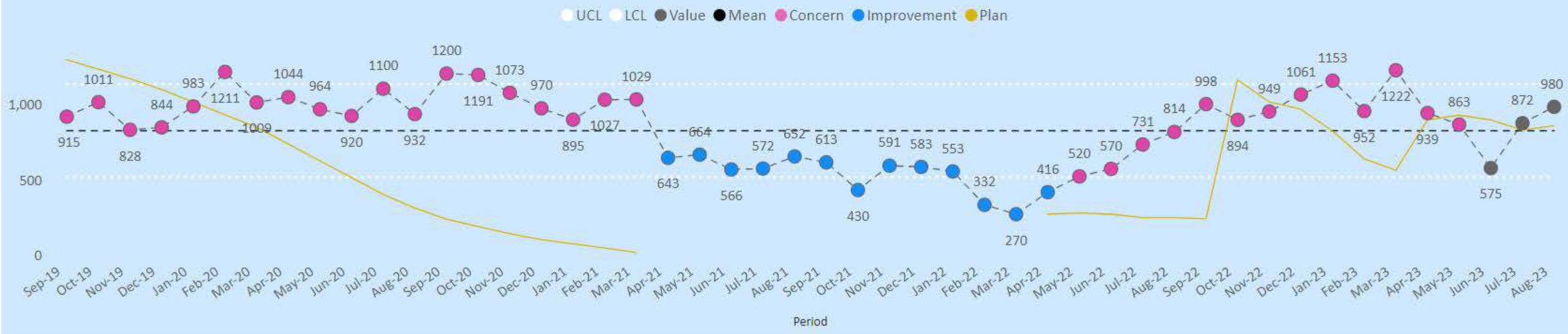
Question	Answers
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during 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. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. A small number of staff have started since April and there are further staff will be commencing in the next couple of months and 9 higher intensity trainees will be offered placements in teams in 2023/24. The staff being recruited are to a range of posts including Counsellors, Psychological wellbeing practitioners, Employment advisors, psychological therapists and High Intensity therapists. Additional capacity (150) for assessment and treatement has been sourced through Xyla (digital Service)and letters are currently being sent out to service users to see if they would like to be seen by the service. A clinical development lead is commencing soon who will support the CSM and the team managers to screen referrals and identify barriers to recovery plan and develop existing relationships with neighbourhood mental health teams. A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff. In addition to this they have been working with the NHS Talking Therapies lead for Commissioning who has proposed a change to the way that our data is recorded which is aligned to recording utilised by other services within BSOL. The effect of this change will: - Improve the waiting times bringing them closer to the national targets - The wait target between first and second treatment appointments will increase above the 10% threshold (over 90 day waits). - The moving to recovery rate is likely to reduce. The changes have not yet been applied to internal reporting. BHM are instigating a number of initiatives to reduce the waits for High intensity CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean that waits for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
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. When the staff are in post we would expect the waiting times to slowly increase and it is unlikely that there will be a significant impact for a few months.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 75% target.

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	1222	939	863	575	872	980
B: Acute and Urgent Care	1222	939	863	575	872	980

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. April 2022 onwards saw a significant increase until March 2023 which has started to fall with June at 679 days due to the increased bed capacity at Kings Norton being counted as appropriate. August has shown a continued increase increase to 980, despite admissions to St Andrews, Northmpton being counted as 'appropriate'. There were 10 admissions to PICU beds and 3 to an acute bed. The number of appropriate placements in August 2023 was 41. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 45 OOA placements. A revised trajectory has been agreed with commissioners from April 2023 to March 2024 to reach 328 bed

Out of Area Bed Days

August 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. April 2022 onwards saw a significant increase until March 2023 which has started to fall with June at 679 days due to the increased bed capacity at Kings Norton being counted as appropriate. August has shown a continued increase increase to 980, despite admissions to St Andrews, Northmpton being counted as 'appropriate'. There were 10 admissions to PICU beds and 3 to an acute bed. The number of appropriate placements in August 2023 was 41. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 45 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 August 2023 is 855 OOA bed days and is over the target this month, this has been driven by the demand for PICU beds. Adult acute beds are under trajectory, however the costs for these remain high. 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 be classed as 'appropriate placements' and internal reporting reflects this change (backdated to February 2023). Admissions to St Andrews, Northampton will also be classed as appropriate (backdated to April 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 (12 PICU and 10 acute beds)and the 10 acute beds at Kings Norton and admissions to St Andrews Northmpton, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has continued 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 increased in August and accounted for 757 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

Detailed Commentary

Out of Area Bed Days

August 2023

Question	Answers
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 (12 PICU and 10 acute beds)and the 10 acute beds at Kings Norton and admissions to St Andrews Northmpton, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has continued 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 increased in August and accounted for 757 lost bed days and remains an issue.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans receive national and commissioner scrutiny which will increase if the Trust is unable to demonstrate continuing progress.
D: What are we doing about it?	The Performance Delivery Group deep dive took place in August and outlined the pressures and actions being taken to try and reduce OOA activity, in addition to those steps already in place. The action plan to transform the acute & urgent care pathway will focus on 4 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 4 workstreams are : - Demand Management - Reducing Length of Stay/DTOCs - Optimise capacity - Locality model development Operational and clinical leads are in the process of being identified to support. Key areas of risk and dependencies have been identified and also expected benefits from each workstream supported by improvement metrics to track progress. 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 a high vacancy rate. Out of area trajectory has been reviewed for 2023/24 and it has been agreed to reach 328 OOA bed days by the end of March 2024.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

Divisions

Statistical Process Control (SPC)

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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	3201	3409	3414	3359	3378	3393
C: ICCR	1419	1312	1303	1207	1202	1214
D: Secure Serv & Offender Health	120	119	127	140	149	152
E: Specialties	1618	1679	1731	1802	1834	1854

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 with July 2023 at 3377. 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 Adult CMHTs, SOLAR and OAKS group therapy programmes, but has increased in Memory Assessment and CAMHS Primary Mental health.
Neuropsychiatry service accounts for 24% and Adult CMHTs 23% of referrals open for over 3 months without a contact.

Referrals over 3 mths with no contact

August 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 with July 2023 at 3377. 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 Adult CMHTs, SOLAR and OAKS group therapy programmes, but has increased in Memory Assessment and CAMHS Primary Mental health. Neuropsychiatry service accounts for 24% and Adult CMHTs 23% 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

Referrals over 3 mths with no contact

August 2023

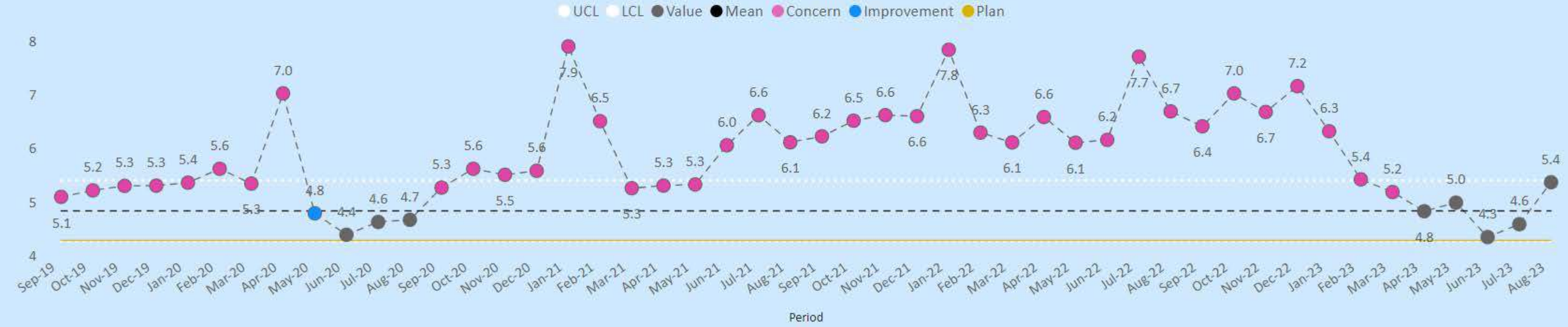
Question	Answers
consequences?	although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service
D: What are we doing about it?	ICCR: ICCR CMHTs are reviewing long waiters and ensuring they have been offered an appointment, either within the CMHT or in the neighbourhood teams if this is appropriate. A large number of those waiting have already been offered appointment dates which they have DNA'd, often multiple times. These are being discussed within the MDT to see whether it is appropriate to offer a further appointment, if they do not reply to a request to contact the CMHT. This process will take time to work through. The DNA rate for first appointments remains high and administrative staff are ringing patients to remind them of the appointment and in some cases are also sending text reminders. Saturday clinics are also being utilised to increase the number of appointment slots available. A number of people waiting are transfers between internal teams and a 3-month target has been set to achieve the transfer Solar have had a focus on new referrals and have reduced those waiting for an initial appointment and have created some additional capacity for assessments using the 3rd sector, however this will result in longer waits for treatment. 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. Solihull CMHT has four band 6 vacancies and agency staff have recently commenced and are in the process of taking over caseloads
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 BSOI 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	5.2%	4.8%	5.0%	4.3%	4.6%	5.4%
B: Acute and Urgent Care	7.0%	6.8%	6.2%	4.9%	3.9%	4.7%
C: ICCR	3.9%	4.3%	4.3%	3.9%	4.4%	5.0%
D: Secure Serv & Offender Health	6.9%	6.0%	6.2%	5.4%	5.4%	7.4%
E: Specialties	4.8%	4.2%	4.9%	4.6%	6.0%	6.2%
F: Corporate	3.0%	2.8%	3.1%	2.8%	3.1%	3.2%

Commentary

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

August 2023

Question	Answers
A: What has happened?	Sickness absence saw an increase in August to 5.4% from 46% in July 2023. Short term sickness absence increased by 0.7% to 6.62% in August. Long term sickness absence in August at 1.73% is an increase of 0.13% from July. Overall sickness absence rates by division for August are as follows: Acute and Urgent Care –4.66% Corporate 3.17%, ICCR – 4.98%, Specialties – 6.25%, Secure Services and Offender Health – 7.42%
B: Why has it happened?	May 23 Cold, Cough, Flu - Influenza Gastrointestinal problems Anxiety/stress/depression/other psychiatric illnesses Cold,Cough and flu are still the highest reason for sickness however this doesnt correlate with seasonal influenza as we should now be out of this. The second highest reason has changed to gastrointestinal problems with it is not celar why this is the case. Anxiety/stress and depression are now the third highest reason for sickness, still expected with cost of living expenses. The levels of sickness absence alongisde the reasons pertaining to these 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
D: What are we doing about it?	The new Health, Wellbeing and Attendance Policy has now been ratified through Transforming our Culture and Staff Experience Committee. The deadline for completing the toolkit and training package was set for 1st September 2023 however, due to annual leave this is being finalised by later September. Training dates and room bookings are being scoped.

Staff Sickness

August 2023

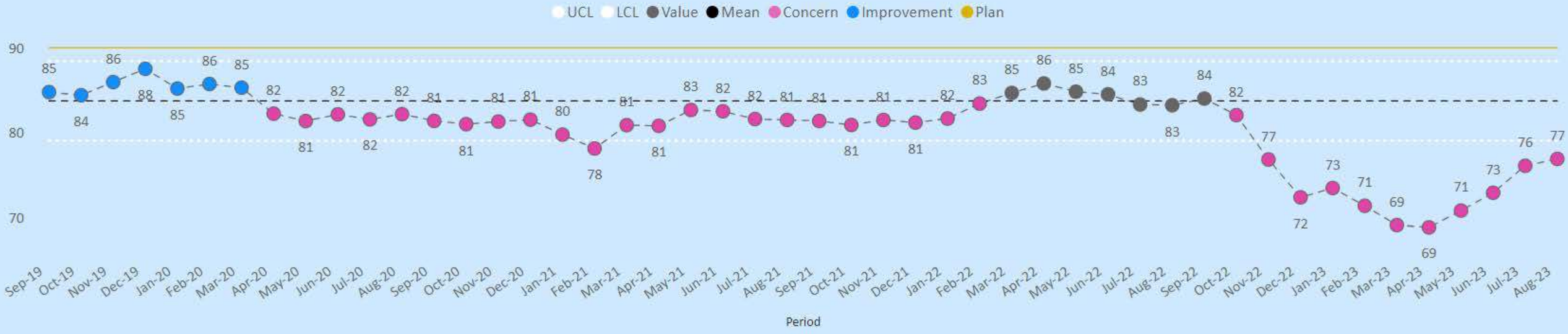
Question	Answers
	training package was set for 1st September 2023 however, due to annual leave this is being finalised by later September. Training dates and room bookings are being scoped. The People Team are starting to monitor HR Clinics. Dates are agreed with service managers and publicised at FPP along with escalating concerns where clinics have not taken place. There are dedicated efforts at investigating long term sickness cases with the emphasis of holding regular (monthly) meetings with individuals off on long term sick in order to support them with various options with a view to being the absence to a close. The People Team are working on updating and maintaining Sickness Recovery Action Plans that will be monitored by the People Partners. The People Partners are working closely with Operational Managers and OD colleagues to embed a culture of wellbeing and ensuring that wellbeing offers are widely known to people with aims to support improved health for people whilst at work. Work is being explored of communicating wellbeing offers effectively to raise awareness and improve access for people in the Trust. 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. The following is the regular activity that the People Team undertake: - Promote Stress Risk Assessments - Review long-term sickness cases that reach 16 weeks - Provide coaching on absence management where needed - Support managers to assess the requirements for a Final Review Meeting - Redeployment activity as recommended by Occupational Health and where it is in the best interest of the person - Ill-health retirements applications and making these supportive and compassionate - Promote ESR user guides for accurate recordings - Review sickness cases with management during HR Clinics on a team by team basis
E: What do we expect to happen?	Sickness absence rates will move closer to the Trust's target percentage as the People Team continue to provide focus on supporting management in the wellbeing of staff. 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	69.0%	68.8%	70.7%	72.9%	76.0%	76.9%
B: Acute and Urgent Care	54.8%	53.9%	55.6%	56.8%	63.2%	66.2%
C: ICCR	74.6%	73.8%	74.8%	80.3%	82.9%	84.4%
D: Secure Serv & Offender Health	75.3%	75.1%	79.0%	80.5%	83.0%	82.0%
E: Specialties	72.6%	75.4%	77.9%	78.1%	79.2%	78.5%
F: Corporate	64.5%	61.6%	61.1%	63.4%	67.4%	69.9%

Commentary

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Detailed Commentary

Staff Appraisals

August 2023

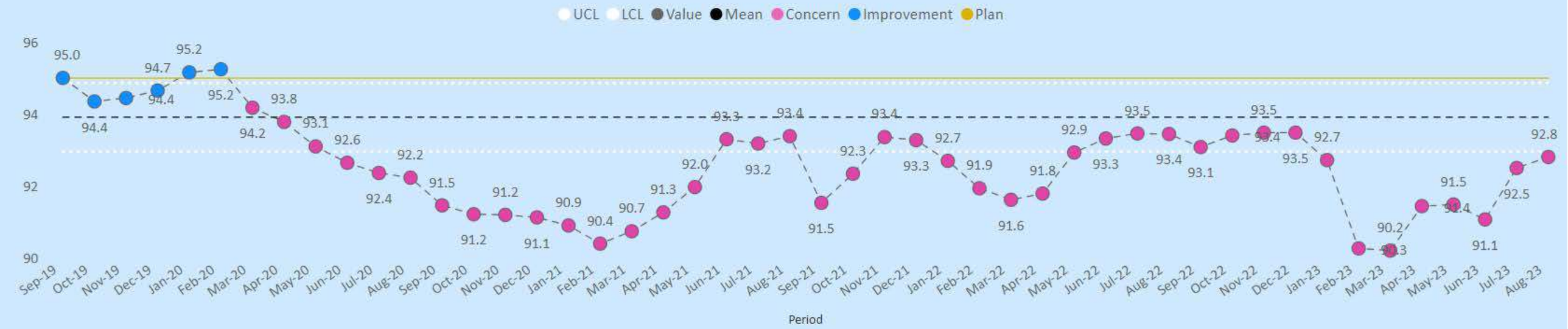
Question	Answers
A: What has happened?	The trust's Appraisal compliance for August is 76.8% which is a 0.8% increase from July which continues to demonstrate that the Appraisal Recovery Plan is steadily improving Trust compliance overall. The teams within the Trust that are below the compliance trajectory of 75% are: Acute and Urgent Care services at 65.15% (improved position from July), Exec Dir-Nursing at 66.9% (improved position from July), New Care Models at 45.8% (decreased position from July) and Exec Dir-Resources at 70.5% (improved position from July). All directorates apart from New Care Models continue to show a steady increase from July. However, the trust remains below the Trust target of 90% and commissioner's target of 85%
B: Why has it happened?	The increase in appraisal compliance can be identified from increased communications and drop-in sessions by the L&D team to support staff.
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?	The recovery plan work continues with analysis of appraisal data completed on a weekly basis and any actions to support 'hot spot' areas are identified. Themes are discussed within the fortnightly appraisal working group to prioritise immediate actions. Business as usual activities continue for instance drop-in sessions and Appraisal training, advertised with the support of the Comms team. AD's have been given access to appraisal reports and offered support in identifying areas with low compliance. The L&D team are working with the Informatics team to understand some of the disparities between the appraisal exclusions and the exclusions applied by Workforce for their KPI dashboard. L&D continue to work with the ESR team to resolve access issues to SMART cards. We have contacted the QI team to discuss/commence the appraisal review process.
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 are beginning to see some recovery in Q1 (May) 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

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	90.2%	91.4%	91.5%	91.1%	92.5%	92.8%
B: Acute and Urgent Care	89.4%	89.4%	89.9%	89.3%	91.4%	92.3%
C: ICCR	91.4%	91.9%	91.2%	90.9%	92.4%	93.1%
D: Secure Serv & Offender Health	91.8%	92.0%	92.9%	92.2%	93.5%	93.6%
E: Specialties	91.5%	92.7%	92.4%	91.2%	92.7%	93.4%
F: Corporate	93.8%	91.1%	90.5%	91.7%	92.1%	90.9%

Commentary

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Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

August 2023

Question	Answers
A: What has happened?	Substantive staff (Trust Target 95%, Commissioners Target 90%)) The Trust's overall compliance with Fundamental Training increased slightly from 92.4% in July 2023 to 92.6%. TSS workers' overall compliance is 89.4%, which is a little down from the 90.6% it was last month. However the Trust has reached the Commissioners' target. FT breakdown by division: • Chief Executive Locality – 89.9%, • Exec Director - Medical Locality – 91.6%, • Exec Director - Nursing Locality – 91.2%, • Exec Director – Operations o Acute and Urgent Care –92.4%, o ICCR – 93.1%, o Secure Services and Offender Health – 93.7% o Specialties – 93.4% • Exec Director - Resources Locality – 97%, • Exec Director - Strategy People and Partnerships Locality – 82.8%, TSS Bank Workers (Trust Target 75%) Bank FT compliance has decreased from 90.6% to 89.4% at the end of August 2023
B: Why has it happened?	Substantive staff FT compliance: The decrease in compliance results from Infection Control Level 2 for clinical staff switching from a three-yearly compliance to a yearly compliance in accordance with the nationally recognised Core Skills Training Framework. The alignment for ILS and ELS has gone live and therefore we expect to see a decrease in compliance next month due to more staff requiring ILS. The Fundamental Training Team keeps reminding staff members to complete their training.
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.

Fundamental Training

August 2023

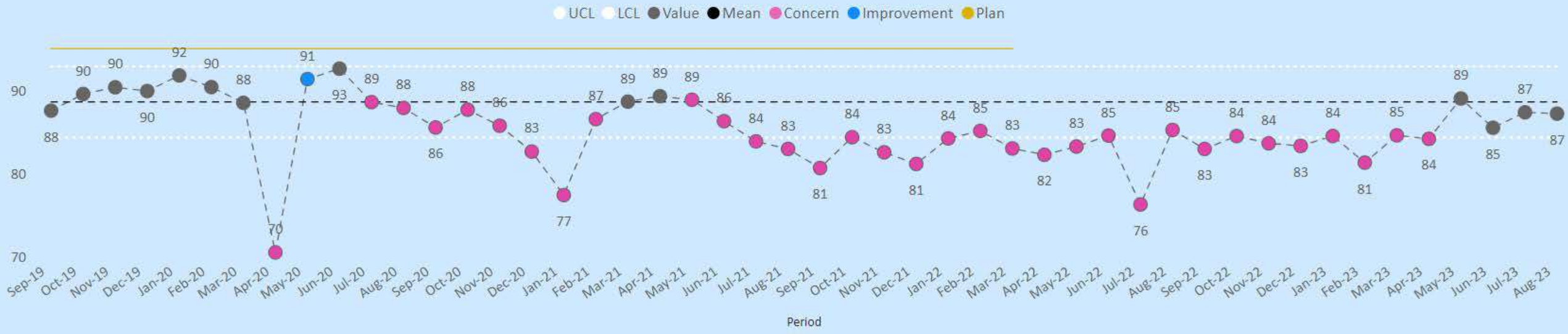
Question	Answers
	o ICCR – 93.1%, o Secure Services and Offender Health – 93.7% o Specialties – 93.4% • Exec Director - Resources Locality – 97%, • Exec Director - Strategy People and Partnerships Locality – 82.8%, TSS Bank Workers (Trust Target 75%) Bank FT compliance has decreased from 90.6% to 89.4% at the end of August 2023
B: Why has it happened?	Substantive staff FT compliance: The decrease in compliance results from Infection Control Level 2 for clinical staff switching from a three-yearly compliance to a yearly compliance in accordance with the nationally recognised Core Skills Training Framework. The alignment for ILS and ELS has gone live and therefore we expect to see a decrease in compliance next month due to more staff requiring ILS. The Fundamental Training Team keeps reminding staff members to complete their training.
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.
D: What are we doing about it?	The alignment for ILS and ELS has gone live and therefore more individuals have been mapped to both ILS and ELS. The Fundamental Training Team keeps reminding staff members to complete their training. We send DNA emails to both staff members and managers, and we send out additional reminders for upcoming training. The external Averts training courses (DMI courses), which have been fully attended by TSS staff members, are assisting in easing the burden.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	84.6%	84.1%	89.0%	85.5%	87.3%	87.2%
B: Acute and Urgent Care	81.3%	81.0%	87.7%	84.0%	87.4%	87.6%
C: ICCR	93.1%	90.6%	94.9%	91.1%	92.9%	91.4%
D: Secure Serv & Offender Health	78.5%	76.3%	81.7%	76.5%	78.3%	79.2%
E: Specialties	85.8%	90.0%	92.4%	90.7%	92.4%	93.5%
F: Corporate	99.5%	98.7%	98.9%	98.0%	98.0%	96.0%

Commentary

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Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

August 2023

Question	Answers
A: What has happened?	The bank and agency fill rate sustained at to 87.22% in August from 87.38% in July. The bank fill rate remained relatively stable, as did the agency fill rate. The fill rate breakdown by division is as follows: Acute and Urgent Care –87%, ICCR – 91.4%, Specialties – 93.4%, Secure Services and Offender Health – 79.19% The number of shifts requested in August increased by 476 compared to July.
B: Why has it happened?	19,901 temporary staffing shifts were requested in August. This is an increase of 476 from 19,425 in July. 16,279 shifts were filled in May (14,685 of these were bank). Fill rate has been stable. The main reasons for requested shifts in June were: Clinical Activity (6,659 shifts requested); Additional Work (3,734 shifts requested); Vacancies (2,992 shifts requested); Block booking (2,048 shifts requested) and sickness (744 shifts requested) . There has been an increase in shifts requested for COVID-19 (101 in May to 85 in June).
C: What are the implications and consequences?	Low fill rates resulting in unfilled shifts has an implication on safer staffing levels and the Trust's ability to deliver high quality patient care. Having less staff also has an impact on workload and staff health and wellbeing. BAF Risk: Fails to look holistically at flexible and transformative workforce models used across all services, resulting in inefficiencies
D: What are we doing about it?	Bank overall Fundamental Training continues to be an area of focus and be above 90% compliant consistently - with the view that providing a trained and competent workforce increases the likelihood of increased fill rates (and less reliance on agency), but more importantly, also increases the likelihood that our service users have a good experience with the trust. A detailed agency reduction options appraisal has been submitted to senior management in order for its proposals to be incorporated in conjunction with impending ICB policies and restrictions. Two areas of renewed focus are the expediating of the TSS bank worker to substantive process and the reduced reliance on block bookings. Other proposals include

Detailed Commentary

Bank & Agency Fill Rate

August 2023

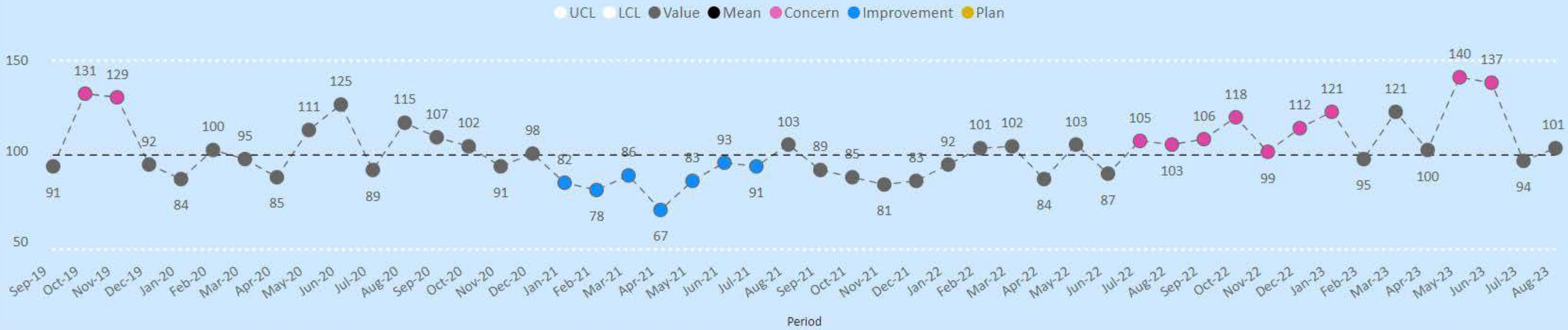
Question	Answers
C: What are the implications and consequences?	Low fill rates resulting in unfilled shifts has an implication on safer staffing levels and the Trust's ability to deliver high quality patient care. Having less staff also has an impact on workload and staff health and wellbeing. BAF Risk: Fails to look holistically at flexible and transformative workforce models used across all services, resulting in inefficiencies
D: What are we doing about it?	Bank overall Fundamental Training continues to be an area of focus and be above 90% compliant consistently - with the view that providing a trained and competent workforce increases the likelihood of increased fill rates (and less reliance on agency), but more importantly, also increases the likelihood that our service users have a good experience with the trust. A detailed agency reduction options appraisal has been submitted to senior management in order for its proposals to be incorporated in conjunction with impending ICB policies and restrictions. Two areas of renewed focus are the expediating of the TSS bank worker to substantive process and the reduced reliance on block bookings. Other proposals include Finance, HR and AD sign-off being required for all future agency block bookings (currently 80% of all expenditure via TSS is block bookings). Meetings are also being arranged with NHSProfessionals as a source of providing temporary staff as a (cheaper) alternative to agency utilisation. TSS's Clinical and Pastoral wing will be visiting universities and colleges to promote BSMHFT as an employer of choice via the bank. Substantial work is being undertaken to ensure adequate availability of induction and averts placements for bank workers – working in conjunction with the trust's L&D department. Joint Projects between TSS and the Trust's Workforce Management Team / Bank staff Healthroster Management Team are being implemented in order to assist TSS Booking Co-ordinators and bank staff with increasing the number of shifts filled. TSS leadership's team held a recent meeting to look at longer term strategic projects and improvements for the TSS function in terms of processes, health and wellbeing, training, and support for TSS workers. In August 41 bank workers started with the trust.
E: What do we expect to happen?	With the work ongoing to reduce agency spend we expect agency fill rates to decrease and bank fill rates to increase. However it should be noted that with the winter season nearly here and a predicted rise in the number of requested shifts may further impact on the Trust's fill rates.
F: How will we know when we have addressed issues?	The overall bank and agency fill rate increases.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff assaults

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	121	100	140	137	94	101
B: Acute and Urgent Care	85	68	88	84	59	70
C: ICCR	5	7	3	2	7	3
D: Secure Serv & Offender Health	19	12	26	13	13	16
E: Specialties	12	13	23	37	15	9

Commentary

(Blank)

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff assaults / 1000 OBD

Divisions

Statistical Process Control (SPC)

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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	6.5	5.5	7.5	7.5	4.9	5.3
B: Acute and Urgent Care	12.4	10.3	13.2	12.9	8.6	10.2
C: ICCR	1.8	2.6	1.1	0.8	2.6	1.1
D: Secure Serv & Offender Health	3.0	1.9	3.9	2.0	1.9	2.4
E: Specialties	4.5	5.2	8.4	13.4	5.3	3.3

Commentary

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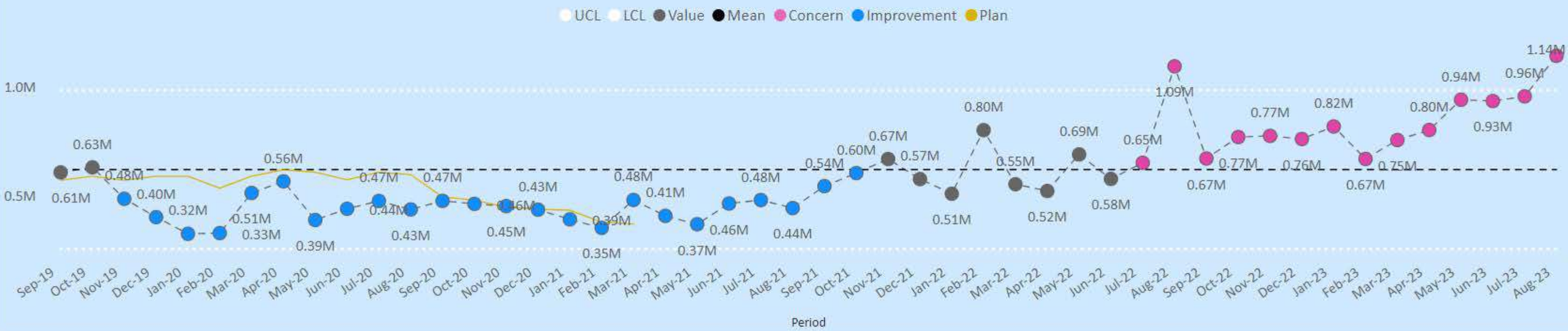
Birmingham and Solihull Mental Health NHS Foundation Trust

Monthly Agency

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	£755k	£801k	£941k	£935k	£956k	£1,143k

Commentary

(Blank)

Detailed Commentary

Monthly Agency

August 2023

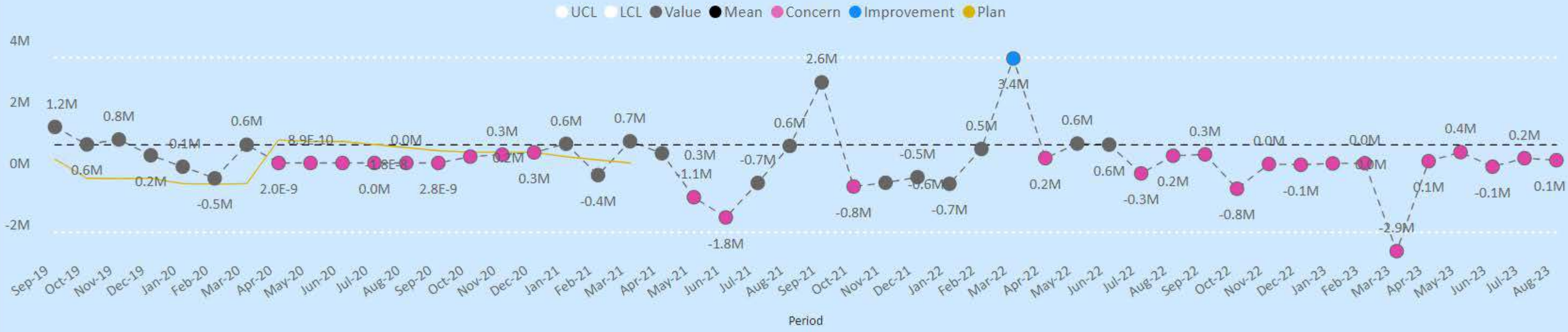
Question	Answers
A: What has happened?	YTD agency expenditure is £3.6m, 4.1% of the year to date pay bill, compared to NHSE ceiling of 3.7% - total breach of £343k
B: Why has it happened?	Level of medical staff expenditure (£2.2m), particularly in ICCR on key staff vacancies
C: What are the implications and consequences?	Breach of agency cap by BSMHFT will lead to increased oversight and controls from NHSE
D: What are we doing about it?	Instituting temporary staffing panel
E: What do we expect to happen?	Reduction in agency spend over time, depends on recruitment to key roles
F: How will we know when we have addressed issues?	When spending is less than 3-7% on a sustainable basis

Birmingham and Solihull Mental Health NHS Foundation Trust

Operating Surplus

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	-£2,873k	£59k	£352k	-£122k	£156k	£90k

Commentary

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Detailed Commentary

Operating Surplus

August 2023

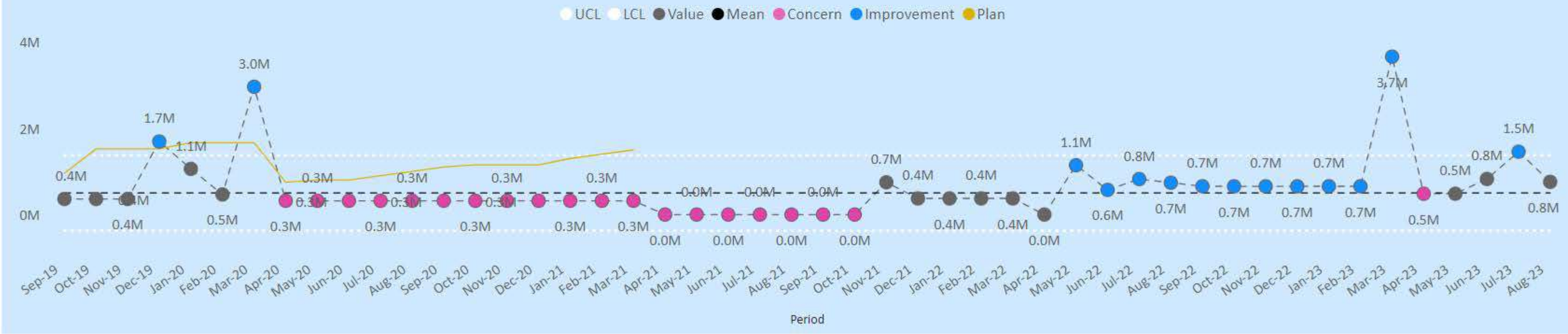
Question	Answers
A: What has happened?	YTD deficit of £444k against plan of breakeven, little changed in month
B: Why has it happened?	Significant pressures in terms of out of area bed usage, temporary staffing and undelivered savings
C: What are the implications and consequences?	Failure to achieve financial plans and concerns with ICS and regulators
D: What are we doing about it?	Driving hard for additional efficiencies for 23/24, out of area steering group - £5m savings target for out of area applied for 2023/24
E: What do we expect to happen?	Considered significant risk of under achievement, need to drive significant transformational change
F: How will we know when we have addressed issues?	When we are delivering in line with requirement and have reliable pipeline of savings

Birmingham and Solihull Mental Health NHS Foundation Trust

CIP

Divisions

Statistical Process Control (SPC)



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

Division	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A: All	£3,662k	£483k	£483k	£825k	£1,457k	£759k

Commentary

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Detailed Commentary

...

CIP

August 2023

Question	Answers
A: What has happened?	YTD efficiencies are £3.3m against £4.9m plan, improved on trend
B: Why has it happened?	Insufficient pipeline of potential savings
C: What are the implications and consequences?	Failure to achieve financial plans and concerns with ICS and regulators
D: What are we doing about it?	Driving hard for additional efficiencies and determining additional controls to manage expenditure
E: What do we expect to happen?	Considered significant risk of under achievement, need to drive significant transformational change
F: How will we know when we have addressed issues?	When we are delivering in line with requirement and have reliable pipeline of savings

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Appendix I - FPPC 20 September 2023

Performance metric trajectory updates

Trust Performance Metrics

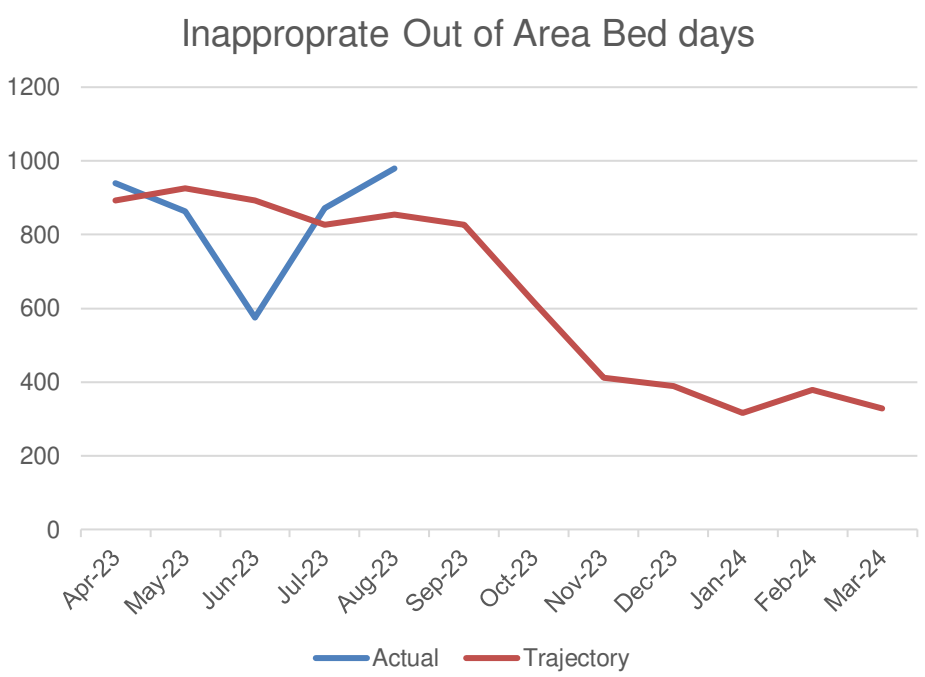
At the February 2023 FPPC meeting, members requested an update on the performance for the following metrics in line with the plans and trajectories already provided:

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 6th June with a focus on providing FPPC feedback from May's meeting to relevant leads. The commentaries below have been updated in line with this.

A monthly update will continue to be provided on progress although as acknowledged there is unlikely to be significant change month on month due to the action plan timelines.

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 bed days in March 2024.

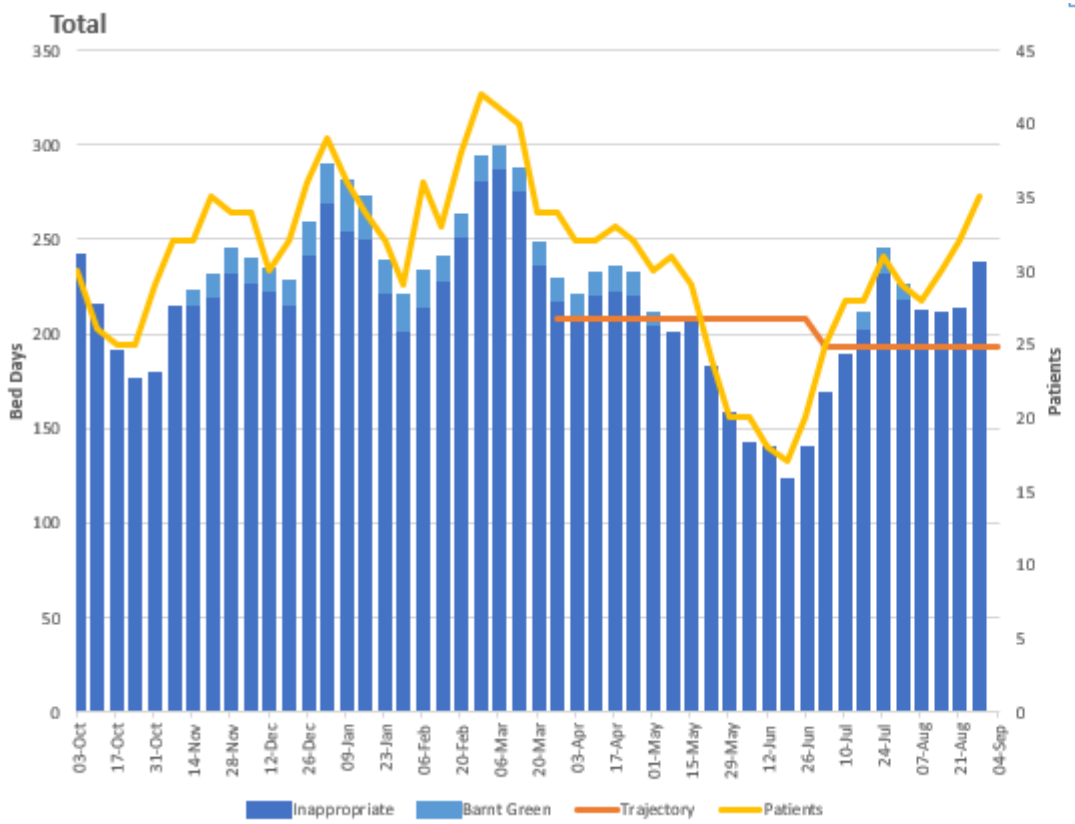
The action plan to transform the acute & urgent care pathway will focus on 4 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 4 workstreams are :

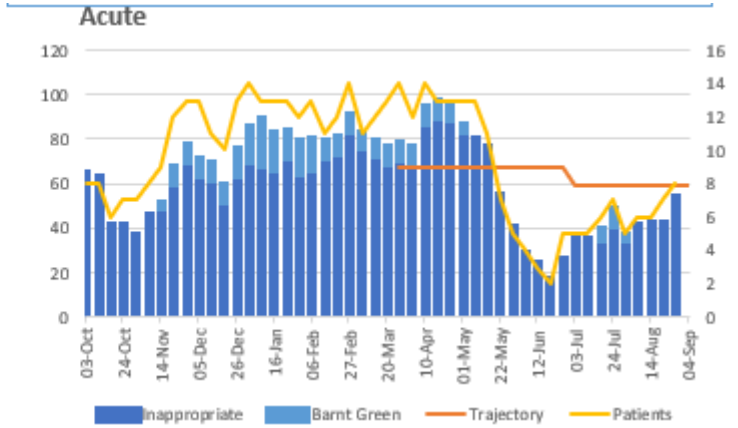
1. Demand Management
2. Reducing Length of Stay/DTOCs
3. Optimise capacity
4. Locality model development

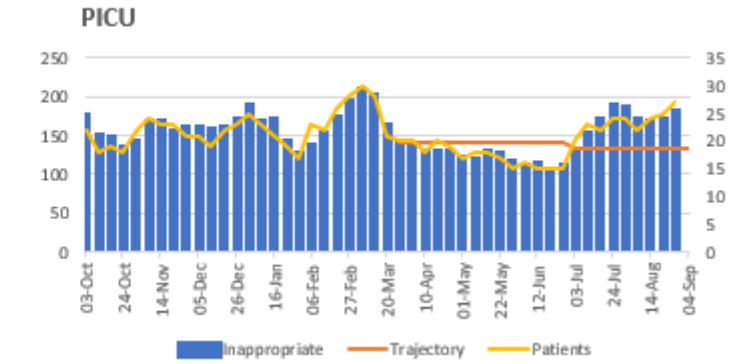
Operational and clinical leads are in the process of being identified to support. Key areas of risk and dependencies have been identified and also expected benefits from each workstream supported by improvement metrics to track progress. Performance is above trajectory due to PICU usage being above trajectory. See slide below for detail on acute and PICU position.

Birmingham and Solihull Mental Health NHS Foundation Trust

BSMHFT - Inappropriate out of area bed usage







- Despite an increase in acute bed usage this week, there is continuing positive performance in acute inappropriate out of area bed usage, acute bed usage is below trajectory
- Barnt Green bed usage (most recently in early May) is still classified as inappropriate pending clarification and shown in light blue on the charts
- St Andrews, Northampton has been classified as an appropriate placement from April 2023

Talking Therapies waiting times 6 &18 weeks

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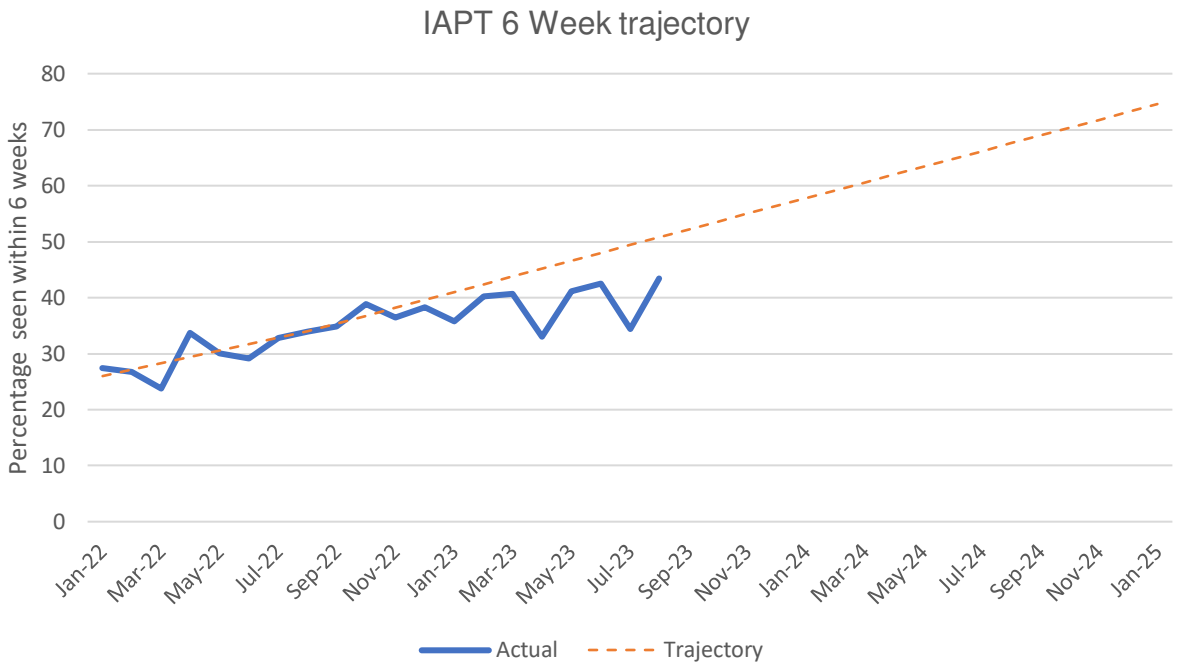
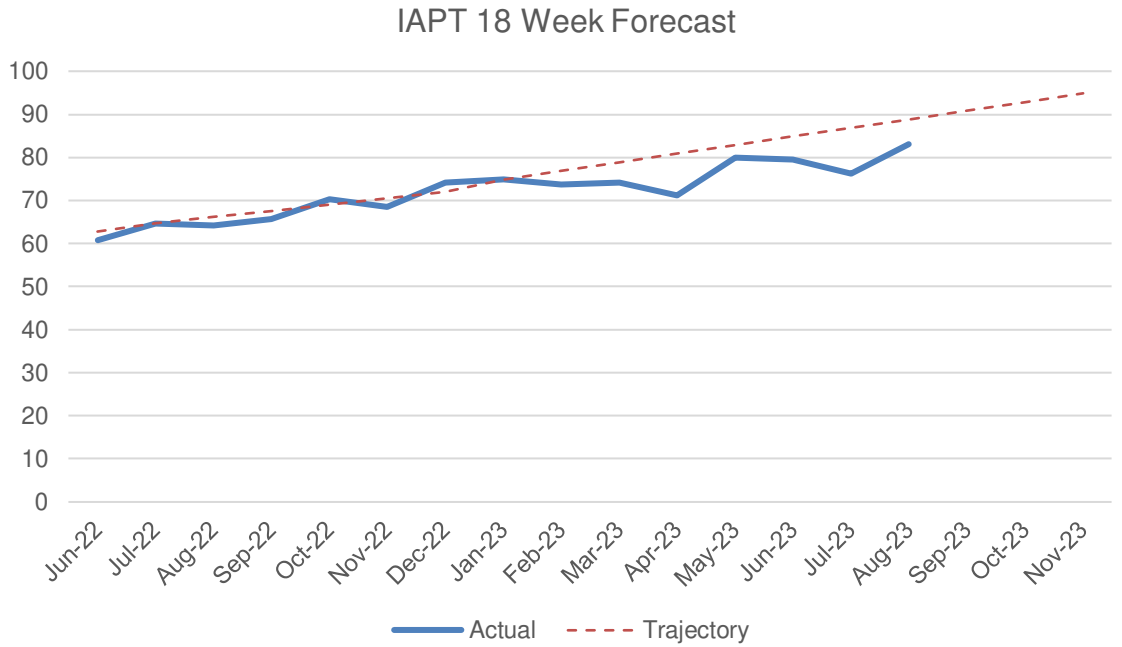




The aim is to reach the 75% target by January 2025.
August 2023 performance at 43.49% which has shown an increase but remains below trajectory.

Trajectory provided by Associate Director for Specialties

The aim is to reach the 95% target by November 2023.
August 2023 Performance at 83.17% below trajectory.

compassionate inclusive committed

Talking Therapies – updated action agreed in July 2023

Following discussions with the NHS Talking Therapies (TT) lead for Commissioning, BHM as a service will now start recording all appointments that meet the criteria for the inclusion of a treatment element as ‘assessment and treatment’, previously recorded as ‘assessment only’.

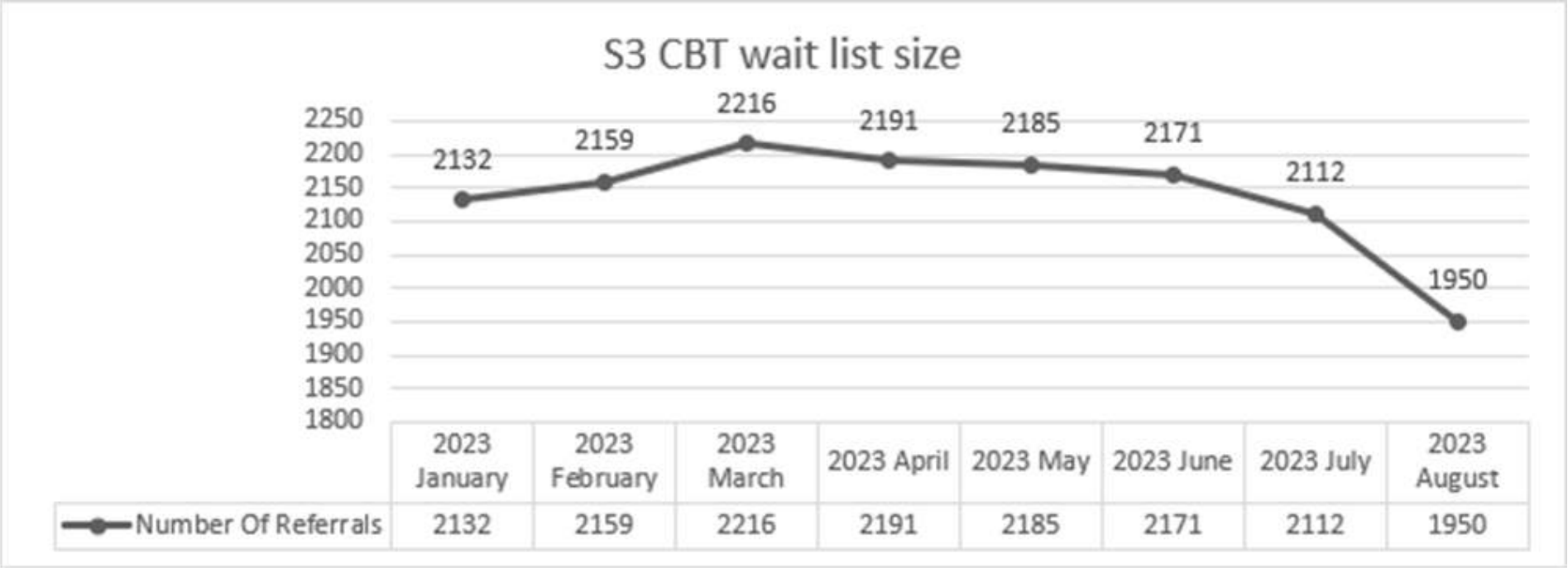
The advice confirms that this will bring BHM recording in line with other BSoL TT Services and will be consistent with national reporting. The change has been backdated to the start of June 2023 and this is reflected in our internal and external reporting.

The impact of this change has been:

- Improved waiting times, bringing them closer to national targets
- It is predicted that the waiting time target between first and second treatment appointments will increase above the 10% threshold for over 90 day waits, but this has not happened yet, with the wait times for both July and August remaining under 10% at 7.9% and 6.1% respectively
- The ‘moving to recovery’ rate has been affected with August falling to 42%.

BHM are also instigating a number of initiatives to reduce the waits for High Intensity CBT and are in the process of registering this as a QI project. The step3 CBT waiting list has reduced in August 23.

Step3 CBT Waiting List Size



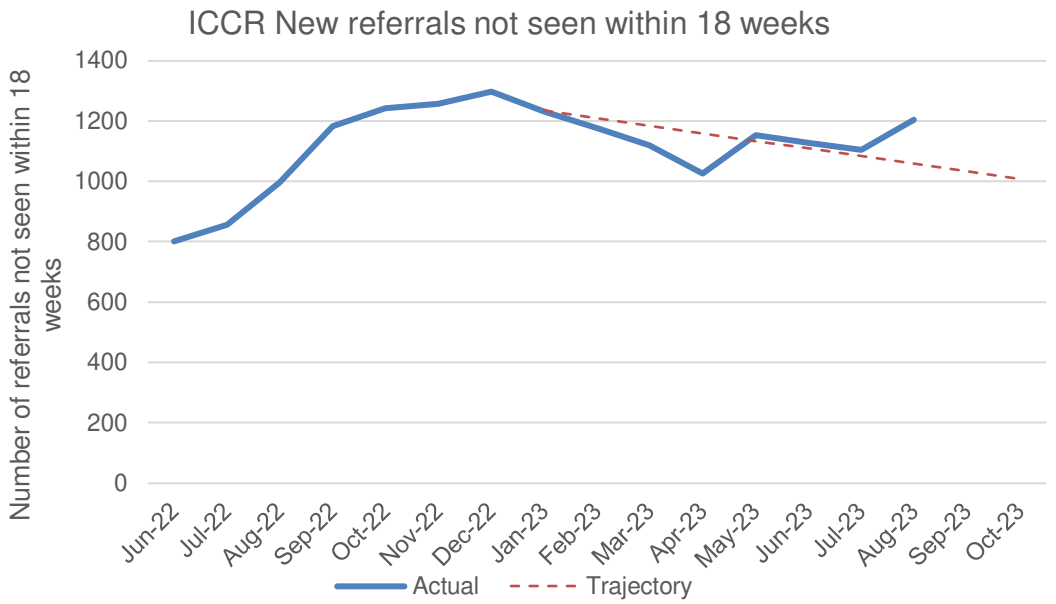
	2023 January	2023 February	2023 March	2023 April	2023 May	2023 June	2023 July	2023 August
Number Of Referrals	2132	2159	2216	2191	2185	2171	2112	1950

Talking Therapies – action plan summary

- The service's action plan is heavily reliant on recruitment of new staff across a range of Bands and skill mix to enable the activity required to be carried out and to then enable reduce waiting times.
- This plan will see 7 high intensity trainees commence training October 2023. There are 8 x newly qualified PWP trainee who will take up substantive post in period September –November 2023. 8 x PWP trainee starting on 18/09/2023 and 4 apprentice PWP starting on 9/10/2023.
- Recruiting time frames and embedding staff into their new roles will take time and the impact therefore will not be immediate but will support progress in the medium term.
- 2 new post has been created in the service. The step 2 lead who commenced post, August 2023 will be instrumental in providing valuable oversight of step 2 interventions and the aligning pathway as well as promoting community engagement and networking with our Neighbourhood Mental Health Teams. The clinical development lead is also in post and will support the team to screen referrals and identify barriers to recovery planning and to develop existing relationships with neighbourhood mental health teams to enable further support. The role also has a focus on access and waiting list targets
- Additional capacity (150) for CBT treatment has been referred through to Xyla digital psychological services.
- A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff.

New Referrals not seen within 3 months

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. August 2023 at 1203 above the trajectory of 1058.



Note: This is different to the metric data for new referrals not seen within 3 months.

Actions: ICCR CMHTs are reviewing long waiters and ensuring they have been offered an appointment, either within the CMHT or in the neighbourhood teams if this is appropriate. A large number of those waiting have already been offered appointment dates which they have DNA'd, often multiple times. These are being discussed within the MDT to see whether it is appropriate to offer a further appointment, if they do not reply to a request to contact the CMHT. This process will take time to work through. The DNA rate for first appointments remains high and administrative staff are ringing patients to remind them of the appointment and in some cases also sending text reminders. Saturday clinics are also being utilised to increase the number of appointment slots available. A number of people waiting are transfers between internal teams and a 3-month target has been set to achieve the transfer.

Note - ICCR Trajectory provided by Associate Director for ICCR.

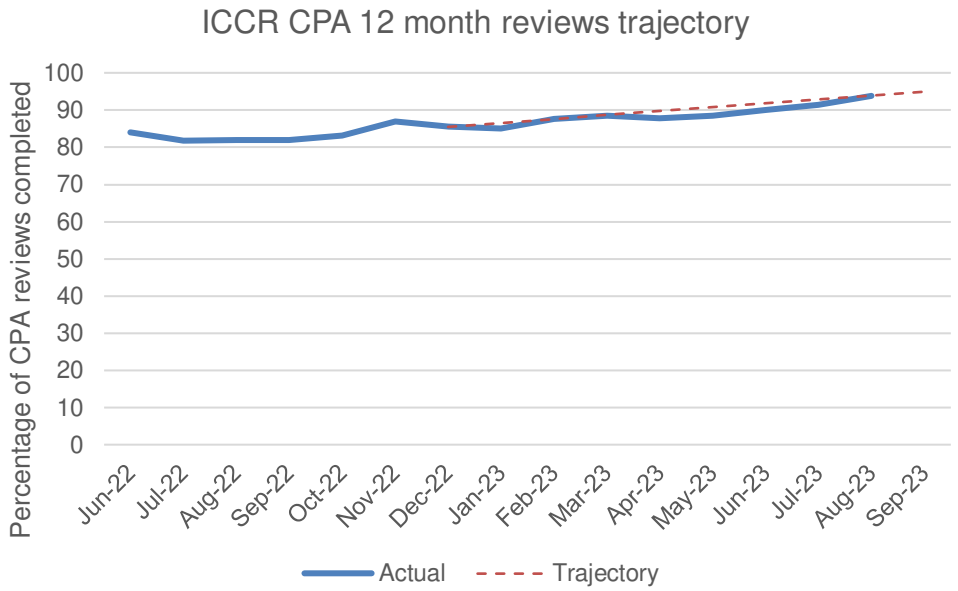
New Referrals not seen within 3 months

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.

Update - The service continues to face significant staffing challenges, particularly in Solihull and North Hubs. Recruitment, new posts and retention options continue to be taken forward without the success required impacting on ability to manage the increase in number of referrals, high caseloads and increased waiting times. All teams have current waiting lists with service users being prioritised by need and level of risk. New assessments with medical staff within CMHTs are currently waiting between 4-7 months.
Solihull CMHT has four band 6 vacancies and agency staff have recently commenced and are in the process of reviewing and managing the caseloads.
Different strategies are being tried to increase and diversify the workforce e.g. four trainee nurse associate posts and 2 advanced nurse practitioner posts being created which are currently being advertised for in addition to the other vacancies within the service.

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

CPA 12-month reviews - ICCR



ICCR performance for August at 93.8%

ICCR CMHTs – Improvement trajectory to achieve 95% by the end of September 2023.

The CMHTs have been reviewing the outstanding CPA reviews to see if they still require to be on CPA or can be stepped down to care support. In addition, as part of the transformation work caseloads are being reviewed to ensure that service users still require the service and are on the correct level of care.

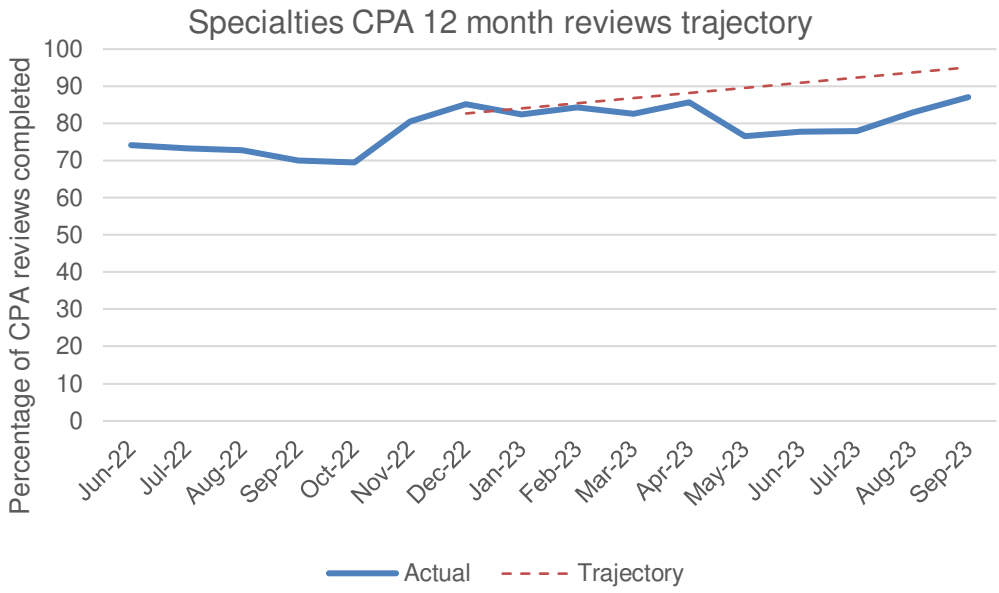
The CMHT in Solihull is experiencing significant staffing challenges and currently has only 1 CPN and staffing will not improve until September so outstanding reviews will be a challenge in the medium term.

Note - Trajectory position provided by Associate Directors for ICCR

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 12 month reviews - Specialties

Specialties performance for August at 87%
Older adults CMHTs – Improvement trajectory to achieve 95% by the end of September 2023 unlikely to be achieved due to the significant staffing challenges described earlier, Solihull Hub having four band 6 vacancies and medic vacancies. Agency staff have commenced and in the process of managing caseloads. Team managers have been asked to review outstanding CPA reviews as part of risk management in caseload supervision to ensure that the service user is on the correct level of care. Demand and capacity issues remain challenging. A revised trajectory will be provided next month.



Note - Trajectory position provided by Associate Director for Specialties

7 Day follow up post discharge

Maintaining a 95% standard on this qualitative metric is impacted on by 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.

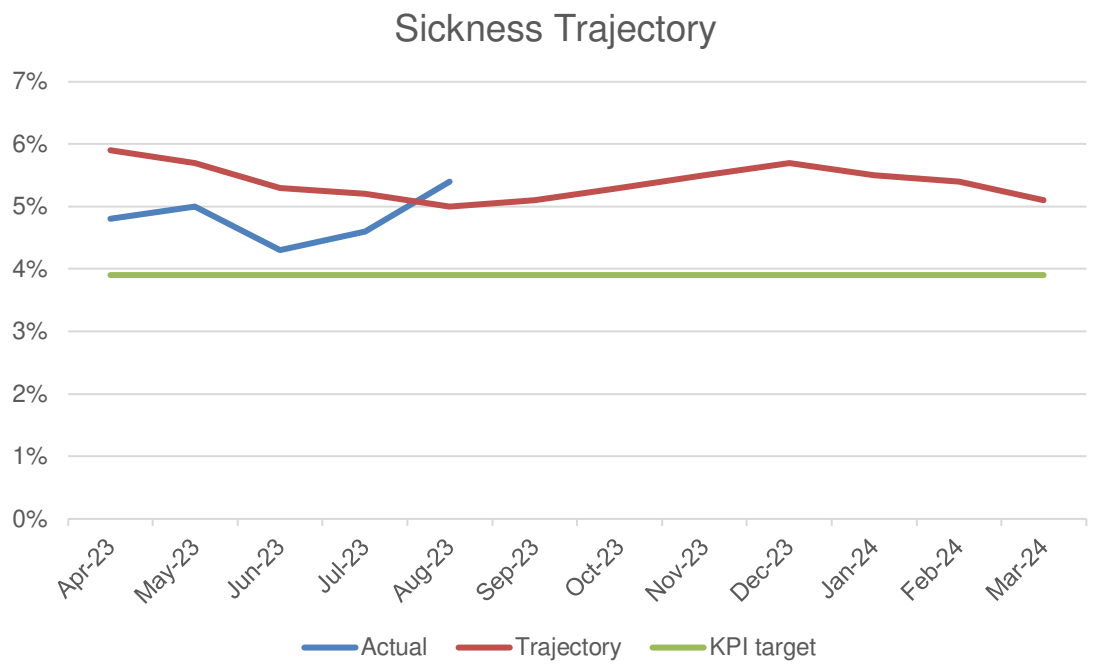
Performance for August 2023 at 90.77% - 1 of 12 service users were discharged to other trusts (including FTB) and 4 follow ups have been completed but awaiting data entry, once confirmed this will take the compliance level up to 93.9%.

Note – Commentary above provided by the AD for Performance & Information

Workforce trajectories

The workforce trajectories commenced in April 2023

Sickness Absence



Note - Trajectory provided by People team

Sickness for August increased to 5.4% above trajectory of 5.2%. In August there was a small increase in short-term sickness to 1.65% and long term sickness at 2.90%.

- The new Health, Wellbeing and Attendance Policy has now been ratified through Transforming our Culture and Staff Experience Committee. The deadline for completing the toolkit and training package was set for 1st September 2023 however, due to annual leave this is being finalised by later September. Training dates and room bookings are being scoped.
- The People Team are starting to monitor HR Clinics. Dates are agreed with service managers and publicised at local FPP along with escalating concerns where clinics have not taken place.
- There are dedicated efforts at investigating long term sickness cases with the emphasis of holding regular (monthly) meetings with individuals off on long term sick in order to support them with various options with a view to bringing the absence to a close.

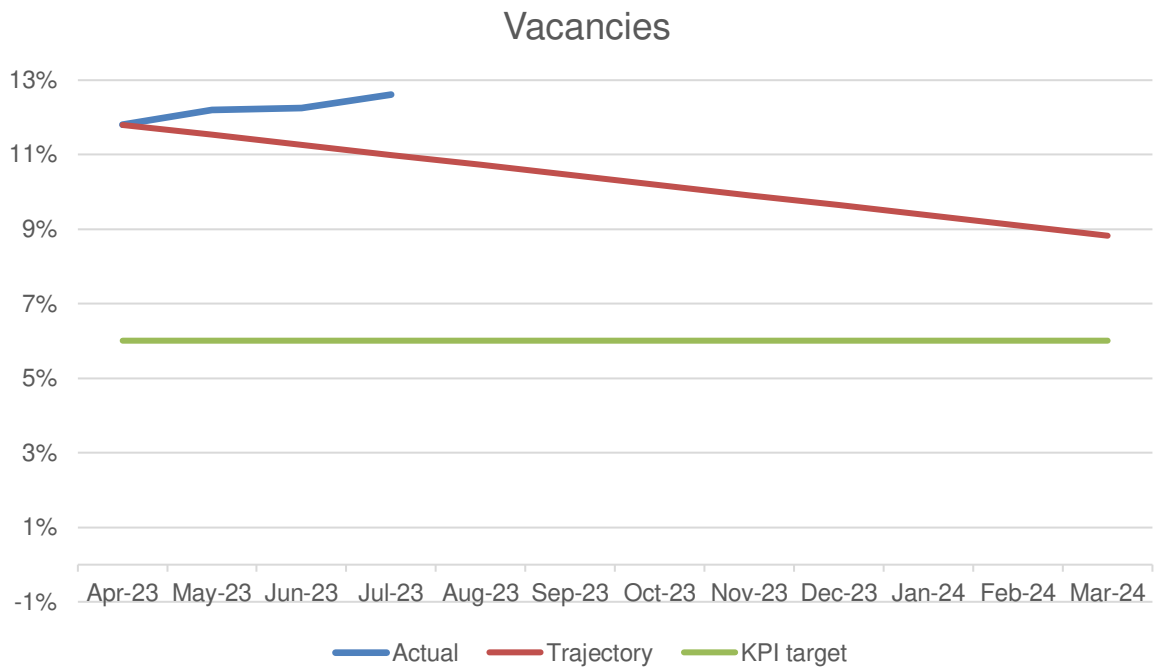
Sickness absence

- The People Team are working on updating and maintaining Sickness Recovery Action Plans that will be monitored by the People Partners.
- The People Partners are working closely with Operational Managers and OD colleagues to embed a culture of wellbeing and ensuring that wellbeing offers are widely known to people with aims to support improved health for people whilst at work. Work is being explored to support communicating wellbeing offers effectively to raise awareness and improve access for people in the Trust.
- Continuous audit of Directorate sickness. Data to be presented in local 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 CSM/Team Leaders in clinics.

The following is the regular activity that the People Team undertake:

- Promote Stress Risk Assessments
- Review long-term sickness cases that reach 16 weeks
- Provide coaching on absence management where needed
- Support managers to assess the requirements for a Final Review Meeting
- Redeployment activity as recommended by Occupational Health and where it is in the best interest of the person
- Ill-health retirements applications and making these supportive and compassionate
- Promote ESR user guides for accurate recordings
- Review sickness cases with management during HR Clinics on a team-by-team basis

Vacancies



The HR lead has confirmed that the agreed target for 2023/24 is a 3% reduction in vacancies over the year, with a trajectory starting at 11.8% and moving to 8.8% by March 2024. The KPI target is 6%.

August 2023 data is not yet available.

A weekly vacancy control panel has been implemented, which is prominently to ensure cost reduction and control measures are in place trust wide. A by-product of these discussions however is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place.

Note - Trajectory provided by People team

Vacancies

Whilst smaller and bespoke recruitment fairs within BSMHFT's differing directorates did provide (varying levels of) success over the last year, the first of quarterly / half-yearly (T.B.C.) trust wide BSMHFT recruitment fairs is being planned for October, with another one around Easter 2024. This will incorporate every discipline and area of the trust inside a conference hall due to large numbers being involved, with a view to maximising the potential of success via strategic advertising and the fact that representatives and management for Nursing, AHP's, ACS's Admin and medical will all be involved

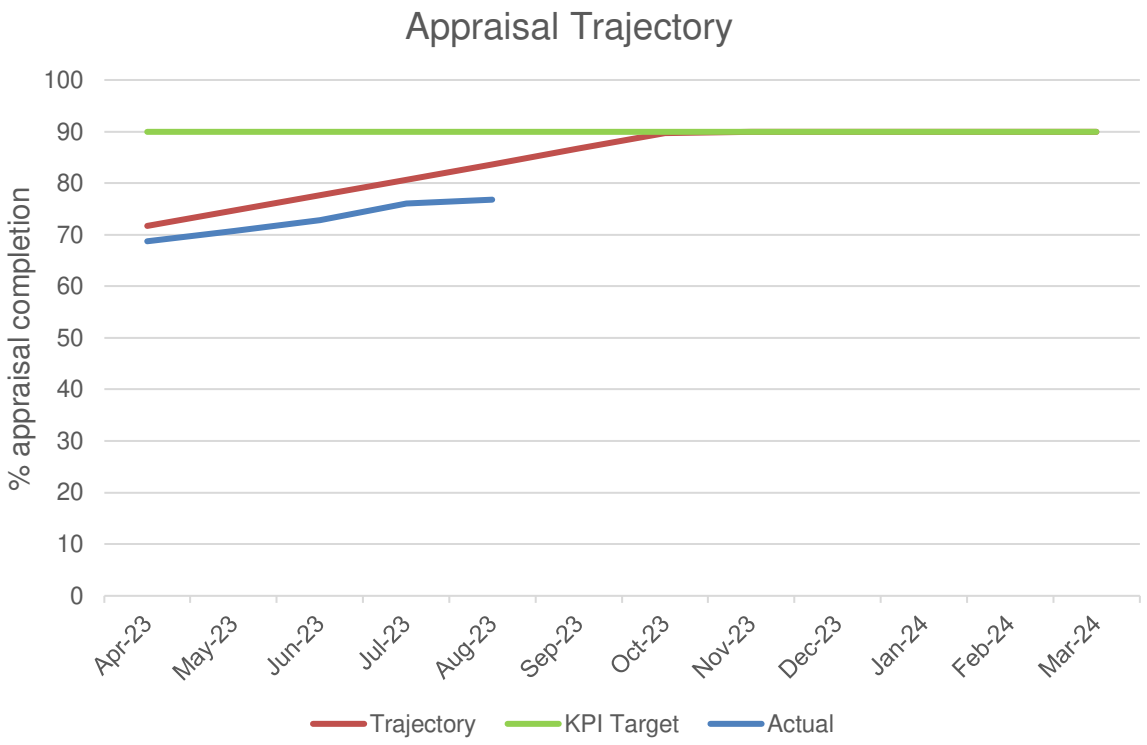
The trust is hosting stands at job fairs at University of Nottingham Nursing, Midwifery and Physiotherapy Careers Fair 2023 at the start of November.
(Awaiting approval for funding) The 5th Student Mental Health Nurse Conference at The Cutlers' Hall, Sheffield at the start of November. There is an expected audience of 250/300 Mental Health Student Nurses from across the UK.

Student & NRN Virtual Job's Careers Fair on 18 October. The event will be promoted to over 39,000 nursing students and thousands more newly registered nurse members of the Royal College of Nursing.

Vacancies

- Currently within the recruitment process - particularly for the autumn onboarding - on top of the usual enrolees, the trust also has 70 bank students and 33 Clinical Psychologists Trainees. Funding has been agreed for 60 international nurses, whilst 43 are active in the system.
- Substantial work is being undertaken to ensure adequate availability of induction and averts placements – working in conjunction with the trust's L&D department.
- A second department wide Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.
- The recruitment department will continue to work in conjunction with the workforce transformation project leads to facilitate long and short-term planning bearing fruition.
- The recruitment department, in conjunction with the trusts workforce transformation processes is working to understand and improve on the levels of vacancies that are current and advertised, compared to the trust actual vacancy rates.

Appraisals



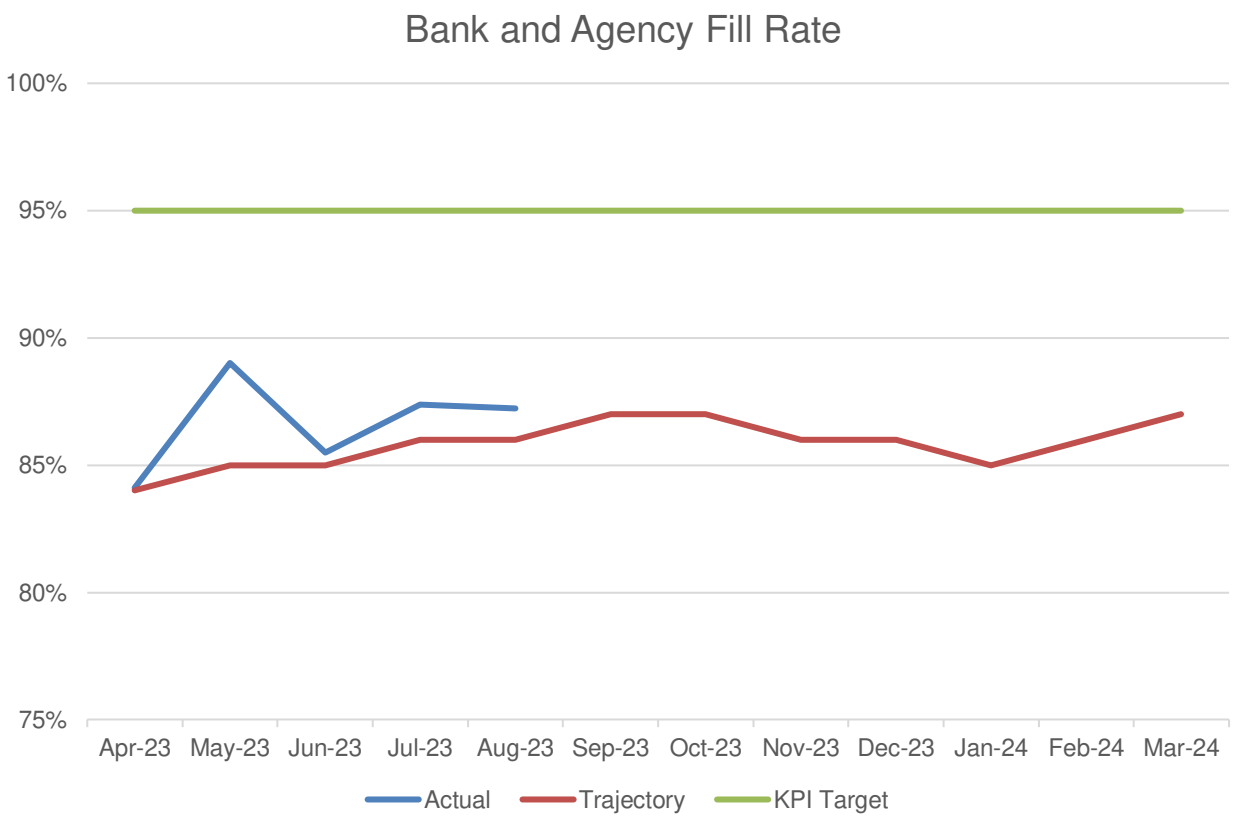
- Appraisals at 76.8% below the trajectory of 83.7% for August 2023.
- The new appraisal system has had a negative impact on performance.
- The recovery plan work continues with further drop-in sessions scheduled and increased communications e.g. Appraisal posters situated across trust sites and up-to-date communications to support staff and availability of training.
- Themes are discussed within the fortnightly appraisal working group to prioritise immediate actions. Business as usual activities continue for instance drop-in sessions and Appraisal training, advertised with the support of the Comms team.

Note - Trajectory provided by People team

Appraisals

- AD's have been given access to appraisal reports and offered support in identifying areas with low compliance.
- The L&D team are working with the Informatics team to understand some of the disparities between the appraisal exclusions and the exclusions applied by Workforce for their KPI dashboard.
- L&D continue to work with the ESR team to resolve access issues to SMART cards.
- We have contacted the QI team to discuss/commence the appraisal review process.

Bank and Agency fill rate



Note - Trajectory provided by People team

Bank and agency fill rate has increased to 87.22% above the trajectory of 86% for August 2023.

Actions include improving Bank Fundamental Training compliance to above 90% - with the view that providing a trained and competent workforce increases the likelihood of increased fill rates (and less reliance on agency), but more importantly, also increases the likelihood that our service users have a good experience with the trust.

A detailed agency reduction options appraisal has been submitted to senior management in order for its proposals to be incorporated in conjunction with impending ICB policies and restrictions.

Two areas of renewed focus are the expediating of the TSS bank worker to substantive process and the reduced reliance on block bookings.

Bank and Agency fill rate

Other proposals include Finance, HR and AD sign-off being required for all future agency block bookings (currently 80% of all expenditure via TSS is block bookings). Meetings are also being arranged with NHSProfessionals as a source of providing temporary staff as a (cheaper) alternative to agency utilisation.

TSS's Clinical and Pastoral wing will be visiting universities and colleges to promote BSMHFT as an employer of choice via the bank.

Substantial work is being undertaken to ensure adequate availability of induction and averts placements for bank workers to aid and increase fill rates – working in conjunction with the trust's L&D department.

Joint Projects between TSS and the Trust's Workforce Management Team / Bank staff Healthroster Management Team are being implemented in order to assist TSS Booking Co-ordinators and bank staff with increasing the number of shifts filled. TSS leadership's team held a recent meeting to look at longer term strategic projects and improvements for the TSS function in terms of processes, health and wellbeing, training, and support for TSS workers.

In August 41 bank workers started with the trust.

Note - Trajectory provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- There has been an increase in agency spend from c. £956K in July to c. £1143K in August. In August 41 bank workers started with the trust, alleviating the need for agency staff.
- A detailed agency reduction options appraisal has been submitted to senior management in order for its proposals to be incorporated in conjunction with impending ICB policies and restrictions (An Agency Staff Diagnostic Toolkit was completed and passed on to B/Sol ICB in January to assist and aid with the reduction of agency spend). Two areas of renewed focus (within TSS's agency reduction proposals) are the expediating and streamlining of the TSS bank and agency worker to substantive process and the reduced reliance on block bookings. Other proposals include Finance, HR and AD sign-off being required for all future agency block bookings (currently 80% of all expenditure via TSS is block bookings). Meetings are also being arranged withNHSProfessionals as a source of providing temporary staff as a (cheaper) alternative to agency utilisation.
- Direct Engagement for Agency workers is being discussed at senior levels of the trust with the aim of meeting potential ICB and NHSE requirements. During 2022 a presentation from 247 Allocate demonstrated how Direct Engagement can have a significant effect on fill rates and also have significant, tangible cost saving implications.
- A temporary staffing panel is being introduced

Appendix II Performance Management framework

Performance Delivery Group meeting on 7th September 2023

The agenda for the meeting focused on the following areas:

i) Feedback from the Trust Board FPPC meeting in August was provided to the Group with a reiteration to update metric commentaries in line with improvement action plans being implemented.

ii) Development of the Trust's Performance Management Framework – with a discussion about Terms of Reference and standardised agenda for the service area deep dives including a discussion on key service area risks. The new process will be trialled for the meetings scheduled over the next couple of months, along with an expectation that all Executive Directors will attend to manage the holistic agenda, although it is recognised that this will take time to establish, however will enable decision making to support services at the meeting in order to prevent delays.

iii) Noted that as part of developing the Performance Management Framework, a review of the metrics is planned although timelines and detail of the plan is yet to be established. It should be noted that the quality domain metrics review is planned to be completed by end September.

iv) The appraisal and supervision recording and reporting were discussed as there were concerns that the process is not fully understood by some operational staff, and this is impacting on reporting completeness levels. In the short term the Interim Associate Director for Nursing and Governance, is meeting services to understand what the issues are and how the reporting is managed with the CQC in order to provide supporting clarification where required. In addition, the Workforce Systems and Process group is being established by the Director of Resources which will look at addressing system barriers being raised.

v) A discussion raised regarding the current status of the Integrated Care Records (ICR) reporting framework which was in place to support and oversee the requirements outlined in the national Care Programme Approach (CPA). Since the national transition away from CPA, the current local Trust guidance for the ICR requires a review and realignment to new ways of working and how service pathways are now operating as part of implementing the transformation agenda across primary, community, rehabilitation and acute and urgent care service areas. This will need to be taken forward via the relevant Trust Lead, but it was agreed that in the interim, the Director of Resources would be a point of contact for any questions to support current discussions.

Service Area Deep Dive Meetings - Update

1. Introduction

The Performance Delivery group has a rolling cycle of deep dives into services to allow time for in depth discussion on key operational issues and challenges. At the request of the Trust Borad FPPC a summary of the deep dives will now be provided on a monthly basis.

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

- Secure and Offender Health Services deep dive on 24th August 2023.
- Specialties deep dive on 7th September 2023.
- ICCR deep dive on 12th September 2023. (A verbal update on this deep dive will be provided at the meeting with the detail to be provided in the report for the October 2923 FPPC meeting).

2. Secure and Offender Health Dep dive – 24th August 2023

Key areas of discussion are outlined below.

- There had been a serious incident at Reaside involving a patient stabbing a staff member on the cheek. Following a review, the Associate Director for the Service area reported that there had been a serious procedural lapse identified. However, this risk was exacerbated due to the majority of staff team being new, from new staff on front line to managers and senior leadership team. Other issues included lack of experience within the new staff cohort and potential impact of reducing restrictive practises. Immediate actions taken to reduce ongoing risks including checks via surveillance monitoring.
  The Medical Director and the Service Clinical Director are also supporting discussions to manage consultant vacancies and support requirements in the service.

  Service Clinical Leads are also reviewing practises between Reaside and Tamarind to reduce variation and support sharing of good practise.

- HR KPIs – improvements noted in appraisal rates reaching 85%, reduced sickness absence levels and improved rates of clinical supervision.
  However, use of bank staff remains high due to vacancies. Actions being taken forward have been impacted by availability of support from the ESR and HR People Team due to pressures and capacity within these teams. The Executive Director of Operations has followed up discussions with the Head of People and expecting to see an improvement in support to manage HR requirements including support to address grievances and mediation needs in a timelier manner. The Executive Director of Finance confirmed that a Workforce Systems & Processes Group is planned to be established to deal with Trust workforce systems including ESR processes.

- Staff survey - developing action plans and implementation challenges raised by the Associate Director due to available capacity of existing service level staff to take forward. Greater central support was identified as being required to assist in taking forward. Feedback to be shared with the People Team in the first instance to review.

3. Specialties Deep Dive – 7th September 2023

The Specialties deep dive meeting focused on the work being taken to review and manage the financial position in the context of the service challenges being addressed to manage patient activity and acuity within older adult inpatient services. The presentation shared by the service lead is attached as Appendix III.

The older adult inpatient Clinical Nurse Manager (CNM) presented the report. Working with the information team, the CNM presented the information analysis report attached as Appendix IV which pulls together a number of strands of information onto one page to allow triangulation of activity, incident and HR data to help provide an understanding of the key drivers of expenditure on the older adult inpatient wards.

Specifically, the report includes individual patient observations, incident data – violence and falls, staff sickness and staff vacancies with additional breakdown of the data to include the number and level of observations, those receiving ECT, red cards (these are areas of the ward which are under observation due to a number of high-risk patients requiring additional staff) and patients in the de-escalation suite.

The aim of the report is to enable the CNM to share this report with Team Managers, raising the profile of local financial management with a review of the qualitative impact considerations in order to help identify new ways to manage activity levels.

Over recruitment of HCA's (Health Care Assistants) has helped as there has never been a time when there have not been observations required and since Covid there has been an increase in the level of observations required which is a reflection that patients are now more challenging to care for.

Next Steps

A range of next steps have been identified which include the following:

- The CNM to meet with ward managers on a monthly basis to review the activity and financial position supported by the provision of a report outlining staff establishment levels, acuity in terms of observations being undertaken, sickness and vacancies being managed to identify risk mitigation actions. Embedding this practise will raise the need for localised actions to align with presenting challenges.
- A number of vacancies are due to be filled when students receive their PIN numbers and international nurses join the trust.
- Over recruitment of HCA's (Health Care Assistants) has helped to manage observation levels that are required on wards for patient safety. Since Covid,

the CNM reported that there has been an increase in the level of observations required reflecting that patients are now more challenging to care for.

- Further development of Insight analysis report and extend the number of wards included to encourage and enable the team to engage in continuous improvement discussions.
- A QI Project to reduce levels of therapeutic observations on Rosemary Ward to be revisited (this was stopped during Covid).
- A number of older adult beds need replacing and the service are looking at a bed which incorporates falls technology, which can alert staff if patients are trying to move or get out of bed. This would help reduce the number of staff observations for patients at risk of falls. The costs of these beds would be covered by a reduction in the level of staff observations.
- Skill mix of staff roles is being reviewed with consideration being given to putting in place falls advisors across the wards to target and reduce this risk.
- Work is being undertaken to standardise the MDT (Multi-Disciplinary Team) admission and discharge standards, to start working on the discharge plan as soon as patients are admitted to try and reduce delays in discharge.
- A range of training and education is being put in place to support Managers and Deputy Ward Managers to manage budgets, resource allocation and the importance of cost control, along with a development day for band 6 staff to look at E-Roster and safer care planning.

Appendix III Overspend in Dementia & Frailty

Next steps to monitor and reduce

Weekly finance oversight committee CNM/Managers and Matron (Finance, HR, Head of Nursing and AD/CD)

- CNM to meet weekly meet with ward area to confirm establishments, acuity, observations, sickness, vacancies etc and narrative to be sent to wider oversite committee.

- Monthly manager CNM meeting with Finance to review vacancies and ward budget overspend.

Birmingham and Solihull Mental Health NHS Foundation Trust

Development of Insight Report

- Insight report with overspend, bank agency use, sickness, vacancies, observation levels, incidents and KPIS to be developed

- Wards are then able to access to all relevant data to enable the team to encourage the team to engage in continuous improvement.

- Please can we request your support to help this be a priority

Projects

- QI Project to reduce levels of therapeutic observations on rosemary to be revisited.

- Purchase of bed with falls sensor on Bergamot, looking at falls and technology


November 12th
16:50
Arm Detection 2
Scale
Patient Risk Mgmt.
Preferences

Birmingham and Solihull Mental Health NHS Foundation Trust

Training and Education

- Provide training and education for Managers and Deputy Ward Managers budget management, resource allocation and the importance of cost control.

- We have booked a Band 6 Development Day for 16th October to look at E-Roster and safer care.

- I would like to involve our Band 6 managers in the establishment meeting with finance on a monthly basis which will increase their knowledge engagement and also support succession planning.

Costings

- Bed cost usual price £3250
- Bed cost with falls sensors £5150

- Cost of staff observing 24 hours £433 –
- Cost of staff observing for one week £3250

- Average costings
- 12 hours band 3 day £188.04 night £245 – Sunday £372
- 12 hours band 5 £236 Night £309 Sunday £473

Appendix IV

Information Analysis

Rosemary Ward - Monthly Stats (Apr 2023 - July 2023)

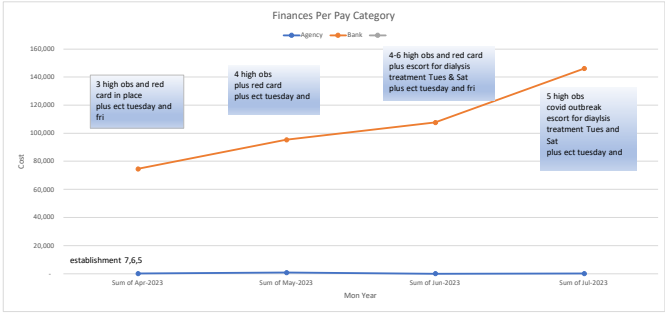
OLDER PEOPLE INPATIENTS WARD

Cost Centre Description	Pay Category	Sum of Apr-2023	Sum of May-2023	Sum of Jun-2023	Sum of Jul-2023
ROSEMARY WARD	Agency	118	769	27	51
ROSEMARY WARD	Bank	74,685	95,263	107,772	146,200
ROSEMARY WARD					
ROSEMARY WARD Total		172,928	194,068	277,757	243,050

Individual Observations

Ward	ROSE

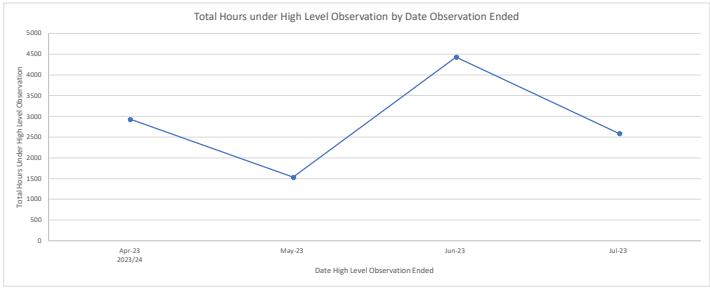
Observation Month End	Total Obs Hours
2023/24	11489
Apr-23	2931
May-23	1535
Jun-23	4435
Jul-23	2588
Grand Total	11489

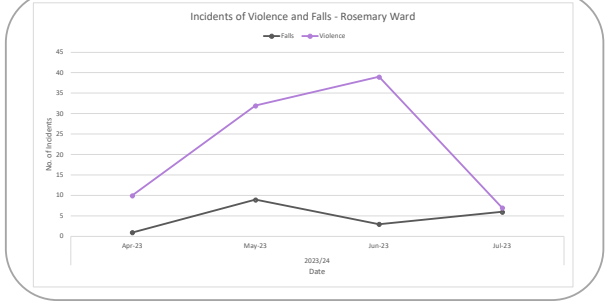


Incident Data - Violence and Falls

Ward	Rosemary Ward

Date	Falls	Violence	Total
2023/24	19	88	107
Apr-23	1	10	11
May-23	9	32	41
Jun-23	3	39	42
Jul-23	6	7	13
Total	19	88	107





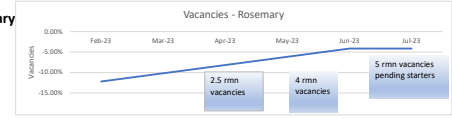
Staff Sickness - Rosemary

Date	Sickness Frequency
2023	
Apr-23	8.72%
May-23	11.00%
Jun-23	13.45%
Jul-23	13.93%

sickness

Staff Vacancies - Rosemary

Date	Vacancies
Feb-23	-12.14%
Jun-23	-4.09%
Jul-23	-4.09%



Bergamot Ward - Monthly Stats (Apr 2022 - July 2023)

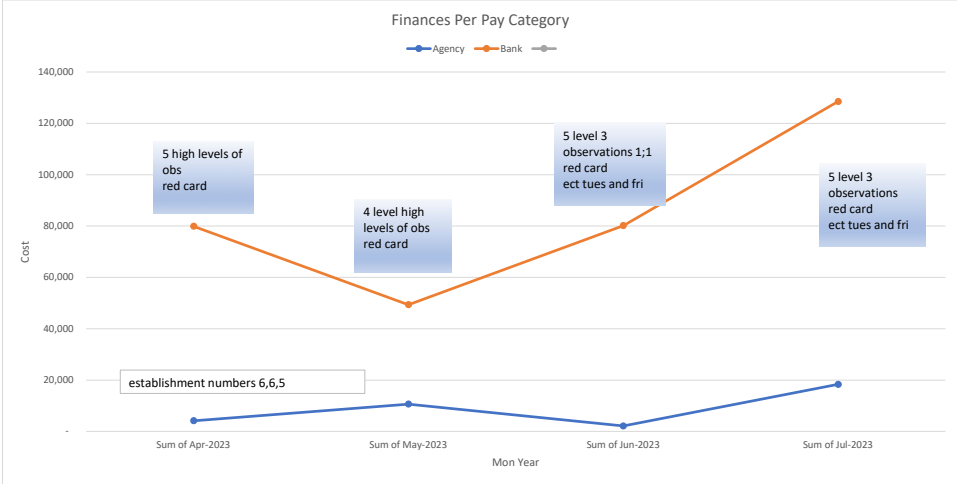
OLDER PEOPLE INPATIENTS WARD

Cost Centre Description	Pay Category	Sum of Apr-2023	Sum of May-2023	Sum of Jun-2023	Sum of Jul-2023
BERGAMOT WARD	Agency	4,153	10,607	2,090	18,315
BERGAMOT WARD	Bank	79,929	49,349	80,170	128,517
BERGAMOT WARD					
BERGAMOT WARD Total		176,709	154,919	256,768	246,610

Individual Observations

Ward	BERG

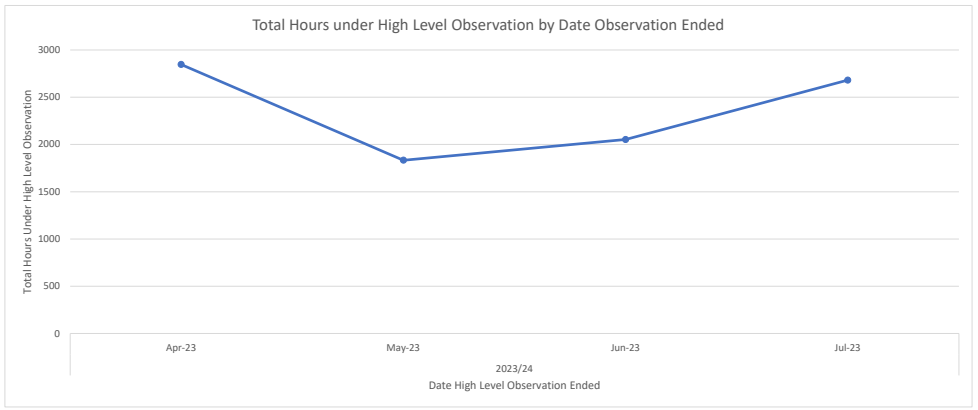
Observation Month End	Total Obs Hours
2023/24	9415
Apr-23	2847
May-23	1834
Jun-23	2053
Jul-23	2681
Grand Total	9415

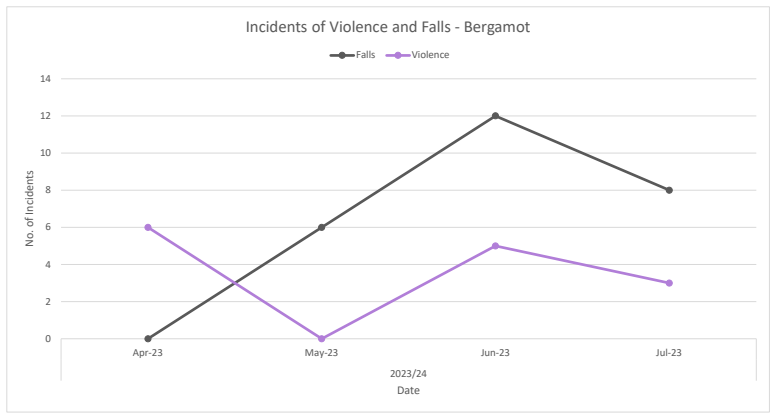


Incident Data - Violence and Falls

Ward	Bergamot Ward

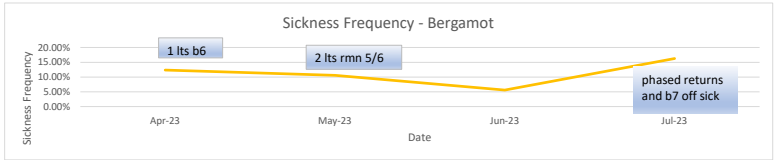
Date	Falls	Violence	Total
2023/24	26	14	40
Apr-23	0	6	6
May-23	6	0	6
Jun-23	12	5	17
Jul-23	8	3	11
Total	26	14	40





Staff Sickness - Bergamot

Date	Sickness Frequency
2023	
Apr-23	12.35%
May-23	10.57%
Jun-23	5.60%
Jul-23	16.28%



Staff Vacancies - Bergamot

Date	Vacancies
Feb-23	-4.50%
Jun-23	-6.66%
Jul-23	-10.11%

Sage Ward - Monthly Stats (Apr 2023 - July 2023)

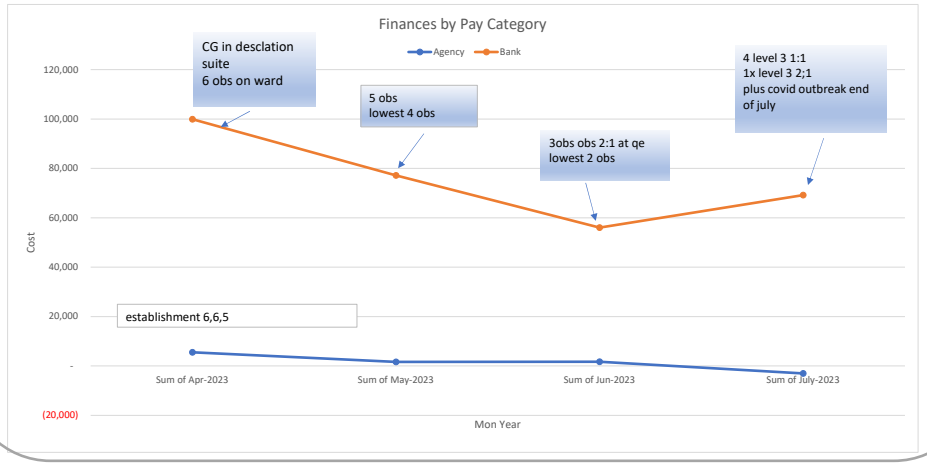
OLDER PEOPLE INPATIENTS WARD

Cost Centre Description	Pay Category	Sum of Apr-2023	Sum of May-2023	Sum of Jun-2023	Sum of July-2023
SAGE WARD	Agency	5,535	1,664	1,693	(3,022)
SAGE WARD	Bank	99,883	77,148	56,031	69,191
SAGE WARD	Substantive				
SAGE WARD Total		218,126	194,821	277,704	184,675

Individual Observations

Ward	SAGE

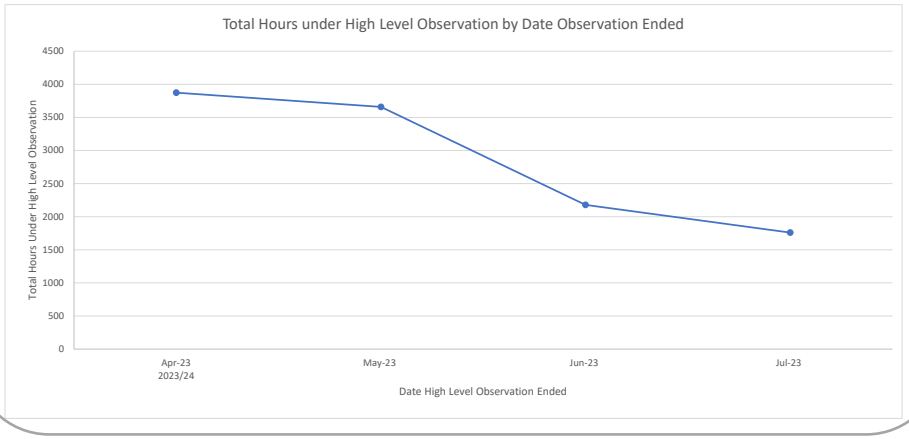
Observation Month End	Total Obs Hours
2023/24	11471
Apr-23	3873
May-23	3659
Jun-23	2178
Jul-23	1761
Grand Total	11471

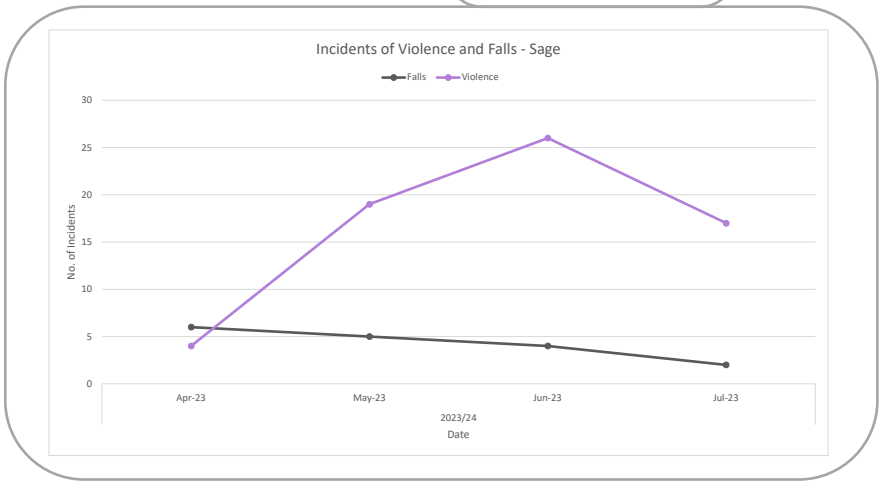


Incident Data - Violence and Falls

Ward	Sage Ward

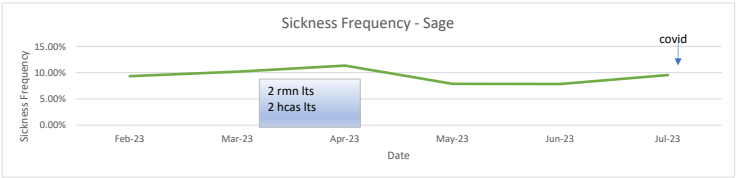
Date	Falls	Violence	Total
2023/24	17	66	83
Apr-23	6	4	10
May-23	5	19	24
Jun-23	4	26	30
Jul-23	2	17	19
Total	17	66	83





Staff Sickness - Sage

Date	Sickness Frequency
Feb-23	9.34%
Mar-23	10.20%
Apr-23	11.36%
May-23	7.88%
Jun-23	7.84%
Jul-23	9.56%



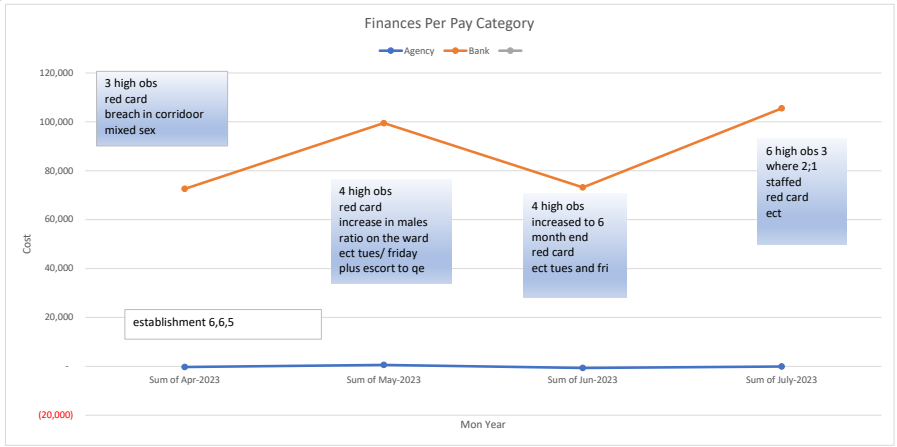
Staff Vacancies - Sage

Date	Vacancies
Apr-23	-29.11%
May-23	-32.63%
Jun-23	-31.52%
Jul-23	-29.66%

Reservoir Court - Monthly Stats (Apr 2023 - July 2023)

OLDER PEOPLE INPATIENTS WARD

Cost Centre Description	Pay Category	Sum of Apr-2023	Sum of May-2023	Sum of Jun-2023	Sum of July-2023
RESERVOIR CO	Agency	(289)	608	(637)	(90)
RESERVOIR CO	Bank	72,621	99,484	73,206	105,534
RESERVOIR COURT					
RESERVOIR COURT Total		181,230	218,834	279,135	229,998



Individual Observations

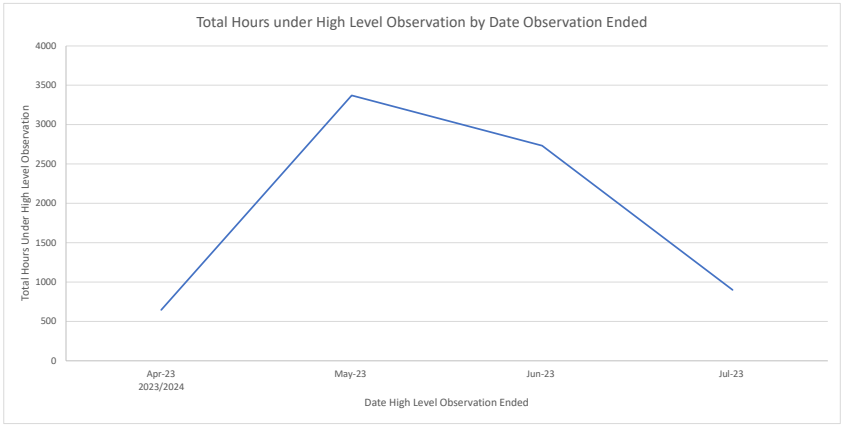
Ward	RES

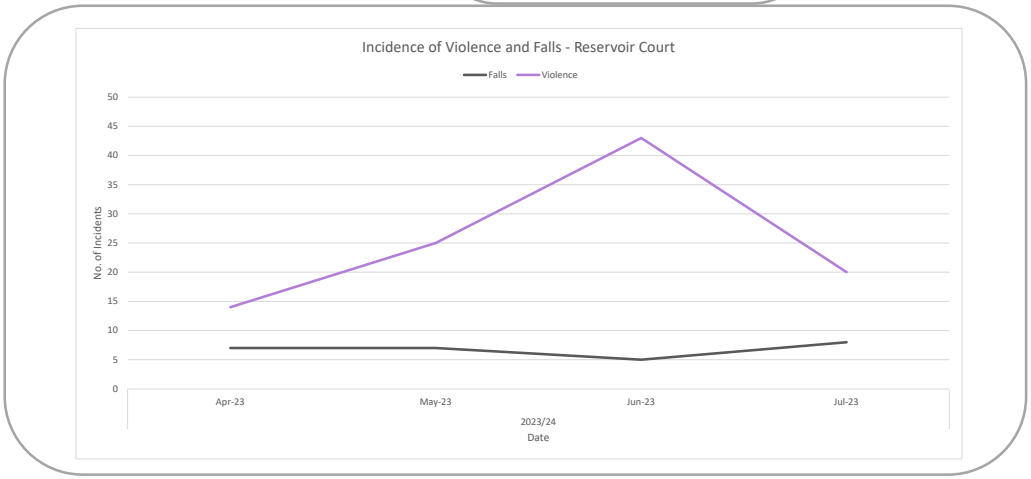
Observation Month End	Total Obs Hours
2023/2024	7651
Apr-23	647
May-23	3371
Jun-23	2733
Jul-23	900
Grand Total	7651

Incident Data - Violence and Falls

Ward	Reservoir Court Inpatients

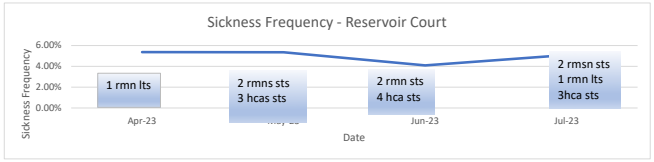
Date	Falls	Violence	Total
2023/24	27	102	129
Apr-23	7	14	21
May-23	7	25	32
Jun-23	5	43	48
Jul-23	8	20	28
Total	27	102	129





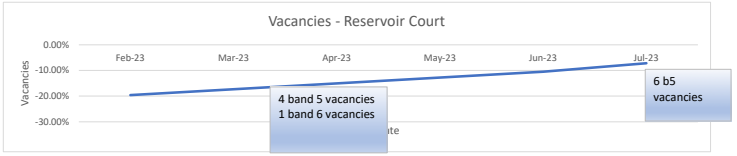
Staff Sickness - Reservoir Court

Date	Sickness Frequency
2023	
Apr-23	5.37%
May-23	5.35%
Jun-23	4.09%
Jul-23	5.09%



Vacancies - Reservoir Court

Date	Vacancies
Feb-23	-19.60%
Jun-23	-10.52%
Jul-23	-7.21%



6.3. EPRR Annual Compliance

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**6.3**		
Paper title	Emergency Preparedness, Resilience & Response Annual Report		
Date	4 October 2023		
Author (s)	Louise Flanagan, Emergency Preparedness, Resilience & Response Officer (EPRRO)		
Executive sponsor	Vanessa Devlin, Executive Director of Operations & Accountable Emergency Officer		
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:

This report provides an account of the Trust emergency preparedness, resilience and response (EPRR) activities. It details the planning progress to ensure the Trusts response in the event of severe disruption; training and exercising and procedures to meeting the EPRR Framework 2015, EPRR Core Standards and Civil Contingencies Act 2004. It sets out the Trust's state of readiness and provides assurance to the Committee of the Trusts continued effective resilience programme.

Key Issues:
- Compliance against NHSEI Core Standards
- Resilience in the event of a cyber attack
- Reach Out Collaborative Mutual Aid
- Priorities for 2023

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

This report is provided for assurance

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)
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)*

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Equality impact assessments:
Engagement *(detail any engagement with staff/service users)*
To be presented to Public Board.
Acronyms *(List out any acronyms used in 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).	

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Emergency Preparedness, Resilience & Response (EPRR) Annual Report

August 2023

1. INTRODUCTION

Under the NHS Constitution 2015, the NHS is there to help the public when they need it most; this is especially true during a significant incident or an emergency. Each NHS funded organisation must therefore ensure it has robust and well-tested arrangements in place to plan for, respond to and recover from these situations. The Civil Contingencies Act 2004 (CCA) outlines a single framework for civil protection in the United Kingdom. The Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. Whilst Mental Health Trusts are not specifically noted to be Category 1 responders, as defined by CCA, subsequently issued guidance such as the EPRR Framework and the NHS Standard Contract make it clear that as an NHS funded organisation we are obligated to plan and respond as though we were Category 1 responders. As such BSMHFT is subject to the full set of civil protection duties and are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency.

The NHS England Emergency Preparedness Framework (2015) provides strategic national guidance for all NHS funded organisations to help with meeting the requirements of these statutory obligations.

This annual report provides an overview of the Trusts emergency preparedness and covers the activities the Trust has undertaken during 2022/23 to ensure the Trust's resilience in the event of a business continuity, critical or major incident, a mass casualty event, pandemic, or other severe disruption occurring.

This report is to provide the Finance, Performance and Productivity Committee/Trust Board with an update regarding activities undertaken since the previous report (March 2022) in relation to emergency preparedness and business continuity, and to ensure that the Trust can meet its responsibility to provide an effective incident response, while maintaining the services the Trust is commissioned to provide.

The Trust continued to experience a serious and sustained period of high pressure during the level 3 response phase to the national incident relating to the Covid 19 pandemic, and this has tested our resilience and ability to respond to and recover from the most challenging period ever experienced by the NHS. The Covid 19 Incident was downgraded to a level 2 in May 2023 as we move to a position of 'living with covid'. This has been further exacerbated by a number of concurrent incidents and planned events which have occurred during 2022/23 (EPMA outage, Commonwealth Games, Industrial Action

etc.) and the long-term absence of our EPRR Officer due to illness which impacted on the ability of the organisation to complete elements of the EPRR Workplan during this time. Efforts were made to provide cover for the role but it became evident that there is a national lack of an appropriate pool of suitably qualified agency staff to cover such a role. Subsequently, only a basic level of cover was able to be provided for the most urgent work and to maintain the Incident Control Centre during this time.

2. GOVERNANCE ARRANGEMENTS

The overall responsibility for complying with the CCA 2004 and EPRR Framework rests with the Chief Executive Officer who is responsible for ensuring, through appropriate delegation of responsibility, that we comply with our statutory requirements and that NHS England & Improvement (NHSEI) Core Standards for EPRR are met.

The Trusts designated Accountable Emergency Officer (AEO) is the Executive Director with delegated responsibility for ensuring resilience across the Trust and the delivery of safe and robust responses to all kinds of emergency disruptions, supported by the Emergency Preparedness, Resilience & Response Officer (EPRRO). Our AEO is currently the Executive Director of Operations.

Operational management support is provided by the EPRRO. The AEO represents the Trust at regional forums including the Local Health Resilience Partnership (LHRP). The Trust has an internal Emergency Planning and Business Continuity Committee (BCEPC) which meets on a quarterly basis. An assurance position is provided to the Finance, Performance & Productivity (FPP) Committee on an annual basis which is then reported to Public Board, as required by NHSEI Core Standards for EPRR. Any other assurance statements required will be presented to FPP on an ad hoc basis.

As of 01 February 2023 the EPRR function was transferred from the Acute & Urgent Care portfolio to the Corporate Governance portfolio under the management of the Associate Director of Corporate Governance.

3. RISK

The National Risk Register (NRR) for Civil Emergencies provides a national picture of the risks of emergencies occurring. The most recent NRR includes a broader range of risks to the safety and security of the UK than previous iterations, reflecting technical improvements to risk assessment approaches and demonstrating the full range of challenges facing the UK.

These risks are taken into consideration in line with the risks identified on the Local Community Risk Register, to ensure that there is an appropriate level of preparedness to enable an effective response to emergency incidents, which have a significant impact on the communities of the West Midlands Conurbation. The Trust must have suitable, up to date, exercised plans which set out how they plan for, respond to, and recover from major incidents and emergencies as identified in the national and local community risk registers (as appropriate to our organisation). The Local Health Resilience Partnership (LHRP) considers all local risks within the West Midlands and has developed an agreed risk register which NHS provider Organisations should align to. On this basis, the Trust has recorded EPRR risks on

our internal register to ensure that it is compatible and that we have plans in place to ensure that we can respond.

Further detail on the risks highlighted in both the national and community risk registers can be found at the following links:

National risk register: Preparing for national emergencies - House of Lords Library (parliament.uk)

preparing-the-west-midlands-for-emergencies.pdf (wordpress.com)

4. PLANNING AND PREPAREDNESS ACTIVITIES

A series of plans have been reviewed and updated throughout 2022/2023, these being:

- Cold Weather Plan
- Heatwave Plan
  NB the current Cold Weather and Heatwave Plans are being amalgamated into an Adverse Weather Plan, in line with current national guidance and will be available shortly
- Fuel Disruption Plan
- Initial Operational Response (IOR) to Incidents Suspected to Involve Hazardous Substances or CBRN Materials
- Local Business Continuity Plans
- Local Evacuation & Shelter Plans

As part of ongoing delivery of business continuity management and in line with Core Standards requirements, the Trust has reviewed its Business Continuity Management Policy GC 09, and this was ratified in November 2022 following approval at the Policy Development Management Group (PDMG) and the Trust Clinical Governance Committee (CGC). A further review/update is underway in response to our 2022 Core Standards confirm & challenge process.

The Major Incident and Business Continuity Plan underwent a comprehensive review and update in 2021 in response to the feedback received from NHSEI Regional Team from our 2021 Core Standards submission. The Plan has subsequently been reviewed as part of the 2022 EPRR work program and further improvements made. The Plan is reviewed annually as a minimum and also following any activation of the plan.

The Trusts Infection Prevention Control Plan for Pandemic Influenza is currently under review. This policy sits in the portfolio of the Executive Director of Quality & Safety (Chief Nurse). It is worth noting that the NHSE pandemic influenza plan has not been updated since 2017.

The Trusts Infection Prevention and Control Team are in the process of developing a Mass Countermeasure Distribution Plan, in line with Core Standards requirements. This has been delayed due to the absence of the EPRRO and the IPC Lead.

5. TRAINING AND EXERCISING

A level 4 National incident was declared by NHSEI in March 2020 due to the declaration of a global pandemic and we have remained stood up in a command & control structure continuously since that time (the incident level was lowered to a level 3 on 25 March 2021, raised again to a level 4 in December 2021 and subsequently lowered again to level 3, then level 2 from May 2023). From March 2020 until June 2023 the Trust has had an operational Incident Control Centre (ICC) stood up (initially based at the physical ICC at B1 and then moving to a virtual ICC as the situation dictated). Only recently standing down in June 2023. As such, the Trust has thoroughly tested its Command, Control and Co-ordination (C3) procedures. During this period, we have also managed several concurrent incidents/events, utilising a single ICC to co-ordinate all communication and actions. With agreement of the Business Continuity & Emergency Preparedness Committee (BCEPC), the planning of any further exercises was postponed (with the exception of communications exercises) during the majority of 2022 and the EPRRO is currently working on an exercising plan for 2023/24 (delayed due to the absence of the EPRRO).

During 2022 The Trust was fully engaged in the extensive planning for the Commonwealth Games (CWG) which was successfully hosted by Birmingham between 27 July and 08 August 2022. As part of the planning and preparedness work for CWG, BSMHFT participated in a system-wide exercise on 12 April 2022. This was a multi-agency, counter terrorism (CT) type exercise, resulting in the need to manage a mass casualty situation and served to:

- Confirm Major Incident arrangements had been tested and any lessons identified implemented before the CWG
- Confirm the NHS-wide roles and responsibilities outlined in the CWG C3 CONOPS
- Meet the requirements of the annual EPRR exercise as outlined within the EPRR Framework

Several internal lessons were identified as part of the above exercise and have since been incorporated into plans, such as a plan for provision of Psychological Site Management, addition of an action card for psychological support to an incident and an update to the major incident plan.

Communications Exercise - Two system-wide, end to end (National to provider) communications exercises were undertaken in late 2022, testing the ability of an external agency (NHSEI/ICB) to contact our on-call/in hours designate director in the event an incident were to be declared. It is clearly evident that our ability to be able to contact appropriate staff and be contacted by external agencies in the event of an incident/emergency has also been thoroughly tested throughout the Covid 19 pandemic response. We await the final debrief/lessons learnt report, but we have not been made aware of any issues upon which we need to act.

The Trust participated in a number of exercises during 2022/23, including:

- Exercise Toucan and Toucan II - system-wide communications exercises, led by the ICB, in October 2022. A further internal communications test has been delayed due to the absence of the EPRRO.
- Exercise Arctic Willow – system-wide adverse weather exercise, held in November 2023.

- Exercise Flamingo Silk – a 'no notice' communications exercise based around cyber security, held in May 2023.

The Trust has also been involved in/supported a number of live incidents such as the Advanced Systems outage, internal EPMA outage and industrial action responses, thoroughly testing our C3 capabilities. Any recommendations from subsequent debriefing will be considered in future plan revisions.

On-Call Guidance - The Trusts on-call pack has been reviewed and revised and the EPRRO worked in collaboration with operational services to provide some specific EPRR related on-call guidance. The EPRRO is currently working on an e-learning package to provide EPRR related on-call training to staff who undertake duties as part of our Manager and Director on-call system.

Incident Response Training - The EPRRO is also working on Personal Development Portfolios (PDP's) for staff who would be called upon to undertake roles within an Incident Management Team (as per our Major Incident Plan). It is a requirement of Core Standards that we have appropriately trained staff to be able to respond to incidents. These PDPs are being developed in line with the Skills for Justice National Occupational Standards for Civil Contingencies and will help to identify gaps in training for key staff. The EPRRO will work with the People Team to determine how these PDP's will be incorporated into individual job descriptions as appropriate and is working with the Learning & Development Team on how best to incorporate this into our current training monitoring system.

Principles of Health Command Training – It is now also a requirement of all staff who undertake duties on the senior on-call rota and who could therefore be called upon to hold the role of Incident Director in the event of a major incident declaration, to undertake NHSE Principles of Health Command Training in line with the Skills for Justice National Occupational Standards for Civil Contingencies. The EPRRO is working to ensure all staff are scheduled to attend this training, subject to availability of sessions.

FFP3 Mask Fit Testing - A comprehensive training program was rolled out by the Trusts IPC team as part of the Trusts response to the pandemic to provide training in the fit testing of FFP3 masks, as a result the Trust now holds a register of trained fit testers and in addition is working with an external agency to provide fit testing via the portacount system.

Decision Loggist Training - The Trust remains in a position of having insufficient trained Decision Loggists who would be called upon to support a Major Incident Management Group in the event we needed to stand up our ICC, particularly out of hours. The EPRRO is working with the People Team to establish a way in which this role could be incorporated into some standard job descriptions and the financial incentives we may be able to offer to retain an appropriate level of loggists and continues to advertise the opportunity to train as a Loggist to existing staff. The availability of the Loggist training has also been raised as an issue by the region.

6. COMMONWEALTH GAMES

The Commonwealth Games (CWG) was held in Birmingham from 28 July to 08 August 2022. BSMHFT were fully engaged in the Joint ICS Planning Groups, CWG Training & Exercising Working Group and the Travel and Transport Planning Group.

Issues were raised as a system, very early on in the planning stages, in relation to the disruption to both staff and patient travel during the period of extensive road closures/restrictions, some of which were in place from 19th July until 10th August. Significant concerns were raised in relation to the wider QEH Campus site which housed a large athlete village and was in very close proximity to some of the event venues and of course houses QEH, Oleaster, Barberry, National Blood and Transplant Services and significant university estate. Circa 19k visitors were expected to travel through University Train Station daily and some local bus routes needed to be re-routed to account for planned road closures/restrictions.

It was not anticipated that the games would have a significant impact on our clinical services as the CWG Organising Committee (OC) provided several polyclinics at event sites and athlete villages, which provided a range of healthcare, including access to mental health support for athletes and the wider CWG family.

BSMHFT experienced no significant impact because as a result of the Games being held in Birmingham and in close proximity to a number of our sites, largely as a result of the comprehensive, system-wide planning.

7. CYBER RESILIENCE

The ongoing situation in Ukraine has led to an increased risk of the NHS being the target of a cyber-attack. As such we were asked by NHSEI to review our plans to respond to a total telecommunications and network outage of up to 96 hours in duration. In response to this, interim plans have been developed to ensure all operational areas are aware how to maintain continuity of critical services during such an incident. In the mid to long-term we will be developing these plans further to ensure they provide robust and clear guidance to operational staff and the Associate Director for Acute & Urgent Care is leading on a project to create a suite of paper-based documentation to be used in the event of systems outages.

8. ASSURANCE AND OBLIGATIONS

<u>NHSEI Emergency Preparedness Resilience and Response Core Standards for EPRR</u>

NHSEI Core Standards underwent its tri-annual review in 2022 and as a result a revised set of standards was issued to Trusts in late August 2022. Additionally, 2022 was the first year in which the Integrated Care Board (ICB) became the organisation responsible for the monitoring of Core Standards, taking over the role from NHSEI. As such, a dual review of submissions was undertaken by both the ICB and NHSEI. Given that some of the standards were completely new it had been acknowledged by NHSEI/ICB that

some Trusts may see a reduction in their overall compliance rating whilst work was undertaken in response to the revised/new standards. Following our self-assessment process, BSMHFT submitted a statement of 'partially compliant'. Following our submission, a significant confirm & challenge was undertaken by NHSEI which was not wholly supported by the ICB EPRR Team. Following a challenge back we confirmed our status as 'partially complaint' and this was reported to the Local Resilience Forum and accepted as our final position. An action plan was subsequently agreed for areas of partial compliance. Work on the action plan has been delayed due to the long-term absence of the EPRRO. Now that the EPRRO has returned to work a revised workplan has been agreed with the Associate Director of Corporate Governance to address the most urgent areas of outstanding work ahead of the 2023 Core Standards submission deadline (31 August). It is unlikely that it will be possible to complete all of the outstanding work ahead of this date, however at the time of writing this report, the EPRRO is in the process of compiling our 2023 submission and it is anticipated that we will be maintaining a position of partial compliance.

9. RESOURCES/RESILIENCE

The EPRR function within the Trust continues to be provided by a single individual (EPRRO). This represents a single point of failure for the organisation and allows for no cover arrangements in the event of the absence of that individual (annual leave/sickness/study etc.). NHSEI Core Standard 5 requires the Trust Board to be "satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties" and this is currently an area of concern and makes delivery of the annual workplan unsustainable. Plans are in place to provide some admin support to the EPRR function as part of the move to the Corporate Governance portfolio, however this still leaves a lack of suitably trained EPRR staff in the absence of the EPRRO.

10. PARTNERSHIP WORKING

The Trust continues to participate in a series of groups, in encouraging a joint approach to emergency preparedness for planning, response and recovery. This includes:

- Local Health Resilience Partnership – Executive Group (LHRP) – quarterly, attended by AEO
- Health Emergency Planners Operational Group (HEPOG – formerly LHRF) – monthly, attended by EPRRO
- Community & Mental Health Network Group – this is a newly established group attended by EPRRO

Since its inception in July 2022 the Birmingham & Solihull Integrated Care Board have been proactive in encouraging a system-wide approach to EPRR, including consideration of joint training provision and joint exercising and have been incredibly supportive in managing the concurrent incidents throughout 2022/23. We are currently working on setting up system-wide Task and Finish Groups for the following areas of priority:

- Training
- Evacuation & Shelter
- Mass Countermeasures
- Mass Casualty

11. REACH OUT EPRR PROVIDER COLLABORATIVE

The Provider Collaborative (PC) consists of representatives from BSMHFT, Coventry & Warwickshire Partnership NHS Trust, Black Country Healthcare NHS Foundation Trust, Midlands Partnership NHS Foundation Trust and St Andrews Healthcare. The PC was formed in 2022 with the specific remit of developing a mutual aid agreement for forensic services. The mutual aid memorandum of understanding is currently being developed and will be circulated for consultation once completed.

12. PRIORITIES FOR 2023

- On-going delivery of statutory requirements under the CCA 2004, the Framework for EPRR and Core Standards and NHS Standard Contract requirements
- Completion of Core Standards Action Plan to improve and maintain Core Standards compliance position
- Exercise to test evacuation procedures for forensic services (joint exercise following completion of provider collaborative mutual aid plans)
- Improve power/systems outage plans – develop suite of paper-based record templates
- Training for Incident Commanders
- Development/completion of our tri-annual live play internal exercise
- Fortify plans in relation to a cyber event
- Business case for increased resource into the EPRR provision

7. PEOPLE

7.1. (a) People Committee Chair’s Assurance Report August

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 October 2023**
Date(s) of Committee Meeting(s) reported	**23 August 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Staff Story 2. Integrated Performance Report 3. Quarterly KPI report (including mandatory training, appraisals etc) 4. E-Rostering (bi-monthly) 5. International Nursing Update 6. Quarterly PULSE Survey 7. Enough is Enough update 8. People Strategy Delivery – Deep dive 9. People Committee Annual Self-Assessment Coversheet for 2022/23 10. People Committee Annual Self-Assessment Monkey Survey Results
Alert:	The Committee wishes to alert the Trust Board to the following issues: - • Staff story and concerns raised. The Committee received an overview of facilities at Endevour House, which is a stand alone unit.It was clear that colleague sanitary and refeshment facilities were very inadequate. Members were very concerned that this situation had arisen and although some issues had been addressed specifically they were not assured this was an isolated position. They requested that an assessment be made for appropriate facilities for all colleagues. This should supplement the Health and Wellbeing Audit currently underway. It was confirmed a charity bid has been applied for funding for breakout rooms across the Trust. • Financial controls and safeguards concerns on making appropriate decisions. There is currently an overspend of half a million National request and ICB system agreed a series of financial controls. As part of the localised controls there would be no continuation of selling back annual leave from this year onwards and a reversion to original Trust mileage allowance rates. • The quarterly Pulse Report not demonstrating many improvements and need to continue work. It was reported that the results were

	disappointing that colleagues aren't satisfied potentially because of terms and conditions and workforce shortage issues. • An update on the centrally funded recruitment of international workforce raised serious concerns that the planned numbers would not be achieved placing the workforce plan at some risk .However, International recruitment via sponsorships has been positive	
Assurance:	The Committee was advised of the following matters: • Sickness rates continue to report a reduction. • Positive self-assessment results. This was significant as it demonstrated that respondents are broadly and strongly in agreement that the People Committee is delivering its key statutory and regulatory responsibilities as well as those delegated to it by the Board. • E Rostering. The Committee noted a delay in MHOST reviews looking at staffing levels and an update will be bought to October Committees.	
Advise	The Committee wishes to advise of the following matters: • The 'Pull up a chair' was agreed to be reinstated. • Enough is Enough. The Committee were informed a review had been completed around the informal process with 13 cases over the last 12 months. The dedicated team is critical to this process. • The Committee received the FTSU National Guardian	
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: 1. None were identified.	
Report compiled by	Anne Baines	**Minutes available from:** Sophie Pierro

7.1.1. (b) People Committee Chair’s Assurance Report September

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 October 2023**
Date(s) of Committee Meeting(s) reported	**20 September 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Integrated Performance Report • Staff Experience and Engagement Approach • Equality, Diversity and Inclusion Improvement Plan
Alert:	The Committee wished to alert the Board of Directors on the following key areas: • The **Freedom to Speak Up Guardian** Quarterly Report was deferred and therefore expected at October's meeting. • A number of initiatives were underway to focus on closing the **workforce gap**. There was a particular challenge in recruiting Registered Mental Health Nurses, although some progress had been made; the Trust was offering contracts to final year students to secure staff as they qualified. The target of 60 **international recruits** had not been realised, however this continued to be pursued. The Trust was also attending recruitment fairs, advertising through usual channels, and was looking to utilise social media to promote the organisation and attract a greater number of applicants. • **Appraisal compliance** was below target, however the Committee noted that this was due to the change in the way that appraisals were recorded on the system; colleagues understood the importance of values-based appraisals and conversations were being held. Technical issues raised by staff are being addressed. • A gap analysis in relation to the six high impact actions outlined in the **NHS Equality Diversity and Inclusion (EDI) improvement plan** was presented to the committee. The Workforce Race Equality Standard, Workforce Disability Equality Standard and Model Employer, would be collated into an overall strategic framework to establish milestones to close the access, experience and outcomes gap. Many amber rated actions arising from the EDI gap analysis related to sustainability and the ability to evidence sustainable change.
Assurance:	The Committee was assured that there was a continued increase in fundamental training compliance. Assurance was also received that

	improvements were being made in relation to management of long-term sickness across the organisation.	
Advise	The Committee was advised of the plans to refine flexible working data which had been newly extracted and would continue to be reported to the Committee. A new staff experience and engagement strategic framework would be developed and would link to the anti-discriminatory framework. The Trust's external website was under development to ensure it aligned to the Trust's EDI commitments.	
Risks identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: No new risks were identified.	
Report compiled by:	Kat Cleverley Company Secretary	**Minutes available from:** Sophie Pierro

8. QUALITY

8.1. (a) QPES Chair’s Assurance Report August

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: Quality, Patient Safety and Experience Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 October 2023**
Agenda Items	**Item 8.1**
Date(s) of Committee Meeting(s) reported	**23 August 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • CQC Update Safer staffing inc. MHOST update Assurance K. • Integrated Performance Report • Chairs Assurance Report from the Clinical • Governance Com • Infection, Prevention & Control Assurance L. Pim (attached) 09:35 • (Quality & Safety) Performance • Dashboard • Patient Safety (including safety alerts) & • Complaints Report • Preventing Future Deaths Assurance • MHA Quarterly Update Assurance • Review of Clinical Governance arrangements from • `Ward to Board` • Strategy update – quality priority Assurance • Strategy update – clinical services priority QPES Committee Annual Self-Assessment • QPES Forward Plan for 2023/24 Approval • Annual Review and update of QPES ToR
Alert:	The Committee wishes to alert the Trust Board to the following (for example): • CQC committee were informed of the recent unannounced inspection of our 12 adults CMHTs between August 8th and 10th.This inspection • follows the SI of a service user who it is alleged murdered another service user and two recent Coroners Regulation 28 reports . Although the CQC advises of good feedback from patients, teams were connected and passionate about their jobs and there were examples of proactive patient engagement activities to support wellbeing and reduce isolation, committee wishes to advise the Board that a new section 29A

	notice is served on the trust due to medicines management, risk assessment and care planning and treatment • Committee were assured that immediate actions are being taken to understand the issues and meet the CQC reporting deadlines. Members identified that these themes were reoccurring over time and therefore leading to a lack of assurance of robust learning and implementation of change. Human factor elements were recognised as significant and the correlation to high case loads, long waiting lists and staff shortages in the context of service transformation ongoing in CMHTs. Committee were advised of a number of initiatives to address these including further work on risk assessments, an immediate review of all those patients on enhanced CPA, risk stratification of cases, fact finding to understand what is going on in practice in teams, plan to audit DNAs, review of local audit cycle for medicines management and effectiveness of the governance structure. • Members agreed that key risks around workforce needs to be shared with the people committee and specific solutions to support clinical teams such as administration infrastructure. • Complaints team is currently of concern in that NHSE did not approve additional resource and although there is bank support to the team this remains a risk as best practice standards are not being met due to resourcing issues. • Staff Assaults: The total number of actual assaults on staff for the quarter has shown variation, continuing to rise above the mean average. Committee were advised that Operation Stonethwaite is being expanded within the organisation and conversations within the medical directorate around Responsible Clinician support for seeking prosecution, that this will be addressed in RRPSG and Trust H&S committee regarding assurance and updates moving forward and that there will be a review of TRiM and post incident support structures.
Assurance:	The Committee was assured on the following: • Committee received the Quality & Safety Performance Dashboard report and noted that although some metrics were showing an improved trajectory that some were of concern. • We were assured that NHSE have agreed the additional support for the patient safety team to manage the current number of SI investigations . • Committee were assured to learn of an additional piece of work commenced in month, led by the corporate teams, pulling together the action plan requirements from across a number of areas including SI's,PFD's, CQC, Safeguarding Reviews, Complaints etc., and cohorting them under themes to commence a mapping process against current organisation wide workstreams and QI projects. This will enable a more comprehensive approach to the closure of actions which are currently managed in silos with multiple areas of duplication and/or unnecessary variation in approach. • Learning from prevention of future deaths was discussed and the findings and themes highlighted including lack of beds and AHMPs provision, communication/interface between teams/organisations, and management and delays in the prescription of Carbamazepine, Clozapine monitoring and management, including clinical understanding/interpretation of blood results, failure to learn from previous PFD and pharmacy resource issues.

	• Committee was partly assured to note that the stakeholder groups set up to assess and action the specific areas of concern found that there are safe systems and processes in place but there appears to be a knowledge gap and as part of the PSIRF implementation a strategic approach to learning through the organisation to address this is ongoing. • We were advised that a review of the previous 2 years of PFD will be presented at Octobers committee • The committee received the Strategy update on the quality and clinical services priorities. We gained good assurance on the progress made in Quarter 1 and that the majority of the level 1 and 2 goals are on track and plans are in place where goals are not on track. • In addition, committee were appraised on the work ongoing to develop a framework to measure the impact of the strategy	
Advise	The Committee was advised of the following matters: • Committee received the Mental Health Legislation Committee Escalation Report and were assured that we have robust systems in place to ensure the MHA is appropriately implemented and monitored. • A concern was highlighted that the current trust locations registered with the CQC need to be formally updated. Currently a number of sites are grouped together for registration purposes, but this impacts the quality of data reporting, particularly for Use of Force data. Action will be taken forward to update the site's locations. • At the next committee a CTO service evaluation report will be presented on health inequalities around the disparity in CTO detentions • Committee discussed the Lucy Letby verdict. Emma Randle attended committee and members were assured by the ongoing actions including increasing the FTSU champions in community teams and senior leadership consideration of conducting a safety culture survey. • LP suggested an additional approach including running a safety culture survey with an early adopter site to be identified.	
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework: No risks were identified.	
Report compiled by	Dr Linda Cullen	**Minutes available from:** Lorraine Joyce

8.1.1. (b) QPES Chair’s Assurance Report September

Committee Chairs Escalation and Assurance Report

Name of sub-Committee	**Quality, Patient Experience and Safety Committee (QPES)**
Report presented at	**Trust Board**
Date of meeting	**4 October 2023**
Agenda Item	**Chairs Assurance Report from the Quality, Patient Experience and Safety Committee – Triple `A` Report**
Date(s) of sub–Committee Meeting(s) reported	**20 September 2023**
Quoracy	**Membership quorate: YES**
Agenda	The committee considered an agenda which included the following items: 1. Apologies 2. Declaration of Interests (as required) 3. Minutes of the Previous Meeting 4. Action Log 5. Matters Arising from Last Meeting 6. Staff Story 7. CQC Update and Action Plan 8. Safer Staffing including MHOST Update 9. Integrated Performance Report 10. Chairs Report from Clinical Governance 11. Safeguarding Quarterly Report 12. Quality and Safety Performance Dashboard 13. Community Treatment Orders Report 14. Trust Food Group Proposal 15. Quality Management System 16. QPES Forward Plan for 2023/24 17. Annual Review and Update of QPES Terms of Reference 18. Matters of escalation to the Board and/or Board Committees/and or BAF register. 19. A.O.B. with assurance provided a
Alert:	The Committee agreed that there were no issues that were required to alert to the Trust Board as assurance was provided against all agenda items with work progressing to reduce risk.
Assurance:	The Committee was assured on the following: • **CQC**: Compliance and Divisional Teams are working closely to ensure appropriate actions are being taken against all areas for improvement. Timely responses have been provided to the CQC confirming that remedial actions have been made against all action points raised.

	• **Safer Staffing**: Assurance was given that a range of processes are in place to ensure that improvement is in place against workforce challenges. This includes workforce management systems, legacy management arrangements, completion of establishment reviews utilising the Mental Health Optimising Staffing Tool (MHOST) and training to support SafeCare implementation and roster management training. • **Performance:** - The Committee were assured that there has been improvement against key areas of performance, this is inclusive of CPA reviews and follow ups, IAPT appointments and whilst there has been a positive increase in relation to incidents low levels of harm have been reported providing an increased opportunity for learning. • **Safeguarding;** Assurance was given that Safeguarding training has improved and is now above the 85% target. Assurance was also given that partnerships with Birmingham Community Health Care are positive with arrangements in place to enhance operational procedures. • **Quality and Safety Performance Dashboard:** Assurance was given that the organisation is prepared to implement the Patient Safety Incident Response Framework and work is continuing to address issues raised through the Serious Incident Framework. NHS England have given approval for additional role against the business case to support resourcing and successful recruitment has taken place.
Advise	The Committee was advised of the following matters: • The need to continue work currently being undertaken to across professional networks to enhance the role of Freedom to Speak Up Guardians. • The Committee will receive detailed reports outlining actions being undertaken in relation to Prevention of Future Deaths reports and complaints. • The Trust has undertaken significant work to comply with Community Treatment Orders, but further work is required with partners to ensure an equitable response is in place between ethic groups. A structure is in place to drive improvement.
Risks Identified	The Committee confirmed that appropriate assurance was given to support delivery against the agenda. No new items were identified to be added to the Risk Register or Board Assurance Framework:
Report compiled by	Gill Mordain Associate Director of Clinical Governance
	Minutes available from: Hannah Sullivan

8.2. Patient Safety Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**8.2**		
Paper title	Patient Safety and Experience Report – Front Sheet		
Date	September 2023		
Author (s)	Lisa Pim - Interim Associate Director of Nursing and Governance Sam Munbodh – Head of Patient Safety		
Executive sponsor	Interim Executive Director of Nursing, Quality and Safety		
Executive sign-off	☐x 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?	

Executive summary & Recommendations:

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

- Following review by the Patient Safety Oversight Group it was agreed that during July and august 11 incidents would proceed to a full RCA investigation, both months were on or below the mean of 7, Duty of Candour has been applied to all of these incidents.

- Trust Board were informed previously of a suspected homicide whereby immediate learning was undertaken with an associated action plan. The learning points from this incident has been shared across our local clinical governance committees and an update on progress has been provided on the agreed actions to our Patient Safety Advisory Group where the appropriate assurance was provided. Work continues across the service reviewing the appropriateness of the frequency and mode of contact and the formulated risk. In addition, a group is scheduled to meet to develop a standard operating procedure to standardise transition of service users between AOT/ICCR/FIRST

- At the time of authoring this report there are 29 live serious incidents in the review process (reduction of 6). 3 incidents exceed the 60-day review deadline. This is a reduction from 5 on previous months and evidences a continued reduction month on month. 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, 10 reports were submitted for consideration of closure. Prior to submission the reports were reviewed by our serious incident oversight group. The themes arising from Serious Incidents have supported the development of our Patient Safety Incident Response Plan which will be shared with Trust Board, following consultation at CGC and QPESC, in December.

- The themes arising from Serious Incidents over the last quarter include the need to ensure the new MDT standards are embedded across the service and the importance of the interface between CMHT and HTT, particularly follow-up from HTT to CMHT. Finally, duty standards are embedded within CMHT with evidence of escalation of risk

- There are currently 2=3 external reviews in process, 1 recently published, 1 not published, and 1 which is in the tendering process. A detailed update is provided in the paper of progress against review findings and actions underway. Key actions of note to Trust Board include;
    - A new service description/operational policy for the prison discharge service is being drafted following detailed review
    - An action plan has been created in response to NICHE pathway review of our AOT and FIRST services. The safeguarding team are leading on the learning points which related to domestic abuse and a Trust wide task and finish group has been established to review our risk management processes, which includes training, documentation, and policy. The lead for Mental Health Act has provided the appropriate assurance that their associated action is complete.

- Data identifies that the highest numbers of deaths reported over the last 12 months are identified as “unknown cause” and relate to the death of our service users in the community, with most deaths occurring in our Dementia and Frailty services.

- With regard to the two inquests where PFDs were issued a formal response has been written and an overview of actions for both PFD’s is included in the detail of the report including completion deadlines.

- There remains a total of 84 overdue actions, which includes our clinical and corporate services. Closure of SI Actions is a new quality metric proposed as part of the new Divisional Deep-Dives which will enable real time challenge, setting of trajectories and closer monitoring and scrutiny of performance.

- During July there were a total number of 2402 incidents reported and in August 2225 incidents, which is a decrease in the overall number reported in the previous months. 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

- The paper details prone and physical restraint figures with SPC Charts in place to support understanding of statistical importance. An increase in overall reporting is noted in month particularly in prone restraint.

- Similarly, the paper details staff assaults which has shown variation. The total

number of actual assaults on staff for the month of July and august totaled 94 and 101 respectively, which is slightly above the median but lower reporting overall than previous months.

- Trust Board previously requested additional information on Operation Stonethwaite. Operation Stonethwaite as it has been known, with a dedicated officer picking up and leading on investigations has now essentially ceased. Instead, this officer is now the West Midlands Police (WMP) Mental Health (MH) Investigation Liaison Lead. All incidents will now be managed within the relevant Force investigations team, with the DC, who was the Stonethwaite lead, providing an overview and support as and where required to assist the investigation teams manage and undertake investigations.

  WMP is also in the process of developing a new operational policy, in line with the Trust Police Interventions Policy, that will provide their operational framework to support their force improvement plan around dealing with incidents where MH is a factor of the alleged perpetrator.

  The work undertaken between BSMHFT and WMP has been acknowledged as best practice with neighboring MH Trusts (Cov & Warks, Black Country), aligning their processes to reflect ours, providing WMP with a consistent approach throughout their force areas. The primary challenge that seems to be a constant, is that operationally both with the police and our colleagues there can be a lack of engagement.

- Patient Assaults: The total number of reported assaults on service users for the month of July is 58. A slight decrease in prior months but remains above the mean.

- The number of open PALS cases has increased from 63 to 91 since last month's report, showing an increase of approximately 44%.

- There are currently 40 open complaints, with 25 awaiting allocation of an investigating officer (IO), this amounts to 63%. The average number of working days to allocate an IO is 56 which is a slight decrease from 61 last month, and 66 the month before that. The average age of a case 59.6 days which is a slight increase from 55.8 last month.

- The oldest open complaint is 5 months, which is an improvement on last month's position. Of the 40 open complaints, only one has had the planned response date extended.

- The current KPIs do not meet best practice standards. Continued work is being undertaken by the team to improve these figures; including recruiting to vacancies within the team, work around team building, additional training, and utilising bank to address backlog.

- The issues of resource within the team have been highlighted at Committee and Trust Board level. A business case submitted to NHSE for additional resource has been declined. A further paper was presented to ET and approval gained for a Band 5 secondment to the team for 12 months. Additional measures such as OD intervention to support team dynamics and behaviours and leadership coaching for

the Band 7 has also been agreed.

- Noting continued poor performance by the service, a further paper was presented to ET in September, and approval gained for a Band 5 secondment to the team for 12 months. Additional measures such as OD intervention to support team dynamics and behaviours and leadership coaching for the Band 7 has also been agreed. A deep dive review on the customer relations service, including mitigation and actions being taken, is due to be presented to QPESC in October and a summative overview will be presented to Trust Board in December

- There are currently 29 outstanding actions, of which 18 are overdue (62%). This an improved position from last month's report where there was a total of 44 actions and 20 were overdue.

- In August we collected 578 FFT with a positive percentage score to the question 'Overall, how was your experience of our service?' of 80% and a negative score of 9%. This represents a fairly static position on prior month.

- Staff was the main positive theme with 188 (47%) of the positive feedback, similar to prior month.

- Waiting time was the main improvement theme with 41 (18%), support had 35 (15%) then information with 31 (14%). Waiting time issues are almost all for Integrated Community Care (90%) and are around waiting a long time for appointments often mentioning long time between appointments, waiting times when on site to be seen and waiting to receive medication. There is some understanding that services are stretched. Support issues are mostly for Integrated Community Care 60% and Acute Care 23%. Support issues relate to needing support between appointments, not being heard or listened to, needing more support for a longer duration, having support suited to the individual and lack of support for families.

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

CGC 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 Trust board

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)*

Note additional agency resource required within the Customer Relations Team.

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

BAF02
There is a risk that the Trust may fail to focus on the reduction and prevention of patient harm and at enhancing its safety culture.
BAF03
There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance.

Equality impact assessments:

The Patient Safety Quarterly Report is at the early stages and data specifically pertaining to protected characteristics are not currently 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	**8.2**
Paper title	Overview- Patient Safety and Patient Experience Report
Date	4 October 2023
Author	Samantha Munbodh - Head of Patient Safety Lisa Pim – Interim Associate Director of Nursing and Governance
Executive sponsor	Steve Forsyth, Interim Executive Director of Quality and Safety (Chief Nurse)

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

Executive summary & Recommendations:

This document provides Trust Board with an overview of the serious incidents, local incidents and complaints reported during the month, alongside external reviews, and prevention of Future Deaths (PFD) information.

The report will outline the number of incidents reported within the month and the categories. It will also outline the serious incident investigations submitted to our commissioners for closure, the associated action plans and learning together with any emerging themes.

1.0 Serious Incidents

Following review by the Patient Safety Oversight Group, during July and August, it was agreed that 11 incidents would proceed to a full RCA investigation, the numbers in month were on or below the mean of 7, duty of candour has been applied to all of these incidents.

As previously reported to Board, one of the serious incidents reported included a suspected homicide.

The immediate learning from the rapid review identified:

1. Less than optimal frequency / modality of review for this service user
2. Individual professional clinical curiosity/accountability
3. Timeframes for appointments agreed in MDT do not always filter through to the booking system.
4. Address details not updated on RIO.
5. No standard operating procedure for transition of service users between AOT/ICCR/FIRST

The learning points from this incident have been shared across our local clinical governance committees and an update on progress has been provided on the agreed actions to our Patient Safety Advisory Group where the appropriate assurance was provided for learning points 2, 3 and 4 which have been completed. Work continues across the service reviewing the appropriateness of the frequency and mode of contact and the formulated risk. In addition, a group is scheduled to meet to develop a standard operating procedure.

At the time of writing this report there are 29 live serious incidents in the review process. 3 incidents exceed the 60-day review deadline. This is a reduction from 5 on previous months and

evidences a continued reduction month on month. The Patient Safety Lead and team will be working closely with the Divisional teams to work towards the 60-day KPI.

1.1 Unexpected Death Reporting

Data identifies that the highest numbers of deaths reported over the last 12 months are identified as “unknown cause” and relate to the death of our service users in the community, with most deaths occurring in our Dementia and Frailty services.

For those deaths that meet the criteria outlined within Learning from Deaths a structured judgment review will take place if the threshold for a serious incident is not met. This supports a robust framework for divisional and organisation-wide learning. The learning identified within the quarter has been shared with the physical health committee and includes non-compliance with the recently updated clozapine policy and management of a fall.

As we continue to use the Serious Incident Framework these incidents will be investigated using these principles until we have transitioned to the Patient Safety Incident Response Framework (PSIRF) in November 2023. All families where details are available will be invited to participate in the review and offered the support of the Family Liaison Officer. Staff involved will be provided with literature signposting them where they access support and reminded of the ‘Just Culture’ within which the Trust operates.

1.2 Completed SI Reviews

In terms of completed reviews, 10 reports were submitted for consideration of closure. Prior to submission the reports were reviewed by our serious incident oversight group.

The themes arising from Serious Incidents have supported the development of our Patient Safety Incident Response Plan which will be shared with Trust Board, following consultation at CGC and QPESC, in December.

1.3 External Reviews

There are currently 3 external reviews in process, 1 recently published, 1 not published, and 1 which is in the tendering process.

NSHE 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 is referenced as H, who committed a number of stabbings in Birmingham city centre on 6 September 2020.

The report has now been published and the following learning was identified:

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 CPNs from 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 of team member; and

• describes the responsibilities, scope, and remit of CPNs from the prison discharge service and care coordinators for service users detained in prison, to ensure effective liaison with prison MHITs and MAPPA

Practitioners have reviewed the current paperwork and scoped the necessary changes for the policy. The proposed changes have been reviewed and the drafting of a new SOP, with associated documentation as necessary, has commenced. This work was scheduled to be completed by Autumn 2023, however, there is an anticipated delay due to staff shortages due to summer leave.

Colleagues will recall from updates provided previously that NHS England Midlands & East (NHSE) Regional Investigations Review Group as a proportionate response commissioned NICHE to undertake a pathway review of our 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%.

Seven learning points have been identified for the Trust which are listed below and are being monitored through the local governance arrangements:

- Care teams not always discussing the decision to recall service users subject to a CTO.
- More than 50% of service users in the sample did not have an up-to-date care plan
- Noncompliance with the Trust policy expectations regarding risk assessment and management
- It is difficult to determine if a risk assessment review has been completed or if there simply a change of date.
- No Trust process that enables the risk of domestic abuse to be easily identifiable in the service user clinical record.
- No clear process for developing keeping safe plans for family members who may be at risk of domestic abuse.
- No evidence that 48% of carers were offered the opportunity to complete a carer engagement tool.

This report has not yet been published NHSE who are in the process of arranging legal review in preparation for publication.

An action plan has been created in response to these learning points, our safeguarding team are leading on the learning points which related to domestic abuse and a Trust wide task and finish group has been established to review our risk management processes, which includes training, documentation, and policy. The lead for Mental Health Act has provided the appropriate assurance that their action is complete.

NHSE have also commissioned Psychological Approached 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

Information has been shared with Psychological Approaches, data review is in process and meetings with key stakeholders are taking place.

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1.4 Inquests

During July and August there has been a total of 4 inquests held, 2 of which concluded as suicide and 2 as natural cause with no issues highlighted for either case.

With regard to the two inquests where PFDs were issued a formal response has been written and submitted to the Coroner. Further detail highlighted below;

PFD 1 - Broadly, the areas of highlighted concern pertain to; lack of beds and AHMPs provision, communication/interface between teams/organisations, and management and delays in the prescription of Carbamazepine

Actions;

- Roll out of Trust work stream relating to the work being undertaken with the police to streamline the S136 process.
- Implementation of the new Dialog Plus Care planning tool trust-wide
- The Trusts Safety Incident Response Plan has identified fragmented working and poor communication as one of the six Safety Priorities with associated QI methodology of approach.
- Completion of a PFD Review with associated thematic review and learning.

It is anticipated that all actions will be completed by April 2024 and at the time of writing there are no overdue actions.

PFD 2 - Broadly, the areas of highlighted concern pertain to; Clozapine monitoring and management, including clinical understanding/interpretation of blood results, failure to learn from previous PFD and pharmacy resource issues

Actions;

- Delivery of a recorded Webinar on clozapine with medical professionals signed up and in attendance
- The Webinar will then be available for all clinical staff on the Trust Intranet
- Development of a series of e-learning modules pertaining to the monitoring and management of Clozapine on the trust e-learning platform form
- Implementation of the Learn It Online resource www.learnitonline.co.uk.
- Implementation of a Pharmacy Clozapine Team

It is anticipated that all actions will be completed by September 2023

1.5 SI Actions

There are currently a total of 84 overdue actions, each service area will be asked to present to our Patient Safety Advisory in November a plan with timeline for closure for those incidents which are overdue. Closure of SI Actions is a new quality metric proposed as part of the new Divisional Deep-Dives which will enable real time challenge, setting of trajectories and closer monitoring and scrutiny of performance.

A breakdown by Division is presented within the report.

2.0 Local Incident Reporting

During July there were a total number of 2402 incidents reported and in August 2225 incidents, which is a decrease in the overall number reported in the previous months. 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 3674 incidents identified as currently awaiting managers sign off. 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.

Closure of local investigations is a new quality metric proposed as part of the new Divisional Deep-Dives which will enable real time challenge, setting of trajectories and closer monitoring and scrutiny of performance.

2.2 Levels of Harm

84% of our incidents reported during August 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.

2.3 Community Suicides

In the 12 months preceding August 2023, 12 suicides have been confirmed through the inquest process. There are 9 inquests scheduled to take place for those incidents reported as a suspected suicide. Themes and trends from inquests will be shared ongoing as part of this report.

Historic information has evidenced established risk factors for suicide, such as previous self-harm, drug and alcohol misuse, multiple mental health diagnoses. In addition, suspected suicides during the pandemic show experiences of isolation or disruption in care may have contributed to some of the suspected suicides.

The Trust has a suicide prevention strategy led by CD Kerry Webb and progress on outcomes will feed regularly into the Patient Safety Advisory Group (PSAG).

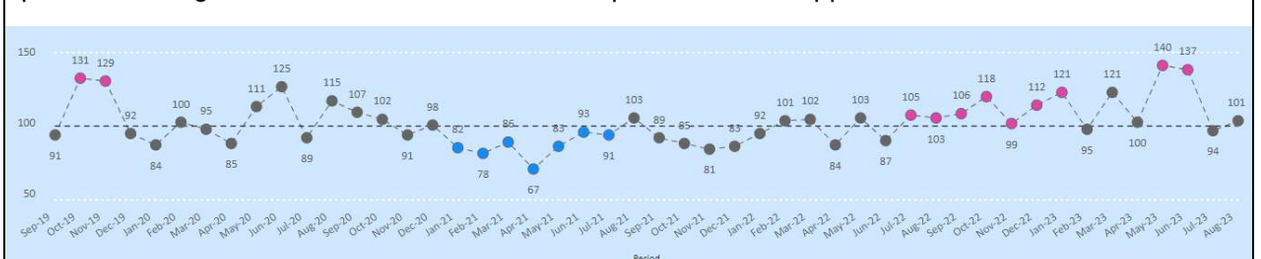
2.4 Prone and Physical Restraint

Prone: The figures evidence there was a significant increase in the number of reported prone restraints for the month of August with 71 incidents being reported, this being an increase of the previous month of 56, which is on the median. Increase in reporting has been across all areas.

Physical: There were 250 reported incidences of restraint during August which includes the 71 prone incidents documented above. The data suggests that a small number of service users were involved in a large number of incidents due to clinical presentation and acuity.

2.5 Inpatient Assaults Staff and Inpatients Assaults on Patients

Staff Assaults: The total number of actual assaults on staff for the month of August totalled at 101 which is an increase in the previous month and slightly above the median. Prior to February there were seven consecutive months in reporting. 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.

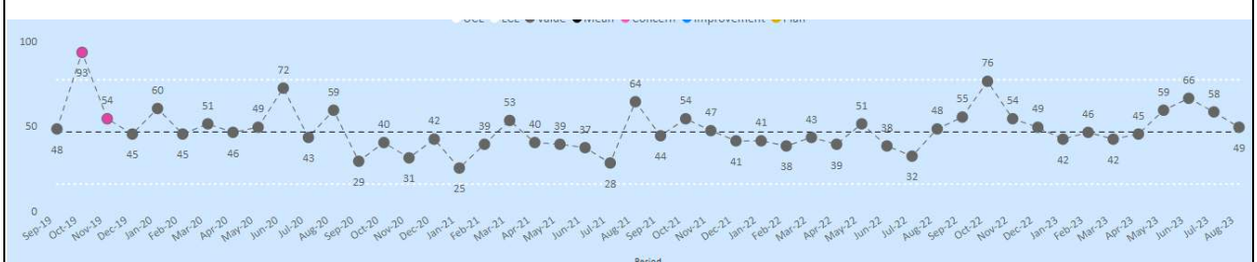


Trust Board previously requested additional information on Operation Stonethwaite. Operation Stonethwaite as it has been known, with a dedicated officer picking up and leading on investigations has now essentially ceased. Instead, this officer is now the West Midlands Police (WMP) Mental Health (MH) Investigation Liaison Lead. All incidents will now be managed within the relevant Force investigations team, with the DC, who was the Stonethwaite lead, providing an overview and support as and where required to assist the investigation teams manage and undertake investigations.

WMP is also in the process of developing a new operational policy, in line with the Trust Police Interventions Policy, that will provide their operational framework to support their force improvement plan around dealing with incidents where MH is a factor of the alleged perpetrator.

The work undertaken between BSMHFT and WMP has been acknowledged as best practice with neighbouring MH Trusts (Cov & Warks, Black Country), aligning their processes to reflect ours, providing WMP with a consistent approach throughout their force areas. The primary challenge that seems to be a constant, is that operationally both with the police and our colleagues there can be a lack of engagement.

Patient Assaults: The total number of reported assaults on service users for the month of July is 58 and August is 49. This is on a downward trend for the last 2 months consecutively.



2.6 Incidents of Self Harm

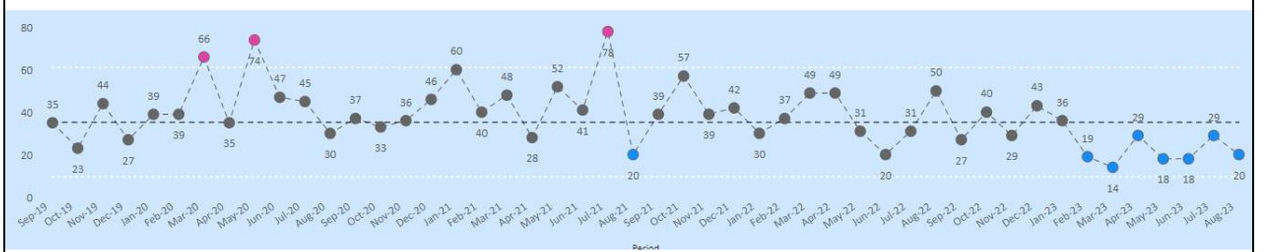
During the month of July 200 incidents of self-harm were reported and in August 186 which is within the mean. Most incidents occurred within the Secure Service setting. A program of works to support the prevention of self-harm incidents is being rolled out across the trust.

During the month of August there were 20 ligature incidents reported, none of these with an anchor point. This is an area of continued focus for the trust. Where an anchor point has been identified, the Patient Safety team will undertake a rapid review to identify if there is any immediate learning for the incident.

Current work underway;

- 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

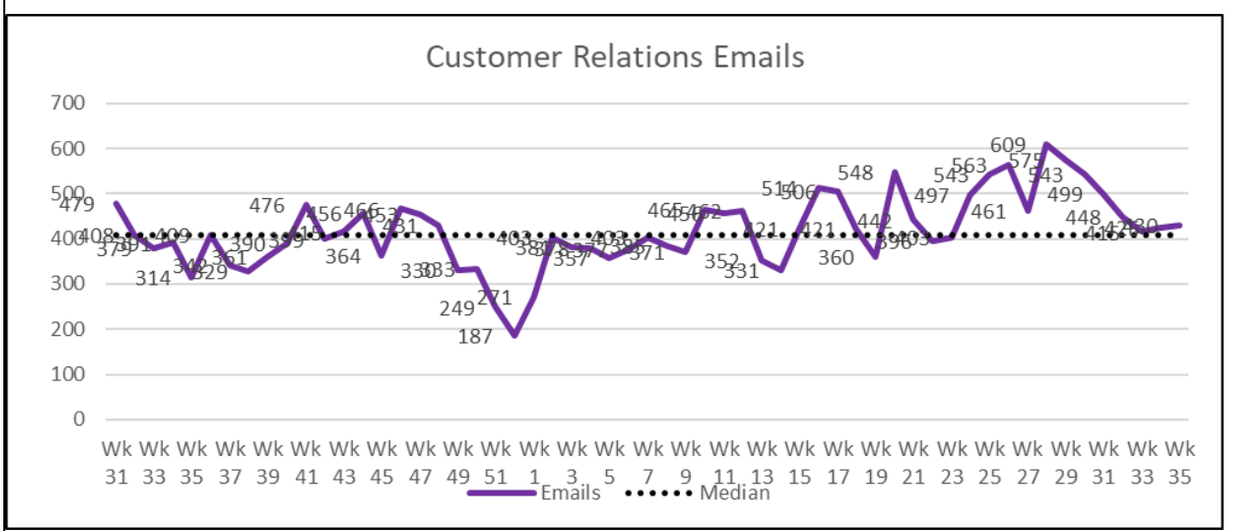
- Reviewing safe staffing levels and implementing daily staffing huddles
- Rolling out additional therapeutic activities



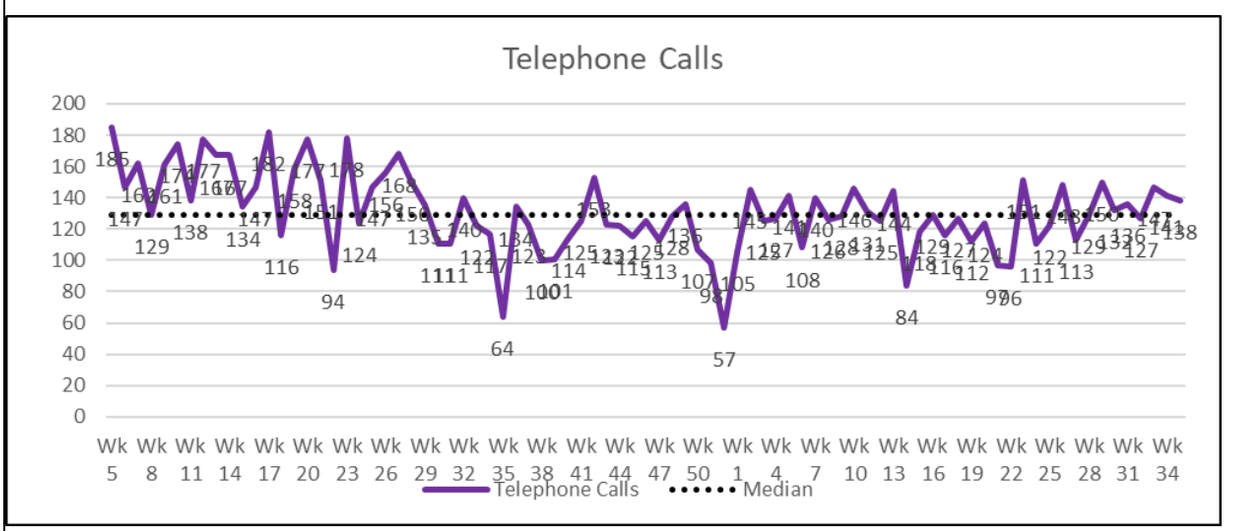
3.0 Patient Experience and Complaints

3.1 Overall Position

The graph below depicts the number of emails the customer relations team have received over the last 12 months. This includes emails regarding PALS concerns as well as formal complaints.



The graph below depicts the number of telephone calls the PALS team have received over the last 12 months.



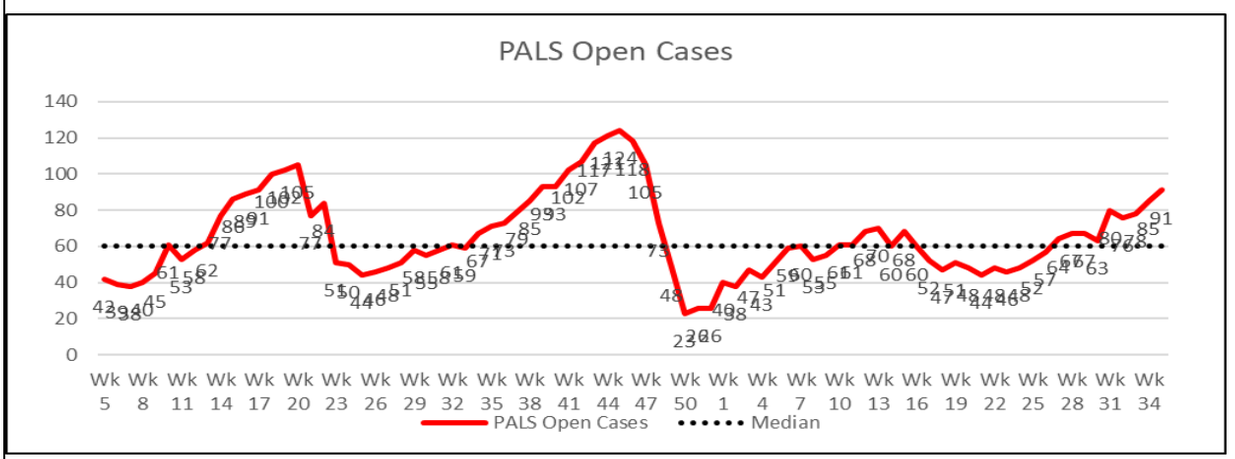
There has been a fluctuation in the number of emails received by the team over recent weeks. This would correlate with the increase in open PALS cases as demonstrated below, which shows the number of open PALS cases over the last 12 months.

The team are currently trailing a new telephone call system which allows a waiting in line facility as well as a call back facility. It will also enable a more detailed level of reporting including the number of calls taken, and the length of time for each call.

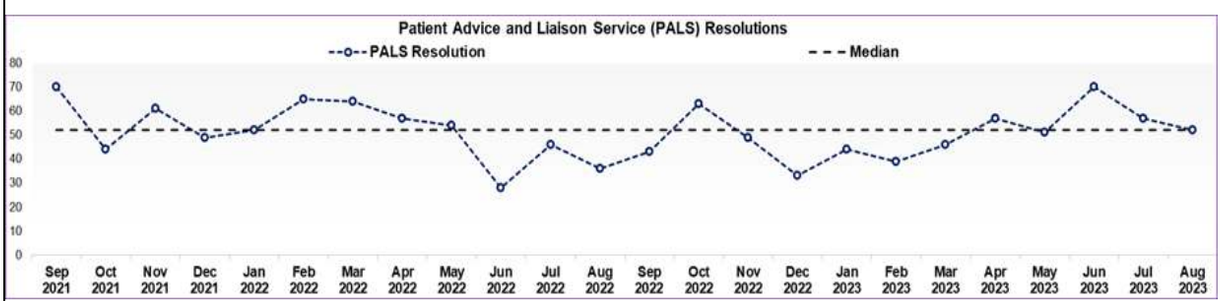
3.2 PALS Contacts

The number of open PALS cases has increased from 63 to 91 over the last 2 months, showing an increase of approximately 44%.

Contact levels overall are captured in the graph below;



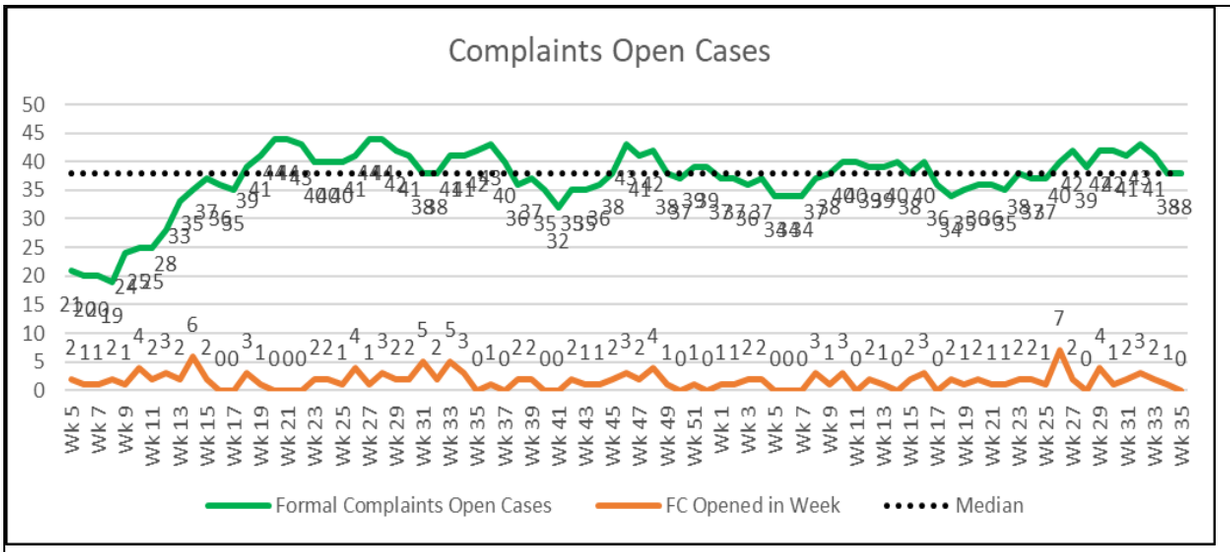
The below graph depicts the numbers of PALS contacts that were resolved and closed over the last 12 months.



This evidences improved performance overall during the last 3 months in comparison to performance June 2022 to February 2023. The improvement in performance has been supported by significant local interventions by the local management team. Sustained performance this quarter has been a challenge due to workforce issues including long-term sickness.

3.3 Formal Complaints

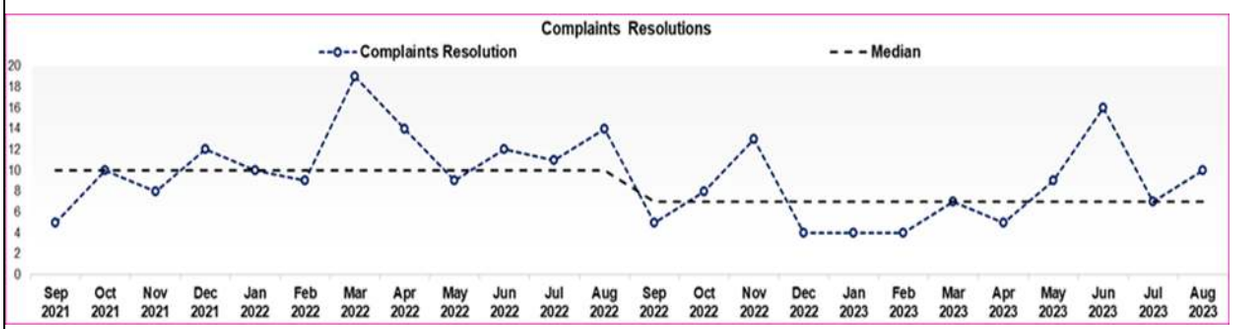
The below graph depicts the number of open formal complaints over the last 12 months, along with the number of formal complaints that were newly registered each week.



There were 10 formal complaints registered this month.

Whilst usually the complaints are mostly from ICCR – the directorate serving the largest population of our service users – this month we saw complaints from a variety of areas. A variety of issues were raised, mainly centring around access to appointments and communication.

The below graphs depict the numbers of formal complaints that were resolved and closed over the last 12 months.



13 complaints were closed this month, of which 100% were closed the agreed time frame. 9 out of the 13 closed complaints had actions identified.

The average number working days from registering a formal complaint to sending the final response was 119, which is an increase of 9 days since last month's report.

2 complaints were returned from a dissatisfied complainant and reopened for further investigation. 0 compliments were registered this month.

Again, the graph evidences overall improved performance in relation to numbers of complaints completed/resolved over the last 3 months in comparison to December 2022 to April 2023 performance. The improvement in performance has been supported by significant local interventions by the local management team.

3.32 Summary Position Complaints

There are currently 40 open complaints, with 25 awaiting allocation of an investigating officer (IO), this amounts to 63%. The average number of working days to allocate an IO is 56 which is a slight

decrease from 61 last month, and 66 the month before that. The average age of a case 59.6 days which is a slight increase from 55.8 last month.

The oldest open complaint is 5 months, which is an improvement on last month's position. Of the 40 open complaints, only one has had the planned response date extended.

The current KPIs do not meet best practice standards. Continued work is being undertaken by the team to improve these figures; including recruiting to vacancies within the team, work around team building, additional training, and utilising bank to address backlog.

Noting continued poor performance by the service, a further paper was presented to ET and approval gained for a Band 5 secondment to the team for 12 months. Additional measures such as OD intervention to support team dynamics and behaviours and leadership coaching for the Band 7 has also been agreed. A deep dive review on the customer relations service, including mitigation and actions being taken, is due to be presented to QPESC in October and a summative overview will be presented to Trust Board in December

3.4 PHSO & CQC Complaints

There have been no new formal PHSO or CQC complaints registered in August. There remain 3 complaints under investigation by the PHSO, and a total of 14 PALS open cases raised via CQC.

3.5 Complaints Actions

The below table provides the current number of actions open across the Trust from formal complaints.

Directorate	Total	1 month	2 months	3 months +
Acute Care	7	2	4	1
Barberry Specialities	2	0	0	2
Corporate	1	1	0	0
ICCR	17	8	8	1
Urgent Care	2	0	0	2
Total	**29**	**11**	**12**	**6**

There are currently 29 outstanding actions, of which 18 are overdue (62%). This an improved position from last month's report where there was a total of 44 actions and 20 were overdue.

As previously reported, 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 the internal process around automatic allocation of timelines for actions which can potentially appear unrealistic. Action trackers are being disseminated on a monthly basis to divisional senior leadership teams. The complaints team are working collaboratively with the Divisions and Clinical Governance Facilitators to close down outstanding overdue actions.

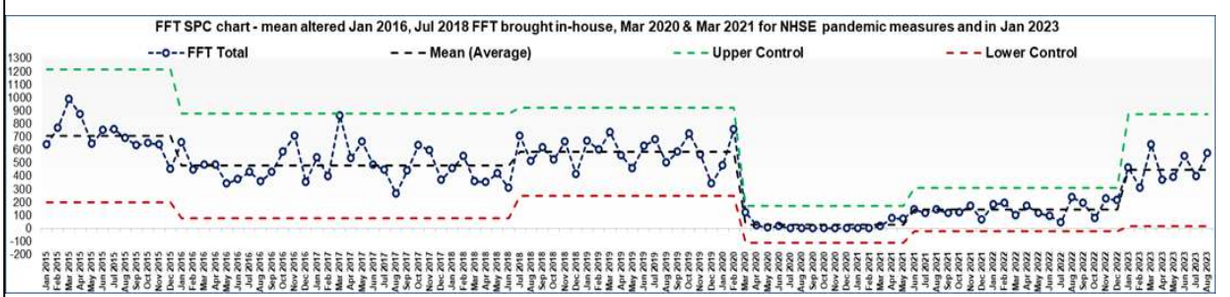
4.0 Friends and Family Test (FFT) Scores

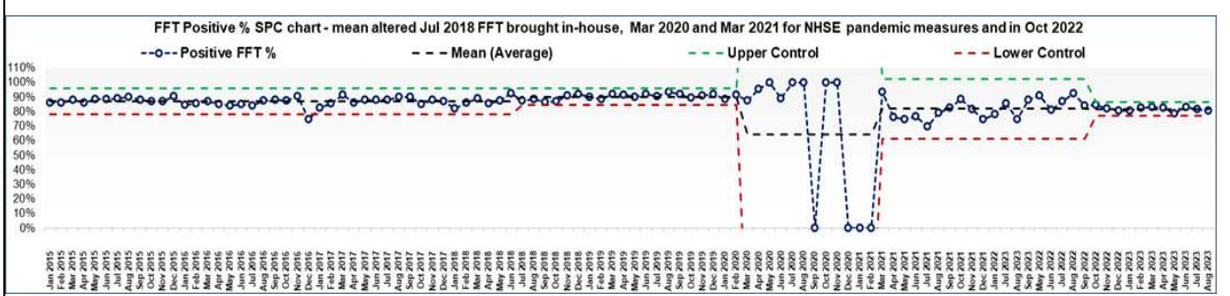
In August we collected 578 FFT with a positive percentage score to the question 'Overall, how was your experience of our service?' of 80% and a negative score of 9%

In August 578 FFT were captured which is 177 more than last month. FFT distribution for August is more in line with pre pandemic levels with 17% of FFT being collected by Acute and Secure care. Integrated Community Care collected the most FFT and accounted for 73% (424) of the FFT collected. Another area with most FFT collected was Acute Care with 15% (89).

Staff was the main positive theme with 188 (47%) of the positive feedback. Waiting time was the main improvement theme with 41 (18%), support had 35 (15%) then information with 31 (14%). Waiting time issues are almost all for Integrated Community Care (90%) and are around waiting a long time for appointments often mentioning long time between appointments, waiting times when on site to be seen and waiting to receive medication. There is some understanding that services are stretched. Support issues are mostly for Integrated Community Care 60% and Acute Care 23%. Support issues relate to needing support between appointments, not being heard, or listened to, needing more support for a longer duration, having support suited to the individual and lack of support for families.

The graphs below demonstrate trends relating to the total number of FFTs since 2015, along with positive scores received during the same time period.





Reason for consideration:

For the Trust Board to be appraised of incidents being raised and actions being taken to reduce harm and improve patient and staff experience and safety. Trust Board is. also asked to be assured that quality governance systems are in place to ensure. continuous learning from Serious Incidents in accordance with BSMHFT policy.

Previous consideration of report by:

Trust Board receives a bi-monthly report for Patent Safety

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 (*detail any financial implications*)

None Known

Board Assurance Framework Risks:

(Detail any new risks associated with the delivery of the strategic priorities)

BAF02
There is a risk that the Trust may fail to focus on the reduction and prevention of patient harm and at enhancing its safety culture.
BAF03
There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance.

Equality impact assessments:

The Serious Incident quarterly report is at the early stages ensuring that specific protected characteristics are examined, currently these include age, ethnicity and gender. The data in the report is recorded looking at these characteristics. This 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 below 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.

Year action due	No of SI open actions	No Overdue	Ongoing (In date)	Year to CGC
Urgent Care				
2022	3	3	0	
2023	5	5	0	
Acute Care				
2019	1	1	0	
2022	33	33	0	
2023	27	21	6	
2024	1	0	1	
No date in report	1	0	1	2023
Dementia & Frailty				
2017	1	1	0	
2021	3	3	0	
2022	7	7	0	
2023	5	0	5	
Specialties				
2023	2	1	1	
HMP				
2022	1	1	0	
2023	3	3	0	
Secure Care				
2023	2	0	2	
SOLAR				
No open actions				
Recovery				
2021	2	2		
No date in report	2	-	2	2022
Community				
2020	1	1	0	
2021	1	1	0	
2022	3	3	0	
2023	27	10	17	
No date in report	1	-	1	2021

8.3. Infection, Prevention & Annual Control Report

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**8.3**
PAPER TITLE	Infection Prevention & Control Annual Report 2022-23
DATE	4 October 2023
AUTHOR	Filipe Leitao, Lead Nurse for Infection Prevention and Control
EXECUTIVE SPONSOR	Sarah Bloomfield, Executive Director of Quality and Safety Steve Forsyth, Interim Director of Quality and Safety

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

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

Executive summary & Recommendations:

- Auditing program ongoing. Average audit score 89.9% for the financial year (amber)
- During the year1 case of C.diff was reported but non toxicogenic. RCA did not identify lapses in care
- Water safety review by ICB and High drop delivered – actions pending
- Improved Water Safety Planning and Management Practices in place
- FFP3 mask fit testing program finished – approved on IPCC option to source external face fitting – sourcing of this solution is still underway
- Mandatory mask use suspended after Q4 IPCC
- Mattress audit – 15% of mattresses were condemned
- Reduction trend on COVID outbreaks along the year (spike on Q3 but trend still reducing)
- Proposed IPC dashboard to inform IPC trajectory.
- Consider contracting food expert for the Trust.
- Support to IPC assurance strategy (with implementation of Dashboard, review of auditing strategy and review against Hygiene code completed)
- Review IPC workload and team structure/capacity
- Work towards re-enforce resilience across the Trust in relation to staff face fitted for FFP3
- Trust remains without food safety expert or decontamination officer

Reason for consideration:

GAIN ASSURANCE on IPC practice for Q4.

Previous consideration of report by:

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

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

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

- Financial implications on implementation of FFP3 face fitting program
- Financial implications on implementing IPC Dashboard and review of IPC team role and work plan.
- Financial implications on contracting food expert

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

- 036 - Risk associated with ill health because of the presence of legionella bacteria in the water systems – Moderate (12)
- 1290 - Risk of several outbreaks in different Trust settings due to current COVID pandemic – Moderate (9)
- 1508 - Increased risk of respiratory infections, in particular flu during winter due to lower exposure of staff and SU to respiratory viruses as a consequence of the respiratory protection measures in place – Moderate (9)
- 1717 - Risk of infection due to low compliance with FFP3 mask face fitting – Moderate (9)
- 1748 - Risk of errors on managing/storage of food in the Trust with associated potential consequences (e.g. food poisoning, listeria, etc.) – Moderate (9)
- 1752 - There is a risk of lower compliance with IPC requirements due to low staffing across the Trust – Moderate (9)
- 1031 - Use of carpets in clinical areas across the trust, including new buildings – Low (4)
- 1647 - Risk of spreading infection across different units due to no longer have staff movement restriction in COVID outbreak areas – Low (4)
- 1646 - Risk of escalating outbreaks or difficulty on controlling already identified outbreaks due to constant admission of new SU to outbreak areas – Very Low (2).

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Infection Prevention and Control

Annual Report 2022/23

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Executive Summary

The 2022/23 annual report outlines the Trust's continued commitment to minimising the risks of Healthcare Associated Infection (HCAI) on our services and to promote best practice in infection prevention and control, as well as the response to the COVID pandemic.

It details the activities undertaken by the Infection Prevention Partnership Committee (IPPC) and the Infection Prevention and Control team (IPCt) to lessen the risk of avoidable harm to service users and promote safe working practices for Trust staff and the measures put in place to minimise the disruption of services due to COVID as well as keeping staff, service users, contractors, and visitors safe.

It demonstrates collaborative working to ensure that national initiatives are incorporated into trust policies, procedures, and guidance to inform best practice and to improve health outcomes for our service users and the wider community.

The Trust has continued to monitor compliance with regulatory requirements and is assured through the IPPC that services are safely and effectively managed through receipt of quarterly reports on audit, training, and surveillance of incidents and outbreaks of infection.

The report follows the format of the Health and Social Care Act (2008) Code of Practice of the prevention and control of infections and related Guidance (Department of Health 2015) to demonstrate our compliance with the criteria and recommendations for 2022-2023 work plan to strengthen assurance.

Introduction

The IPC team workload has had a substantial challenge during this reporting period, in particular, due to the ongoing COVID pandemic and the path to a new type of normality.

The Trust has a contract with Public Health England Laboratory, Birmingham, to provide expert infection prevention and control advice by a Consultant Medical Microbiologist, referred to as the Trust Infection Control Doctor.

This report sets out the activity undertaken by the IPC team and the Infection Prevention Partnership Committee under the Executive Director of Quality and Safety (Chief Nurse) (DIPC).The report is not exhaustive of all work undertaken, focusing on the main areas of progress against the annual plan of work and items of note by exception.

1. Compliance with The Health Act 2008 Code of Practice on the prevention and control of infections and related guidance

The table below sets out the actions taken by the Trust to evidence compliance with the code of practice and actions for 2022/23 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of Trust compliance	Recommendation/action for 2023-24 work plan
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• Director for Infection Prevention and Control • Infection Prevention Partnership Committee (IPPC). • Annual Programme of Work. • Annual Audit Programme • Annual Report to Trust Board. • Quarterly report to Clinical Governance Committee. • Risk Register review ongoing and presented monthly at IPPC. • IPC champions programme • Policy, procedures, SOP's development and review programme • Water Safety Group (WSG) (quarterly and when needed and Water strategic meeting monthly). • Trust Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist.	1. Development of IPC Dashboard to aggregate IPC monthly audits performed by the clinical areas as well as hand hygiene and ensure compliance is met. 2. Revision of IPC community monthly audit to ensure it is still relevant and cascade the new tool to the relevant teams. 3. Acquire electronic system for management and records purpose for IPC (e.g., ICnet®), including recording and management of outbreaks – Single point of access for IPC information.

		• Access to microbiological testing	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	• Quarterly reports on cleanliness standards to IPPC • Annual PLACE inspections • Rapid Response team • Monitoring of contractors cleaning performance. • Cleaning Policy • Decontamination Policy. • Quarterly Dental Suite audits • Waste Management Policy • Access to Food Safety Advisor • Food Safety Policy • Water Safety Group • Control of Legionella Policy • IPC input to the built environment new build and refurbishment projects.	4. Auditing control of legionella policy requirements undertaken by the WSG. 5. Ensure learning points from water safety review are implemented. 6. Recruit food safety advisor or procure external service. 7. Recruit decontamination officer for the Trust
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	• Electronic prescribing. • Quarterly Antibiotic Audit Report to be presented at IPPC. • Trust antimicrobial guidance document. Access to microbiological advice.	8. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice (Chief Pharmacist); 9. Include SEPSIS awareness training for IPC champions; 10. Ensure Trust Pharmacist antimicrobial use report is presented quarterly to IPC committee.
4	Provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• IPC notice boards • Hand washing notices. • BBV (Blood borne Virus) Screening secure care • Close work with communications department to ensure adequate messages and information is available on internal and external sites – Currently reviewing internal and external pages.	11. Provide information to be cascaded to clinical areas with relevant information displayed on the IPC boards in the clinical areas – Discuss processes to ensure information continuous to be successfully cascaded. 12. Regular meetings with matrons/managers for IPC update (through weekly matrons meeting) 13. Review internal and external web page and discuss with Comms process to ensure

			the pages are curated and timely updated;
5	Ensure prompt identification of people who have or are at risk of developing infection so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people	• Electronic notification forms to the IPC team from RiO patient record. • Electronic pathology reports • Expert infection Control advice from the Trust IPCN's and contracted service of a Consultant Microbiologist. • Access to specialist TB service at Birmingham Chest Clinic. • BBV screening • Sepsis awareness of risk associated conditions such as pneumonia, urinary tract, and wound infections.	14. Ensure information given on training IPC champions is cascaded to the team – Discuss processes to make this feasible. 15. Keep support from band 6 nurse to monitor RIO notifications and lab results in a timely manner and ensure the adequate advice is given and information cascaded within the team. 16. Discuss team structure and staffing.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.	• IPC fundamental care e-learning for all staff on induction and updates. • Link worker training x3 per annum • Infection Control responsibilities included in job descriptions. • Infection control training of contractors included in estates and facilities report to IPPC (report in appendix).	• Discuss update of local risk assessments to ensure staff are aware of national guidance and enable to make informed risk assessments in the workplace. • Ensure FFP3 mask fitting program is continued and compliance is improved to ensure adequate coverage is achieved.
7	Provide or secure adequate isolation facilities.	• Ensuite bedrooms to most inpatient services. Dedicated toilet facilities made available in non-ensuite areas. • Management of Isolation Procedure in place and reviewed. • COVID testing on admission and day 3, 5-7 and according to National guidance.	17. IT development of a solution to capture and monitor isolation information/checklists (within the integrated solution proposed in point 1).
8	Secure adequate access to laboratory support as appropriate.	• Pathology services provided by Sandwell & West Birmingham Hospitals NHS Trust.	18. Consider reviewing contract. Currently our microbiologist works for PHE labs at Heartlands and the results go through City Hospital which can create challenges on communication since the microbiologist will not have access to the result.

9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	• Suite of procedures and policies aligned to the Trust Overarching Infection Prevention and Control Policy. • Annual plan of policy/procedure review in line with national standards and guidance and monitored through IPPC.	19. Policies/Procedures are reviewed according to annual plan of work.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	• Occupational Health provides vaccination at employment screening. • Flu Vaccination plan for employees. • Liaison with Birmingham Chest Clinic in response to staff exposure to TB. • Occupational Health activity reported to IPPC quarterly. • Monitor COVID cases in staff – Manage advice/ support; Prevalence (HR).	20. Occupational Health to provide input to Seasonal Flu Planning. 21. Occupational Health to support staff in vaccination as well as sharp injuries and any further needed support regarding infectious diseases.

2. Compliance with Key Performance Indicators

Standard	Progress
Compliance with national mandatory surveillance for bloodstream infection MSSA and E.coli.	*E. Coli Bacteraemia (1)* – Not multiresistant *Clostrifium diffcille (1)* - Non Toxicogenic
Zero tolerance of MRSA bloodstream infection, minimise rates of *Clostridium difficile* (C. diff)	*Nil to report*
Completion of Root Cause Analysis (RCA)/Post Infection Review (PIR) and other significant HCAI's within set time scales.	*Clinical reviews were undertaken in line with trust risk management policy in response to outbreaks of infection.*
Compliance with Hand Hygiene Audit. 95% threshold	*The Trust has met its overall compliance of 95%.*
Compliance with Antibiotic Audit. 80% Threshold	*Quarterly reports on usage and recommendations/actions presented to IPPC by Chief Pharmacist – No reports have been presented during the first 3 quarters. Report due for Q4 for the Q4 IPPC*
Compliance with national cleaning standards/British Standards 90% threshold.	*The Trust has consistently met its overall compliance of 90% or above.*

3. Training activity

3.1 Training delivered:

Q1	Q2	Q3	Q4
The IPC Champions webinar was delivered on 09/06/22. Topics covered were the new National standards of cleanliness, Tissue viability and infection control, Infection control news and updates (including regional surveillance and policy update); Monkey pox and COVID19 update and program of audits.	None	The IPC Champions webinar was delivered on 10/11/21. Topics covered: Update on COVID & Flu, Back to basics, National Cleaning standards & Decontamination. 02/10/2023 – Trust microbiologist provided a webinar open to all the Trust around Legionella awareness.	The IPC Champions webinar was delivered on 09/02/23, topics covered: Water safety, policy updates, regional surveillance, inoculation injuries, IPC board requirements, discussion on current IPC issues across the Trust.

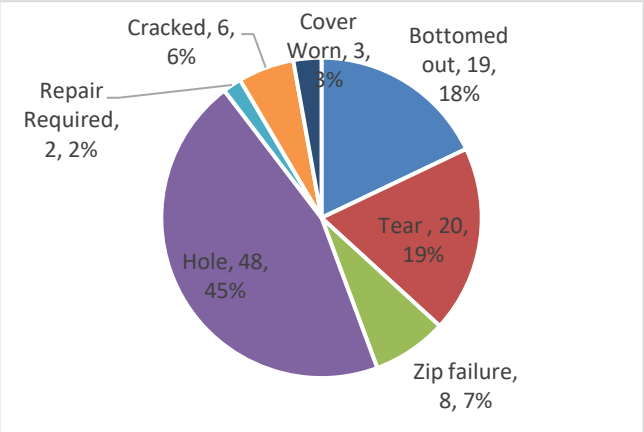
3.2 Training attended:

The IPC team continue to be an expert service to the Trust and have kept updated in their professional development as follows:

Q1	Q2	Q3	Q4
2/12/20 Transforming conversations – Building a Coaching Culture Mental Health and Covid-19 - Telling the Story in Mental Health Settings led by NHS England and NHS Improvement		27/10/2022 – Water safety Training LCA9010 (1 staff member) 02/11/2023 – Webinar – Legionella provided by Trust microbiologist (team) 13-14 December 2022 – Water Safety Training LCA9010 (1 staff member) 17-18 January 2023 – Water Safety Training LCA9010 (1 staff member)	10/01/2023 – Strength based Supervision (1 staff member) 07/03/2023 – NHSE session about Sepsis – 2 staff 08/02/2023 - Lunch and Learn – Mouth care matters – 1 staff

4. Annual Audit and Inspection Programme

Audit/Inspection	Findings	Recommendations/Actions
IPC Standards	The IPC team continued the IPC audit program above the established KPI of 5 audits per quarter, aiming at visiting all areas at least once during the financial year. A total of 119 audits were performed and 132 Covid target spot checks during the financial year. An agency IPC nurse has been recruited to ensure that IPC audits would still be performed as well as auditing outbreak sites as fast as possible and monitor action plans in place. This nurse has ceased working with the team during March 2023.	Cascading findings to Matrons and link workers and request action plan – Discuss communication routes to ensure flow of information is optimum. Involve estates and facilities on the audits and action plans – A recurrent meeting has been established between estates and facilities and IPC to discuss the challenges both teams face and find solutions to work together more closely. Cleaning roadshows have been put in place aimed at raising awareness about the new cleaning standards. Future aims will be having joint visits from estates and facilities and IPC to areas identified of higher concern. The framework for this is still being worked on. Monitoring improvements through inspections and actions in service area surveillance reports to IPPC Implement dashboard of IPC monthly audits and hand hygiene to ensure compliance is monitored and IPC is able to plan target auditing, including with the presence of representatives from estates and facilities. Continue to utilize the iAuditor platform for IPC audits. Consider looking at electronic auditing platforms for the wards with IT support.
Dental Suite Checks	Dental suits are open, however, AGP (aerosol generating procedures) only take place on Tamarind, since Reaside clinic does not have ventilation systems which guarantee the recommended air exchanges.	HTM 01-05 requirements to be designed into any new build/ upgrade.

Hand Hygiene	The quarterly hand hygiene overall trust score met the Threshold of 95%.	Hand Hygiene audits are now submitted monthly and weekly during outbreaks. Bare Below Elbows to be promoted across all staff groups. Review lonely work teams and consider removing them from list of teams to submit score. Discussion to happen at IPCC on mitigation measures when those teams are removed.
Cleaning Standards	Annual PLACE inspections exceeded the National Average scores in all six categories. Trust KPI of 90% consistently surpassed.	Actions monitored through IPPC where standards fall below those required.
Antibiotic Use	Antimicrobial use across the Trust is low and reflects the fact that in our client group, whilst there are infection risks, the incidence of infection is low compared to many other healthcare settings. All mental health services, in keeping with national guidance, have a responsibility to use antimicrobials judiciously. Antimicrobial audits suggest that antimicrobials are primarily used in line with the antimicrobial prescribing guidance.	Medicines Management Committee to be informed of audit results and support the improvements and optimise the low usage level. Antimicrobial report to be quarterly presented to IPPC.
Sharps Safety	Due to COVID the annual audit was postponed. The audit took place during Q3.	Sharps injuries and findings of the audit have been shared with IPC champions by including these findings in Q4 training. Findings shared through weekly matrons' meetings.
Mattress Inspection	Mattress audit was re-instated. Rejection rate was 15%, which is significantly high. This is particularly concerning to patient safety, not just from an IPC perspective but also tissue viability and health and safety of the service users.  	Matrons to continue to report against mattress standards/replacements in quarterly reports to IPPC. All wards to ensure that correct mattresses for service need are ordered. Mattresses to be stored off the floor. Needed discussion with matrons to understand why such a high rate of rejection was found during the inspection and prevent a repeated finding in the next audit. One of the contributing factors is likely related to the postponing of the audit during COVID pandemic.

Food Safety	Completion of annual food safety audits by an independent food safety advisor. The audit did identify issues that had been picked up in the previous year's audits (please see report attached). This may suggest monthly kitchen inspections are not being undertaken/not undertaken correctly.	Food safety expert conducted audits across the Trust. Matrons to keep updates on actions from inspections. Trust does not have a food safety adviser. IPC advises the Trust to recruit one, since currently the Trust has no staff with this expertise and relies on ad-hoc support from Amey.
Legionella Policy compliance	Water Safety Group (strategic and operational) in place There was an external review of IPC and Estates that now needs to be analised and an action plan put in place to ensure the lessons learned are incorporated in the daily practice. A new WSP is due for approval. At the present moment the elements of sampling and actioning results have been approved due to the urgency to have those in place.	Develop a regular weekly meeting with estates and IPC to ensure IPC is kept informed of all the new results and current situation. Currently there is a flood of emails that make it very difficult to follow up on results and have a clear picture of the situation. The WSP must ensure that it covers all necessary actions to be triggered automatically and extraordinary actions by IPC or meetings only occur if anything out of the expected/planned has occurred – this also needs to be clearly delimited in the WSP.

4.1 PLACE Scores

BSMHFT 2022 PLACE scores are included within Estates & Facilities IPC 2022-23 Annual Report – attached to this report.

4.2 Hand Hygiene

4.2.1 Inpatient

The Trust has consistently kept the Hand Hygiene score above the 95% threshold.

The table below provides average Hand Hygiene scores for 2022/23 for the hand hygiene audits performed monthly.

	2021/22	2022/23	Variance
Trust-overall score:	**97.2**	**97.5**	**+0.3**
Trust inpatients:	**97.4**	**97.6**	**0.2**
Community:	**97**	**97.4**	**+0.4**

Table 1 - Hand Hygiene Scores for 2021/22

To enable the hand hygiene to be adequately monitored in the areas and local training delivery, the IPC team provides regular training to staff. Hand hygiene training is always part of the training package offered to the IPC champions during the IPC champions days. The following table shows the hand hygiene specific trainings promoted by the IPC team:

Date of HH training	No attendees
09/06/2022	24
28/09/2022	2
29/09/2022	9
12/10/2022	7
10/11/2022	19
14/12/2022	1
20/01/2023	7
09/02/2023	12
22/02/2023	6
16/03/2023	1
22/03/2023	8

Table 2 - Hand Hygiene trainings delivered by the IPC team

By the end of the year there are 15 teams that reported not having the hand hygiene trainer, but this is a dynamic situation, and the IPC team has delivered training along the year to ensure new hand hygiene trainers were prepared to cover the gaps identified. Table 3 lists the teams that by the completion of this report were still outstanding an HH trainer:

ServiceArea	Site	Department
Integrated Community Care	Warstock Lane Health Centre	25Plus Adult ADHD Service
Primary Care & SPS	Ashcroft	BHM West
Secure Care	Reaside Clinic	Blythe
Secure Care	Ardenleigh	Coral
Urgent Care	Liaison Psychiatry	Liaison Psychiatry - City Hospital
Urgent Care	Liaison Psychiatry	Liaison Psychiatry - QE Hospital
Recovery	Northcroft	North AOT
Urgent Care	Oleaster	Place Of Safety
Integrated Community Care	Small Heath Health Centre	Primary Care Liaison Hub - East
Integrated Community Care	Northcroft	Primary Care Liaison Hub - North
Integrated Community Care	Longbridge	Primary Care Liaison Hub - South
Integrated Community Care	Orsborn House	Primary Care Liaison Hub - West
Urgent Care	Oleaster	Psychiatric Decision Unit
Secure Care	Reaside Clinic	Severn
Dementia & Frailty	John Black	Solihull HuB

Table 3 - Areas with no hand hygiene trainer

There are several teams with lone workers where undertaking hand hygiene audits is not possible. The IPC team has been working towards ensuring those teams have up to date training on hand hygiene, but the auditing will not be possible do to the fact they are lone working teams and, therefore, they would be auditing themselves, which fails to give us any assurances. A discussion needs to be held to find an alternative way to gain the required assurance from those teams since auditing monthly is not feasible. This will be taken to the next IPCC to discuss options.

4.2.2 Reasons for non-compliance

The main reasons for non-compliance with hand hygiene were:

- Staff member not bare below the elbows.
- Issues with hand hygiene technique.
- Use of false nails or nails varnish.
- Use of watches/bracelets/jewellery

All issues were addressed with reinforcement of training and surveillance. The most common issues are related to false nails/varnish and staff not being bare below the elbows.

The hand hygiene audits' frequency kept increased to monthly to ensure a higher level of assurance.

There have been challenges with the submission of hand hygiene audit results with some teams. This has been escalated.

The auditing results report is generated in a format that makes the monitoring difficult. The IPC team Will be implementing a dashboard to aggregate all scores monthly for hand hygiene allowing an easier and more accurate follow up of the audit results and as a consequence enabling a more curate approach on the support given to the areas.

4.3 IPC auditing program

During this year the IPC team had the support of an agency IPC nurse, allowing us to increase the auditing program and the number of support visits performed. The IPC team undertook a total of 119 (from 59 last year) audits and 132 COVID Spot checks as can be seen on the table below:

Area	Quarter	Score	Type
Northcroft - North HTT	Q2	85.64%	Community
Endeavour Court	Q2	94.03%	Inpatient
Reservoir Court	Q2	88.65%	Inpatient
Endeavour House	Q2	86.50%	Inpatient
Northcroft	Q2	84.47%	Community
Ashcroft - west Hub CMHT	Q2	77.54%	Community
Ashcroft - Birmingham Healthy Minds - Perinatal	Q2	86.40%	Community
Ashcroft - Birmingham Healthy Minds	Q2	82.40%	Community
Juniper Centre - Bergamot	Q2	95.28%	Inpatient
Juniper Centre – Sage	Q2	87.34%	Inpatient
Juniper Centre - Rosemary	Q2	89.79%	Inpatient
Adams Hill	Q2	85.97%	Community
Reservoir Court - CMHT	Q2	76.89%	Community

Juniper Centre - Rosemary	Q2	85.81%	Inpatient
Grove Avenue	Q4	80.21%	Inpatient
Oleaster – Caffra	Q4	85.21%	Inpatient
Oleaster - Magnolia	Q4	98.94%	Inpatient
Oleaster - Tazetta	Q4	91.99%	Inpatient
Oleaster - Melissa	Q4	91.13%	Inpatient
Oleaster - Japonica	Q4	88.63%	Inpatient
Dan Mooney House	Q4	87.35%	Inpatient
Ardenleigh - Adriatic	Q4	94.21%	Inpatient
Ardenleigh - Pacific	Q4	94.06%	Inpatient
Ardenleigh - Atlantic	Q4	94.21%	Inpatient
Ardenleigh - Citrine	Q4	89.78%	Inpatient
Ardenleigh - Coral	Q4	93.00%	Inpatient
Rookery Gardens	Q4	98.71%	Inpatient
David Bromley house	Q4	85.01%	Inpatient
Mary Seacole - Ward 1	Q4	81.47%	Inpatient
Oleaster South East HTT	Q4	81.72%	Community
Oleaster South West HTT	Q4	83.06%	Community
Reaside First	Q4	78.23%	Community
Ardenleigh - Adriatic	Q4	86.15%	Community
Hertford House	Q4	96.27%	Community
Zinnia CMHT	Q4	90.96%	Community
Callum Lodge	Q4	86.39%	Community
Ashcroft	Q4	91.41%	Community
Ashcroft Perinatal	Q4	87.30%	Community
Longbridge CMHT	Q4	91.15%	Community
Warstock Lane CMHT	Q4	85.25%	Community
Lyndon CMHT	Q4	85.67%	Community
Reservoir Court - North Hub	Q4	91.80%	Community
Oleaster – Caffra	Q3	87.52%	Inpatient
Oleaster - Tazetta	Q3	85.06%	Inpatient
George Ward	Q3	86.23%	Inpatient
Oleaster - Tazetta	Q3	85.16%	Inpatient
Oleaster - Melissa	Q3	88.53%	Inpatient
Oleaster - Japonica	Q3	88.10%	Inpatient
Oleaster - Magnolia	Q3	92.06%	Inpatient
Eden Acute	Q3	88.85%	Inpatient
Eden PICU	Q3	84.89%	Inpatient
Endeavour House	Q3	90.36%	Inpatient
Endeavour Court	Q3	90.54%	Inpatient
Reservoir Court	Q3	82.78%	Inpatient
Zinnia - Lavender	Q3	73.20%	Inpatient

Zinnia - Saffron	Q3	89.78%	Inpatient
Grove Avenue	Q3	83.42%	Inpatient
Newbridge House	Q3	83%	Inpatient
Little Bromwich	Q3	92%	Inpatient
Newbridge house – Perinatal	Q3	90.24%	Community
Dan Mooney House	Q3	79.14%	Inpatient
Freshfields	Q3	95.16%	Community
Hertford House	Q3	86.94%	Community
Sycamore	Q3	80.52%	Inpatient
Hibiscus	Q3	73.18%	Inpatient
Acacia	Q3	82.87%	Inpatient
Laurel	Q3	82.42%	Inpatient
Lobelia	Q3	85.56%	Inpatient
Cedar	Q3	89.71%	Inpatient
Larimar	Q3	74.93%	Inpatient
Rookery Gardens	Q3	65.77%	Inpatient
Myrtle	Q3	86.97%	Inpatient
Forward House	Q3	81.11%	Inpatient
Tourmaline	Q3	88.28%	Inpatient
Coral	Q3	84.99%	Inpatient
Citrine	Q3	88.77%	Inpatient
Rosemary	Q3	84.13%	Inpatient
Bergamot	Q3	89.39%	Inpatient
Atlantic	Q3	84.05%	Inpatient
Pacific	Q3	84.66%	Inpatient
Osborne House	Q3	87.15%	Community
Orchard House	Q3	90.37%	Community
Handsworth & Ladywood HTT	Q3	80.44%	Community
Aston CMHT	Q3	78.10%	Community
Adriatic	Q3	73.19%	Inpatient
Berberry - Vetiver	Q1	90.06%	Community
Oleaster Caffra	Q1	86.26%	Inpatient
Oleaster Tazetta	Q1	92.98%	Inpatient
Oleaster Japonica	Q1	90.98%	Inpatient
Oleaster Melissa	Q1	92.35%	Inpatient
Oleaster Magnolia	Q1	90.92%	Inpatient
George Ward	Q1	88.36%	Inpatient
Tamarind Sycamore	Q1	94.49%	Inpatient
Tamarind Myrtle	Q1	94.21%	Inpatient
Small Heath Day Service	Q1	75.53%	Community
Small Heath CMHT	Q1	76.60%	Community
Tamarind Hibiscus	Q1	95.13%	Inpatient

Tamarind Lobelia	Q1	96.32%	Inpatient
Tamarind Laurel	Q1	93.40%	Inpatient
Tamarind Acacia	Q1	93.51%	Inpatient
Tamarind Cedar	Q1	97.11%	Inpatient
Eden Acute	Q1	79.54%	Inpatient
Eden PICU	Q1	78.17%	Inpatient
Small Heath AOT	Q1	76.26%	Community
Juniper Centre South CMHT	Q1	84.77%	Community
Zinnia Central HTT	Q1	83.27%	Community
Zinnia CMHT	Q1	55.22%	Community
Zinnia Day Services	Q1	76.82%	Community
Zinnia Lavender	Q1	88.53%	Inpatient
Zinnia safron	Q1	85.51%	Inpatient
Osbourne House Outpatients	Q1	81.15%	Community
Osbourbe House Handsworth &Ladywood HTT	Q1	77.01%	Community
Oleaster HTT East & West	Q1	82.39%	Community
Mary Seacole House – Ward 1	Q1	81.46%	Inpatient
Mary Seacole House – Ward 2	Q1	89.04%	Inpatient
Meadowcroft	Q1	80.91%	Inpatient
Newbridge House	Q1	90.06%	Inpatient
Recovery Near You - Wolverhampton addictions	Q1	75.52%	Community
Hillis Lodge	Q1	91.04%	Inpatient
Average		**86.05%**	

Table 4 - Audits undertaken by IPC team

And the IPC Spot Checks:

Area	Quarter	Score
Reaside Trent	Q1	72.00%
Reaside Swift	Q1	88.00%
Northcroft Reservoir Court	Q1	88.00%
Ardenleigh Tourmaline	Q1	80.00%
Juniper Bergamot	Q1	100.00%
Northcroft Eden Acute	Q1	73.08%
Reaside Swift	Q1	88.46%
Reaside Severn	Q1	80.77%
Reaside Trent	Q1	100.00%
Ardenleigh Tourmaline	Q1	92.31%
Juniper Bergamot	Q1	92.31%
Reaside Swift	Q1	84.62%
Reaside Trent	Q1	76.92%
Reaside Severn	Q1	84.62%

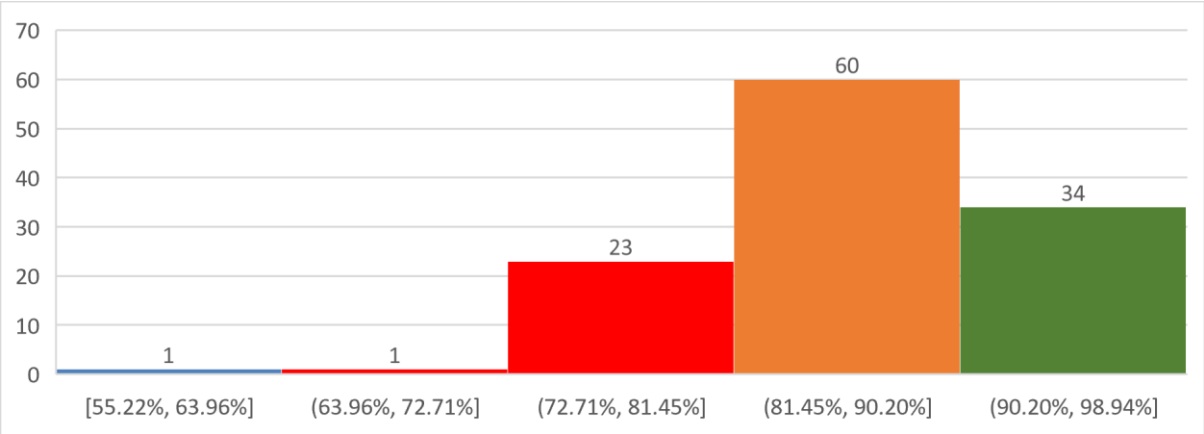
Northcroft Eden acute	Q1	88.46%
Northcroft Reservoir Court	Q1	100.00%
Ardenleigh Tourmaline	Q1	96.15%
Northcroft Eden Acute	Q1	76.92%
Northcroft Reservoir Court	Q1	100.00%
Ardenleigh Tourmaline	Q1	96.15%
Reaside Dove	Q1	96.15%
Reaside Severn	Q1	100.00%
Reaside Swift	Q1	92.31%
Juniper BErgamot	Q1	96.15%
Mary Seacole Ward 1	Q1	65.39%
Mary Seacole Ward 1	Q1	51.85%
Mary Seacole Ward 1	Q1	88.46%
Mary Seacole Ward 1	Q1	100.00%
Ardenleigh Coral	Q1	88.46%
Oleaster Japonica	Q1	92.31%
Ardenleigh Coral	Q1	100.00%
Oleaster Japonica	Q1	100.00%
Barberry Chamomile	Q1	92.31%
Barberry Cilantro	Q1	88.46%
Meadowcroft ICU	Q1	92.31%
Reaside Swift	Q4	96.15%
Juniper Bergamot	Q4	96.15%
Tamarind - Hibiscus	Q4	92.31%
Tamarind Lobelia	Q4	96.15%
Tamarind Hibiscus	Q4	100.00%
Tamarind Lobelia	Q4	89.19%
Reaside Trent	Q4	97.30%
Juniper Bergamot	Q4	81.08%
Oleaster Melissa	Q4	89.19%
Reaside Trent	Q4	100.00%
David Bromley House	Q4	97.30%
Oleaster Melissa	Q4	89.19%
Oleaster Tazetta	Q4	91.89%
Juniper Bergamot	Q4	78.38%
Juniper Bergamot	Q4	94.60%
Oleaster Tazetta	Q4	97.30%
Oleaster Melissa	Q4	94.60%
David Bromley House	Q4	94.60%
Larimar	Q4	86.49%
Larimar	Q4	89.19%
Tamarind Laurel	Q3	61.54%
George Ward	Q3	80.77%
Dan Mooney House	Q3	84.62%

Tamarind Myrtle	Q3	96.15%
Tamarind Myrtle	Q3	100.00%
Hillis Lodge	Q3	76.92%
Dan Mooney House	Q3	100.00%
George Ward	Q3	76.92%
Hillis Lodge	Q3	88.46%
George Ward	Q3	96.15%
Reservoir Court	Q3	92.31%
Urgent Care Oleaster	Q3	88.46%
Reservoir Court	Q3	84.62%
Maple Leaf Centre	Q3	92.31%
Ardenleigh Tourmaline	Q3	76.92%
Endeavour Court	Q3	88.46%
Endeavour COurt	Q3	100.00%
Oleastra Caffra Unit	Q3	62.96%
Oleaster Melissa	Q3	84.62%
Oleaster Caffra	Q3	76.92%
Endeavour Court	Q3	100.00%
Caffra Unit	Q3	84.62%
Oleaster Melissa	Q3	65.39%
Barberry Chamomile	Q3	88.46%
Barberry Chamomile	Q3	93.10%
Endeavour House	Q3	100.00%
Endeavour House	Q3	80.77%
Reaside Swift	Q3	100.00%
Juniper Bergamot	Q3	96.15%
Tamarind - Myrtle	Q2	84.62%
Tamarind - Cedar	Q2	80.77%
Northcroft George Ward	Q2	96.15%
Northcroft - Eden PICU	Q2	77.78%
Barberry - Cilantro	Q2	96.15%
Small Heath AOT	Q2	79.31%
Small Heath Day Service	Q2	93.10%
Mary Seacole House - Meadowcroft ICU	Q2	84.62%
Mary Seacole House - MSH Ward 2	Q2	79.31%
Mary Seacole House - MSH Ward 1	Q2	92.31%
Osborne House - Handsworth &Ladywood CMHT	Q2	78.57%
Northcroft - Eden PICU	Q2	100%
Tamarind Centre - Cedar	Q2	100%
Tamarind Centre - Myrtle	Q2	100%
Small Heath CMHT	Q2	96.55%
Osborne House - Handsworth &Ladywood CMHT	Q2	82.76%
Mary Seacole House - MSH Ward 2	Q2	81.48%
Reaside Avon	Q2	92.59%

Reaside Avon	Q2	92.31%
Tamarind Centre - Acacia	Q2	88.46%
Mary Seacole House - MSH Ward 2	Q2	84.62%
Reaside - Kennet Ward	Q2	77.78%
Juniper Centre - Rosemary	Q2	62.96%
Juniper Centre - Bergamot	Q2	96.15%
Reaside - Kennett	Q2	96.15%
Reaside - Avon	Q2	96.00%
Tamarind Centre - Acacia	Q2	59.26%
Juniper Centre - Rosemary	Q2	88.46%
Juniper centre - Bergamot	Q2	80.77%
Newbridge House	Q2	48.15%
Oleaster - Tazetta	Q2	80.77%
Dan Mooney House - Dan Mooney	Q2	74.07%
Newbridge House	Q2	96.15%
Northcroft - George Ward	Q2	65.29%
Oleaster - Tazetta	Q2	96.15%
Dan Mooney House - Dan Mooney	Q2	85.19%
Northcroft - Endeavour House	Q2	73.08%
Oleaster - Tazetta	Q2	92.31%
Northcroft - Endeavour House	Q2	96.15%
Oleaster - Melissa Unit	Q2	88.46%
Japonica - Oleaster	Q2	85.19%
Japonica - Oleaster	Q2	92.31%
Oleaster - Melissa Unit	Q2	88.46%
Juniper Centre - Rosemary	Q2	96.15%
Tamarind Centre - Laurel	Q2	100%
Little Bromwich Centre	Q2	82.86%
Little Bromwich Centre - CMHT	Q2	79.31%
Juniper Centre - Rosemary	Q2	88.46%
Average		**87.87%**

Table 5 – IPC Spot Checks by IPC team

The result distributions is as follows:



Graphic 1 - Histogram audit score distribution along the finatial year

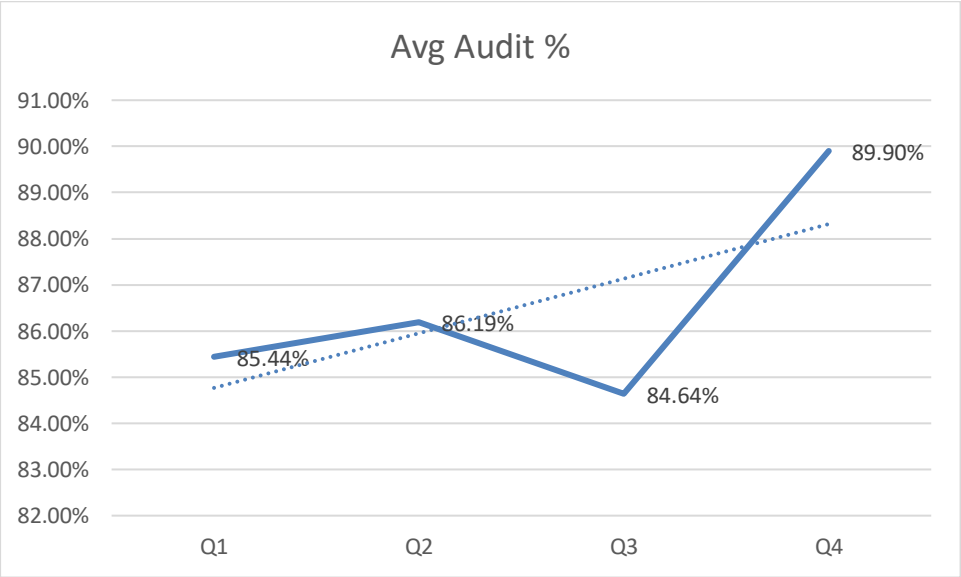
As can be seen in the above histogram, most of the results are above 81% and under 90% positioning them in amber. The second highest category is above 90.2% followed by under 80% (red).

When looking at the audit results we had an overall average score of 86.05%, therefore under the aim of 90%, nonetheless the distribution per quarter is as follows:

Quarter	Avg Audit %
Q1	85.44%
Q2	86.19%
Q3	84.64%
Q4	89.90%

Table 6 - Average audit score per quarter

And the following graphic:



Graphic 2 - Average audit score per quarter

According to this information there is a growing trendline and by the end of Q4 the auditing score average was 89.9%, therefore 0.10% under the 90% goal. This represents a shift from quarter 1 of 4.46%, which is small but significant. More targeted work will need to be developed across the new financial year, in particular finding more accurate and reliable ways to identify areas of concern so that

IPC support can be targeted, maximizing the use of resources were they are more needed. The actual model aimed at visiting all the clinical areas during the year and plan revisits according to the scores and level of concern resulted from the audit. A shift on the current paradigm is needed where clinical areas are responsible to undertake the audits and needed assurances and IPC team is able to analyse and determine were to direct its resources to achieve better outcomes.

For this to become possible, it is essential the implementation of an assurance dashboard were monthly all IPC local audits are collected as well as the results of the hand hygiene scores. Allowing to monitor the areas compliance with auditing the scores and more easily identify areas that will need further support.

5. External Inspections and Audit

5.1 Water Safety Review

Issues were identified within the water management in the Trust, following this a review was carried out by the ICB/ Hydrop on request of the Trust. Findings of the review have been received by the ICB.

The water safety group will produce an action plan to address issues identified from the review once both reports are received.

The findings of the review undertaken by the ICB were:

- Gap in systems and or process for accessing and viewing sampling dates.
- The IPC team and E&F working relationships and communication processes in relation to water safety including actions taken by whom and when require strengthening.
- There is little or no evidence to support that the IPC advice and recommendations are actioned by clinical staff.
- The process for completing legionella patient risk assessment requires clarity, including who completes these, when are these done, when are they reviewed and how are they accessible to all relevant parties.
- The process for completing legionella patient risk assessment requires clarity, including who completes these, when are these done, when are they reviewed and how are they accessible to all relevant parties.
- Governance processes and strategic oversight relating to water safety are unclear.
- written evidence to support running and flushing activity is inconsistent and is not always available for the IPC team to view.
- Clarity is required on management of positive clinical results and processes that support escalation of IPC concerns i.e. what triggers escalation, who is informed and by what route etc.

The recommendations from the report were:

1. A live, up to date, single, centralised, accessible system that is regularly monitored. This system is to be accurate, auditable, and organised. Clear communication and process to ‘close the loop’, with evidence to support timely reporting and actions taken.

2. Clarity in water safety plan and water safety group terms of reference (TOR) for IPC and E&F roles and responsibilities. Again, this record of communication needs to be accessible and auditable.

3. A written, clear operating procedure/process to support action in response to a service user/individual who develops respiratory symptoms, testing requirements and if they test positive for legionella, who is this reported to and what are the next steps. This should be reflected in relevant IPC policies i.e. outbreak, overarching, flu etc. and the water safety plan.
4. Sampling requirements, results, actions, flushing and running evidence to be presented at water safety group for monitoring.

Training activity to be evidenced, monitored and presented at IPC committee and water safety group.

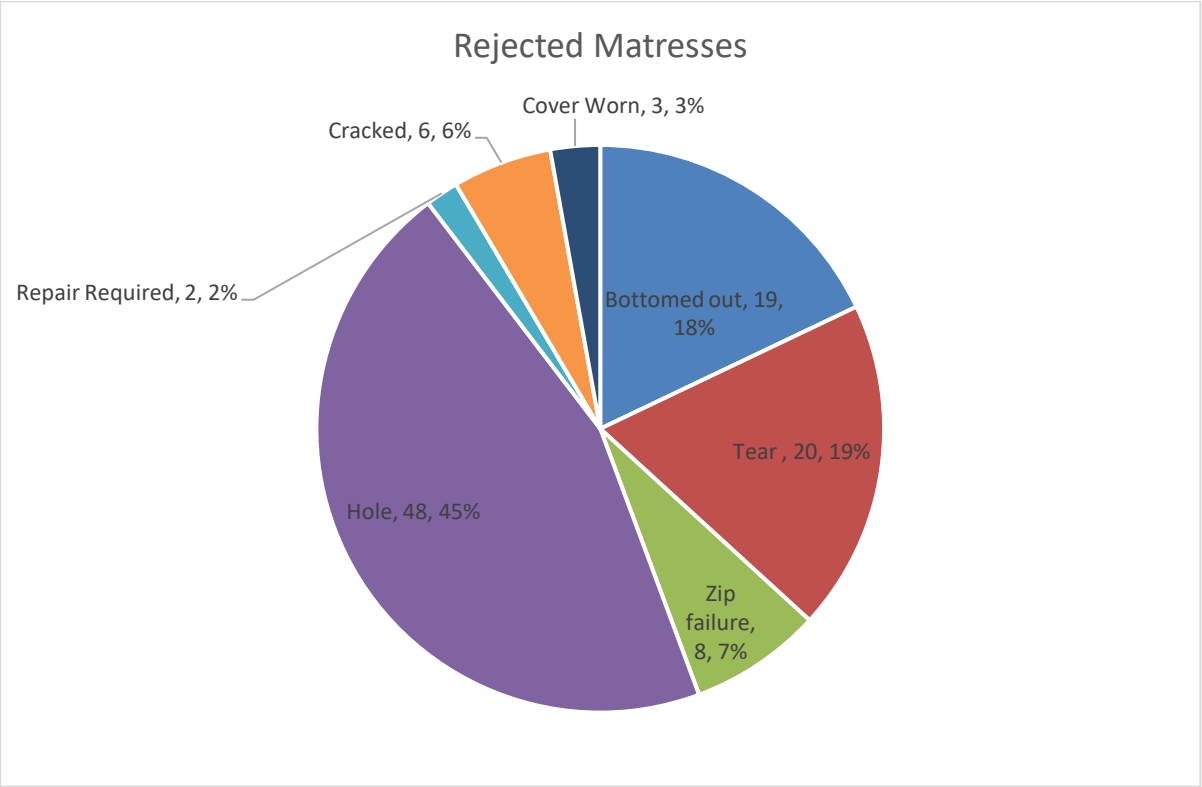
Following this report the IPC team produced comments to each recommendation and started to develop actions for some of those points, but this will need a wider working group to be implemented.

The following summarize the preliminary IPC comments:

1. The IPC team agrees, and we has suggested to Estates in several meetings that information regarding water management should be held in a centralised record, easily accessible by anyone that needs access to it. This should also apply to flushing records, as this is only shared with IPC by request. It would be ideal if this system allowed the IPC team to add notes in a similar fashion to other clinical systems in the Trust. The IPC team are sent numerous emails from the Estates team and it is very challenging to ensure continuity of case management/high counts of Legionella.
2. Clear actions need to be established – WSP in development. Actions must be guided by the water safety plan – any additional meetings must only be held in exceptional circumstances. Clear lines of action are needed to prevent any delays and ensure patient safety.
3. IPC Lead is ensuring that IPC activity in relation to water safety is part of the IPC team quarterly reports to IPC committee, as well as including this as an agenda item at water safety group. IPC Lead has written a clear operating procedure to support action in response to a service user/individual who develops respiratory symptoms, testing requirements and if they test positive for legionella, who is this reported to and what are the next steps, to be presented to the next IPCC for discussion and eventual approval.
4. Estates colleagues must come to IPC committee and present sampling results, actions, flushing and running evidence. A more robust system needs to be developed regarding water running logs, as these are kept locally at present.
5. It is not the IPC team's responsibility to monitor the training of Estates colleagues. According to the proposed WSP there is training for Trust Microbiologist and IPC team lead (management) that needs to be clarified.

5.2 Mattress Audit

Mattress audit conducted during March, in the week commencing 13/03/2023. 709 mattresses have been audited with 106 rejected (15%), which is a very significant number of mattresses. This brings concerns on how the quality of the SU mattresses is being monitored at ward level. The reasons for rejected mattress were:



The mattress audit result will be discussed during the next IPPC on 26th of April with the aim of understanding why such a significative number of mattresses were rejected, and why these findings had not taken place in local audits. We also need to have robust assurance in place regarding mattress audits, to ensure that faulty mattresses are identified and replaced mattresses when they are not of the required standard.

Some mattresses were found to have been condemned in the past, but not replaced. This is concerning and something that we also need to see addressed going forward.

The COVID pandemic may go some way to explain these findings, as some aspects of clinical work haven't been given the due priority needed due to the focus on the pandemic and outbreak management.

5.3 Sharps Audit

The Infection, Prevention & Control Team at Birmingham & Solihull Mental Health Trust requested that Daniels Healthcare undertake a sharps safety audit of their sites. The Daniels Healthcare auditor(s) undertook the survey in June 2022.

The following areas were audited:

1	OSBOURNE HOUSE	46	OUTPATIENTS
2	ASHCROFT COMMUNITY	47	LONGBRIDGE COMMUNITY
3	MARY SEACOLE	48	REASIDE CLINIC
4	WARD 1/2	49	SWIFT
5	MEADOWCROFT	50	KENNETT
6	NORTHCROFT	51	TRENT
7	EDEN - MALE	52	BLYTHE

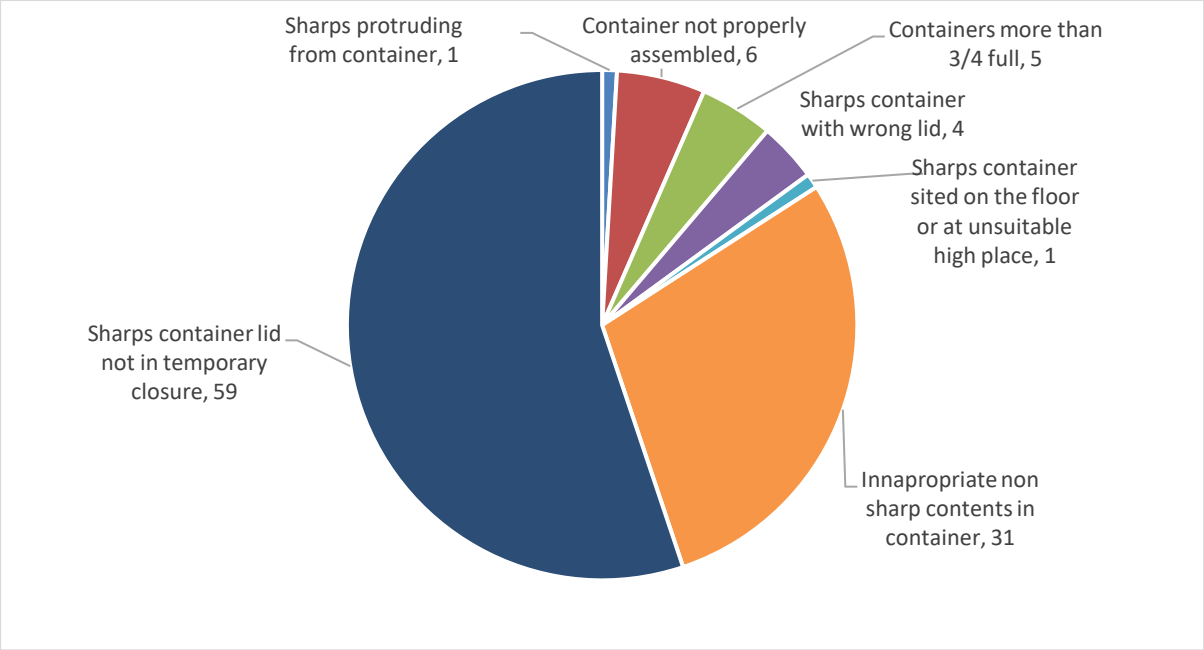
8	EDEN - PICU	53	AVON
9	GEORGE WARD	54	SEVERN
10	HOME TREATMENT/ASSERTIVE OUTREACH	55	DOVE
11	COMMUNITY	56	GP ROOM DENTIST
12	RESERVIOR COURT COMMUNITY	57	HILIS LODGE
13	RESERVIOR COURT IMPATIENTS	58	WARSTOCK LANE
14	ENDEAVOUR COURT	59	SMALL HEATH CENTRE
15	ENDEAVOUR HOUSE	60	DAN MOONEY
16	FORWARD HOUSE	61	DAVID BROMLEY
17	ARDENLEIGH	62	LYNDON CENTRE ASSERTIVE/COMMUNITY
18	ROOKERY GARDENS	63	HERTFORD HOUSE
19	LARIMAR	64	MAPLE LEAF
20	TAMARIND CENTRE	65	CLINIC A
21	NEWBRIDGE	66	CLINIC B
22	LITTLE BROMWICH	67	CLINIC C
23	OLEASTER	68	NEWINGTON CENTRE
24	COMMUNITY	69	
25	MAGNOLIA	70	
26	TAZETTA	71	
27	CAFFRA	72	
28	JAPONA	73	
29	MELISSA	74	
30	BARBERRY CENTRE	75	
31	JASMIN	76	
32	CILANTRO	77	
33	CHAMOMILE	78	
34	OUTPATIENTS	79	
35	VETIVER	80	
36	MOSELEY HALL	81	
37	OUTPATIENTS	82	
38	BERGAMOT	83	
39	ROSEMARY	84	
40	SAGE	85	
41	GROVE AVENUE	86	
42	ZINNIA CENTRE	87	
43	HOME TREATMENT	88	
44	SAFFRON	89	
45	LAVENDER	90	

The object of the site survey was to establish whether or not sharps are disposed of in a safe manner, containers are correctly used from the point of storage, assembly, security during use and dispose as well as if they are being used for the correct purposes.

The method used was to visit wards and departments and observe existing practices.

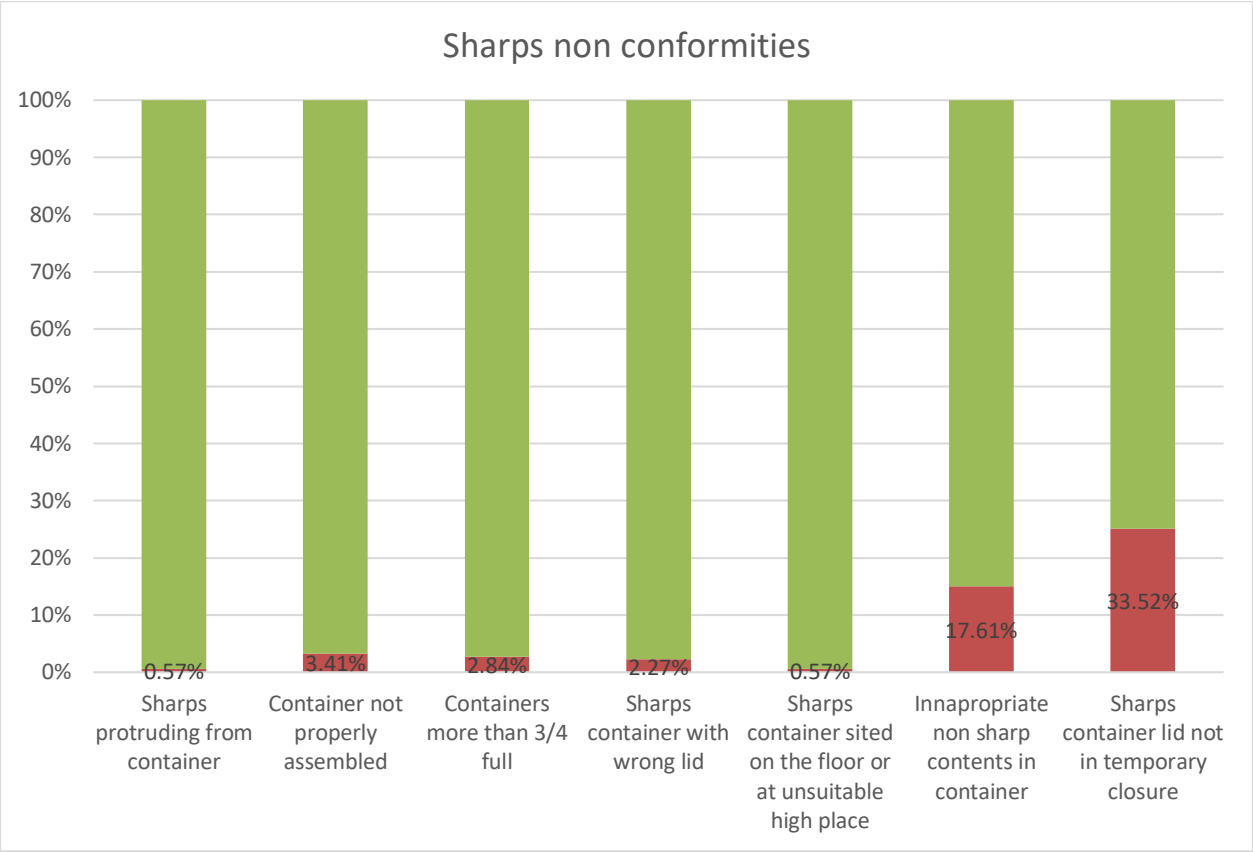
64 Wards/Departments were visited during the audit and 176 sharps containers were sighted.

The findings of the audit were:



Graphic 3 - Findings Sharps Audit

Looking at this information from a percentage perspective we can see in the following graphic:



Graphic 4 - Relative % findings sharps audits

The most significative finding was sharps bins not in temporary closure with 33.52% of the audited containers non compliant – This finding is in line with findings during IPC visits.Followed by finding of inappropriate non sharp contents in the bins. These findings will be addressed in future trainings for IPC champions and have been shared during the matrons meetings.

During IPC visits the sharps compliance is always monitored and on spot education is given as well as escalated as part of the wider audit to the ward manager and matron/manager.

6. Surveillance of Alert Organisms and Outbreaks

The IPC team have responded to numerous inquiries on the management of potential and actual infectious organisms; the following is a summary of the activity of individual cases and outbreaks.

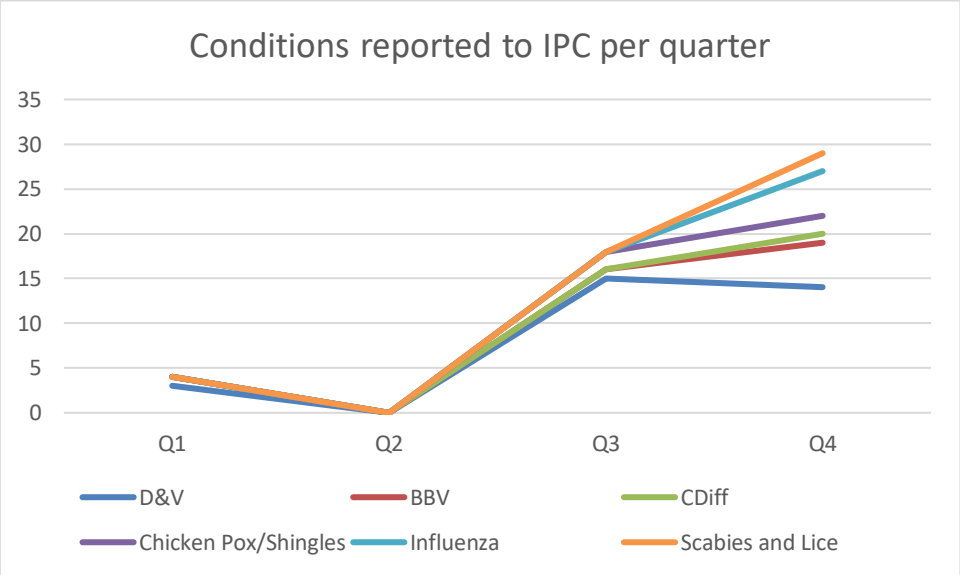
6.1 Total number of organisms reported

We had a total of 98 reports of infection (excluding MRSA and COVID related).

The following table and graphic shows the conditions reported to IPC during the financial year as well as the following graphic.

Organism/Condition	Q1	Q2	Q3	Q4	Grand total
D&V	3		15	14	32
BBV	1	0	1	5	7
CDiff				1	1
Chicken Pox/Shingles			2	2	4
Influenza				5	5
Scabies and Lice				2	2

Table 7- Conditions reported during the financial year



Graphic 5 - Conditions reported during the finantial year

D&V had the highest prevalence, flollowed by blood borne virus infections (BBV) and influenza.

On what concerns to D&V there does not seem to be a patter in the cases with exception than that most of the cases were reported during the last 2 quarters of the year, likely as a reflection of the ease of the Covid pandemic and the progressive returned to as close as possible to normality.

In the next table is the distributions of cases of D&V along the quarters:

Service area	Sites with D&V	Q1	Q2	Q3	Q4
Secure Services & Offender Health	Blythe				1
Acute & Urgent Care Services	Tazetta				1
Secure Services & Offender Health	Pacific				1
Secure Services & Offender Health	Lobelia				1
Secure Services & Offender Health	Tourmaline				1

Acute & Urgent Care Services	Endeavour House			1	
Primary Care & Dementia Services	Reservoir Court			2	2
Acute & Urgent Care Services	Chamomile	3		2	2
Primary Care & Dementia Services	Rosemary			1	
Primary Care & Dementia Services	Sage			1	
Secure Services & Offender Health	Coral			2	
Acute & Urgent Care Services	Jasmine			1	
Secure Services & Offender Health	Laurel				1
Acute & Urgent Care Services	Dan Mooney				1
Acute & Urgent Care Services	Grove Avenue				1
Primary Care & Dementia Services	Bergamot				2
Integrated Community Care & Recovery	Rookery Gradens				3
Secure Services & Offender Health	Hillis Lodge				2

Table 8- Cases of D&V per quarter in each clinical area and site

The following table summarizes all the microorganisms detected and reported to IPC for advice during the year:

Microorganism	Q1	Q2	Q3	Q4	Totals
E.Coli (urine)	8	2	8	11	29
E. Coli (Feaces)				1	1
Citrobacter koseri - UTI	1				1
Enterococcus faecalis	1	1	1		3
Acinetobacter nosocomialis in urine				1	1
Beta Haemolytic Streptococcus Group C		1			1
Candida Albicans		1			1
Carbapenemase producing Enterobacteriaceae			1		1
Citrobacter koseri	1		2	1	4
Enterobacter Cloacae		1	3		4
Enterococcus faecalis		1	1		2
Haemophilus Influenzae			1		1
Hepatitis E			1		1
Hepatitus B				1	1
HIV1&2Antibody positive				1	1
Klebsiella oxytoca in urine		1		2	3

Klebsiella pneumoniae			2		2
Morganella Morganii			1		1
Proteus Mirabilis - UTI	1	1	1	1	4
Respiratory syncytial (sin-SISH-uhl) virus, or RS			1		1
Serratia marcescens			1		1
Sputum Stenotrophomonas maltophilia			1		1
Staphylococcus aureus		1	2	3	6
Streptococcus agalactiae		3	1	1	5
Syphillis			1	1	2
Threadworms			1		1
	12	**13**	**30**	**24**	**79**

Table 9 - Microorganisms reported to IPC during the finantial year

All reported cases had IPC advice and follow-up as needed.

6.2 Outbreaks (non-COVID)

No non-COVID related outbreaks declared.

6.3 MRSA Admission Screening

According to the Health and Social Care Act, the Trust continues to have management systems to ensure that MRSA colonisation is promptly identified. This includes screening patients admitted from other healthcare settings or have existing wounds or indwelling devices that could increase the risk to both the individual and other vulnerable patients of developing an MRSA infection. We had no patients MRSA colonised on admission.

7. COVID-19

The first confirmed cases of COVID-19 in the UK were on 29th January 2020, followed by more cases on the 6th of February. The first suspected patient case recorded in BSMHT was on 2nd March 2020, before the scope of the current report.

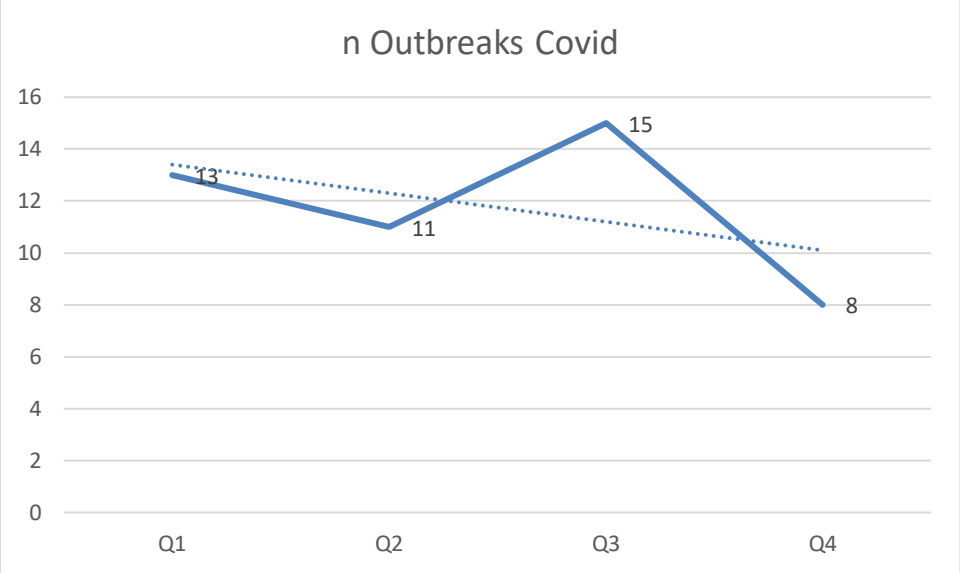
The IPC team was given continuous support of an extra staff members to cooperate with surveillance and local advice, freeing the team to provide specialised support to all Trust departments. The agency nurse that was supporting the team has ceased cooperation from the end of March 2023

8.1 Reported outbreaks

We reported a total of 47 outbreaks (+12 than last year). The following table and graphic illustrates the number of outbreaks per quarter:

Quarter	n Outbreaks Covid
Q1	13
Q2	11
Q3	15
Q4	8

Table 10 - Outbreaks per quarter



Graphic 6 - Covid outbreaks per quarter and trend

These findings come in line with what was the reality in the health economy during the year, with a sharp increase in the number of outbreaks during Q3 and a decrease from January. The sharp increase during the last months of the civilian year justified the re-instate of masks.

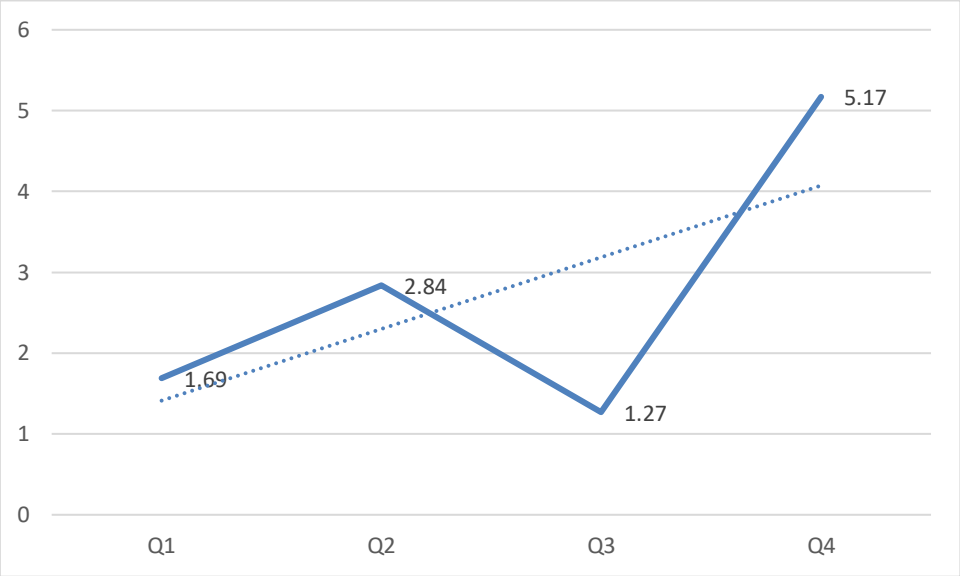
The use of masks topic will be discussed along this report.

A total of 239 SU (service users) have been affected during the outbreaks and 116 staff members:

Row Labels	Sum of SU affected	Sum of Staff affected
Q1	61	36
Q2	54	19
Q3	62	49
Q4	62	12
Grand Total	**239**	**116**

Table 11 - SU and Staff affected during COVID outbreaks

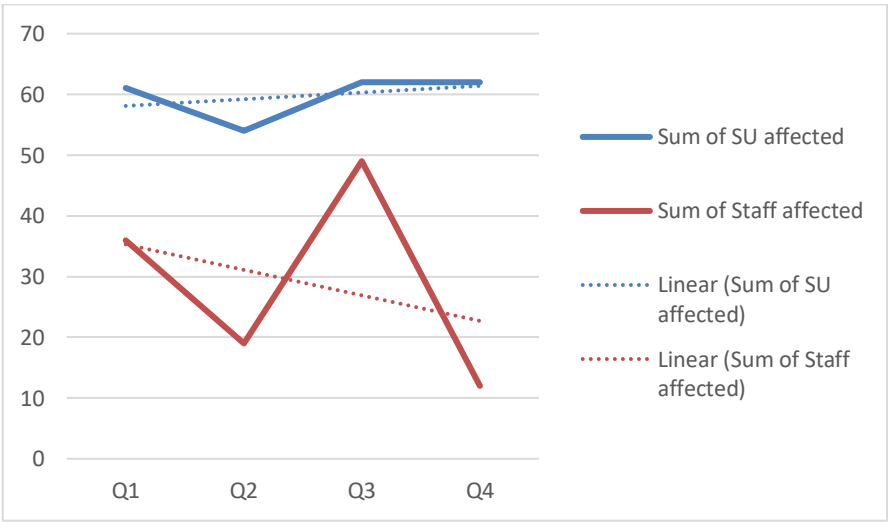
The overall SU/Staff affected ratio was 2.06 along the year. The following graphic shows how the ratio changed along the quarters:



Graphic 7- Ration SU/Staff affected during COVID19 outbreaks per quarter

The overall ratio SU/Staff affected is 5.17(62 SU and 12 Staff), Q3 the ratio was 1.7 with 62 SU involved and 49 Staff. Q3 had a ratio near 1, which shows that the number of SU affected, and staff were very similar, this is not what so far is being seen in the outbreaks in the last quarter where the proportion of SU affected is significantly higher than staff. This is likely related to the mandatory use of masks started at the end of December and it is now being reflected on the number of staff cases.

This can also be seen on the following graphic where we compare the evolution of positive cases in staff and in SU. We can see that the trendline for SU stabilized with a dip during Q2, which reflects the nature of COVID within the community, but there was a sharp increase on cases for staff during Q3 followed of a rapid decrease. This was likely related to the re-instatement of masks near Christmas and New Year's festivities that seems to successfully halted the progress of outbreaks to staff members:



Graphic 8 - Sum staff and SU affected during outbreaks per quarter

IPC has developed a risk assessment and options appraisal to inform around Trust wide mandated mask use to be approved at the IPPC committee.

The following table summarizes all outbreaks along the financial year:

Site	Date Reported	SU affected	Total SU area	Staff affected	Total Staff area	Ratio SU/Staff
Juniper Centre: Bergamot Ward	04/04/2022	7	18	6	36	1.17
Tamarind Centre: Lobelia Ward	04/04/2022	6	15	0	22	N/A
Reaside Unit: Swift Ward	04/04/2022	4	15	3	31	1.33
Eden - Acute	11/04/2022	4	16	0	22	N/A
Reaside Severn	13/04/2022	6	8	8	25	0.75
David Bromley House	19/04/2022	5	14	4	25	1.25
Reaside Dove ward	25/04/2022	6	14	0	25	N/A
Tamarind: Sycamore Ward	29/04/2022	3	8	0	35	N/A
Mary Seacole House: Ward 1	03/05/2022	5	16	2	27	2.50
Ardenleigh: Coral Ward	14/06/2022	4	6	1	40	4.00
Oleaster: Japonica Ward	20/06/2022	2	15	4	30	0.50
Orsborn House	21/06/2022	0	0	6	130	0.00
Tamarind: Cedar Ward	30/06/2022	9	15	2	27	4.50
Newbridge House	25/07/2022	6	16	0	50	N/A
Oleaster Centre: Tazetta Ward	25/07/2022	6	15	0	27	N/A
Mary Seacole House: Meadowcroft PICU	28/06/2022	6	10	6	23	1.00
George Ward	02/08/2022	3	16	0	22	N/A
Dan Mooney House	04/08/2022	3	14	1	26	3.00
Endeavour House	04/08/2022	7	11	0	20	N/A
Oleaster Melissa	28/08/2022	7	14	4	25	1.75
Oleaster - Japonica	30/08/2022	3	0	1	0	3.00
Juniper Centre: Rosemary Ward	09/09/2022	8	17	1	35	8.00
Little Bromwich CMHT	20/09/2022	0	0	6	23	0.00
Tamarind: Laurel Ward	26/09/2022	5	12	0	33	N/A
Dan Mooney	04/10/2022	5	13	3	26	1.67
Tamarind: Myrtle Ward	07/10/2022	2	11	0	23	N/A
George Ward	06/10/2022	3	16	0	22	N/A
Hillis Lodge	08/10/2022	11	15	0	25	N/A
Reservoir Court	17/10/2022	5	17	4	35	1.25
Admiral Team - Little Bromwich	17/10/2022	0	0	4	8	0.00
Urgent care CEntre	16/10/2022	1	0	10	0	0.10
Endeavour Court	04/11/2022	10	14	5	35	2.00
Caffra PICU Oleaster	11/11/2022	7	10	5	27	1.40
Melissa Ward - Oleaster	22/11/2022	4	16	2	21	2.00
Chamomile inpatient ward Barberry	07/12/2022	1	6	3	28	0.33
George Ward	16/12/2022	3	14	0	20	N/A
Endeavour House	20/12/2022	6	12	3	22	2.00
Juniper - Bergamot Ward	28/12/2022	2	17	6	37	0.33

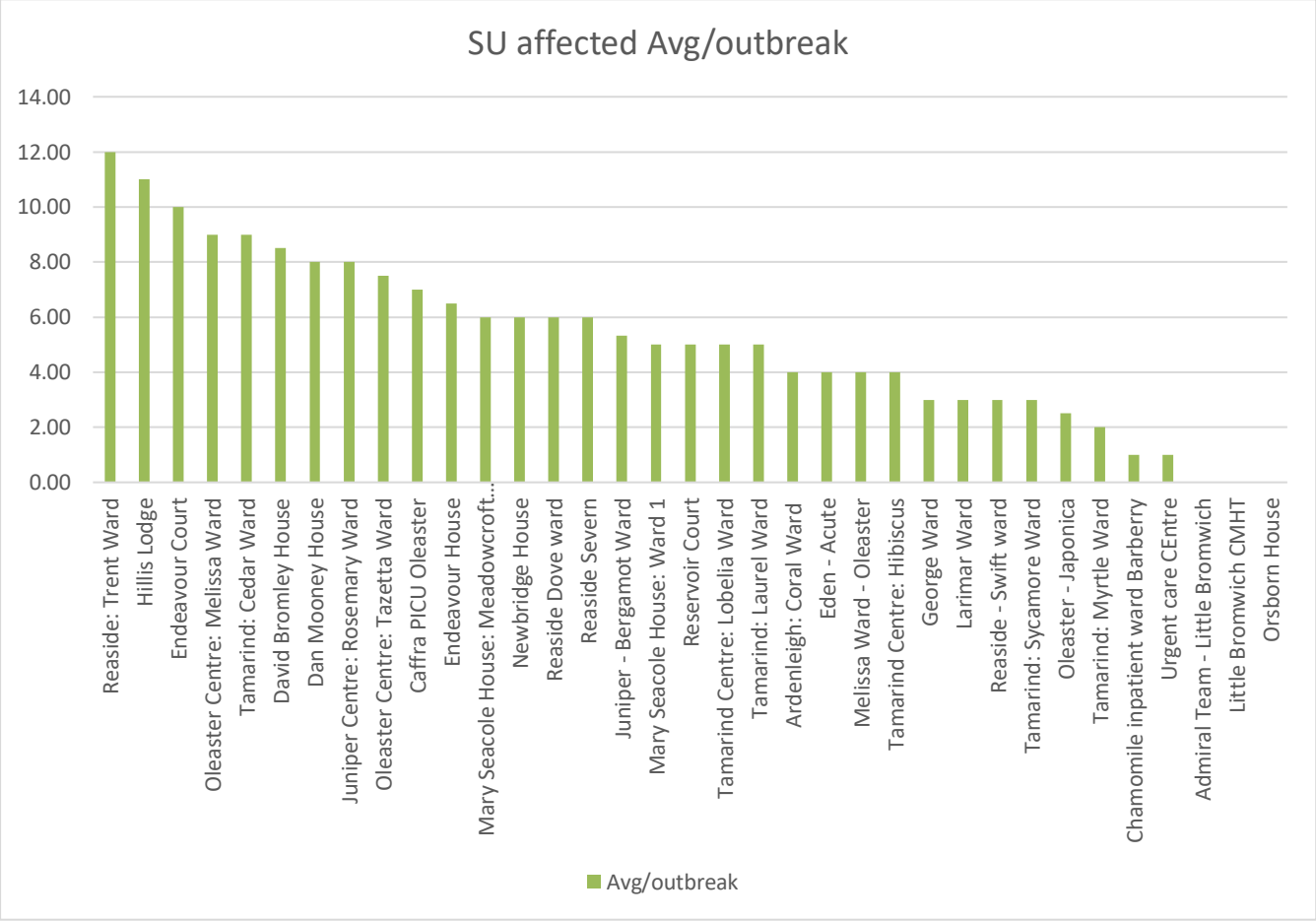
Reaside - Swift ward	28/12/2022	2	10	4	24		0.50
Tamarind Centre: Lobelia Ward	04/01/2023	4	15	1	22		4.00
Tamarind Centre: Hibiscus	04/01/2023	4	10	0	27	N/A	
Reaside: Trent Ward	03/02/2023	12	14	1	23		12.00
Juniper Centre: Bergamot Ward	20/02/2023	7	16	0	25	N/A	
Oleaster Centre: Melissa Ward	20/02/2023	11	16	4	40		2.75
David Bromley House	22/02/2023	12	16	3	22		4.00
Oleaster Centre: Tazetta Ward	27/02/2023	9	16	2	25		4.50
Larimar Ward	28/03/2023	3	15	1	23		3.00
Totals		239	574	116	1319		2.06

Table 12 - Ratio Positive cases/number of outbreaks

8.1.1 COVID outbreaks per site and areas of concern

The COVID outbreaks were widespread on the Trust, including some outbreaks in community settings (none of those had SU affected). There have been no areas with significant higher number of episodes than other areas.

When looking at areas with more SU affected on average per outbreak we can see the following:



Graphic 9 - SU affected in Average per outbreak

According to the graphic, the most affected area was Reaside – Trent ward, followed by Hillis Lodge, Endeavour court, Oleaster – Melissa ward and Tamarind Cedar ward.

The areas with the highest rates are areas with particular challenging cases of SU, as well as challenging environments, which can justify these finding. Regardless, by the graphic we can see that there is no particular trend on the type of service user most affected by the outbreaks, since the 5 highest rates fall within secure, acute, rehab, and dementia and frailty.

In conclusion, the number of SU affected seems to be stable across the quarters in line with the situation of COVID in the community. In future reports, the support of a data analyst would be beneficial to further deepen our knowledge of factors that might have contributed to these findings, including aspects related to the implementation of Trust policies in these areas.

8.1.2 Outbreak surveillance

All outbreaks were followed up with the local management area, Director of Infection Prevention and Control (DIPC), IPC team, Trust Microbiologist and external stakeholders invited to outbreak meetings (UK HSA, NHSE/I, ICB, Health protection team).

The Trust has continued with a weekly review meeting where all the outbreaks were discussed and assurances were given.

During the year, the Themes identified relating to the COVID Outbreaks were:

1. SU sharing in communal areas
2. Personal protective equipment (PPE) breaches by staff
3. Staff not bare below the elbows
4. High dust
5. IPC boards not up to date
6. Physical damage

Point 1 – In many of our areas, SUs have long lengths of stay, or may be too acutely unwell to to avoid congregations, as we work in the context of a mental health organization, which strongly relies on the interaction between human beings. IPC has advised all inpatient areas to ensure high levels of cleanliness are kept, staff keeps using PPE at all times and an individual and global risk assessment is made for each SU to be able to offer them a mask (if not jeopardizing other SUs safety). The result of the risk assessment and the SU adherence should be recorded on the care plan by the clinical team.

Point 2 and 3 – PPE breaches and staff not bare below the elbows has been frequently identified. HR team was involved in discussions around how to tackle this issue and a letter was produced to be delivered to staff who repeatedly demonstrated this behaviour (only substantial staff), reminding them of the possible disciplinary proceedings going forward. The delivery of the letter is preceded by a conversation to ensure the staff member is fully aware of the Trust guidance and our expectations. Besides these, PPE compliance continues to be a frequent noted point during IPC visits, in particular mask wearing. On this topic we believe that the resistance sometimes seen regarding correct mask use may be the result of some degree of mask use “fatigue”, due to the long period of time its use has been mandatory, including outside COVID outbreaks. Besides this, staff using cardigans, or not bare below the elbows are still a frequent find. The IPC team always brings this to the attention of the areas where the non-compliance was identified, as well as in external outbreak meetings, and the information/concern is shared with the Trust matrons while attending the Friday Matron meetings. IPC

has included a dedicated hand hygiene session to provide training to new Core Hand Hygiene all its training to the Trust IPC Champions.

During outbreaks, the compliance with use of PPE is recorded in the daily spot checks performed by ward managers. Any findings are discussed during the weekly outbreak meetings with the IPC team.

Point 4 – High dust has been a frequent finding. Whenever these were detected, an immediate escalation to the estates and facility team took place, to ensure cleaning is at the expected level. The Estates and facilities teams have frequently been involved during IPC visits, in areas that have been felt as more problematic. Regardless of this, the general cleanliness level of the Trust is very high as can be seen on the KPI consistently above the 90% mark. During outbreaks, Estates and facilities were always proactive in enabling adequate and fast response, even during the peak of the pandemic, when their teams were also struggling with high levels of absenteeism due to COVID.

IPC has organized a regular joint meeting (monthly) with estates and facilities to discuss ways to work together in a more efficient manner. From these meetings the Cleaning Roadshow initiative was born, where a member from Estates/facilities and an IPC staff member visit areas across the Trust to discuss the new cleaning standards, and aspects related to bare below the elbows. This initiative seemed to be very well received by staff in general with good informal feedback. At the present moment IPC and Estates/facilities are looking at possible new ways to cooperate, including performing some joint visits/audits.

Point 5 – The IPC team has found that IPC boards regularly have information that is out of date. This is part of the IPC audits. The findings are escalated to the area Matron and local managers. Teams are frequently reminded of the importance of updating the information in the IPC boards.

During IPC champions training sessions, the IPC team reiterates this message. On Q4 IPC training, the boards standard was discussed with the IPC champions to then be cascaded to the clinical areas.

Point 6 – The physical damage encountered mostly relates to wear and tear and planned upgrades/maintenance. Regardless of the challenges encountered during the COVID-19 pandemic, all measures have been taken to reduce risk of cross contamination between contractors, staff and SU's. During outbreaks only essential work has been carried out. Estates and Facilities keep a log of all works undertaken and outstanding. IPC supported on the planning of these activities, when contractors had to go to areas with known COVID-19 cases.

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8.2 COVID-19 guidance

The COVID-19 National Guidance had constant revisions and changes, which made it very challenging to keep the team and Trust staff updated. . This issue was even more significant because there is limited mental health specific guidance. Some of the advice provided was not applicable to Mental Health organisations.

To ensure the guidance changes were quickly cascaded, regular meetings between IPC and the deputy director of nursing were arranged (variable frequency depending on need) and weekly matrons meeting with IPC presence. This allowed us to cascade any changes, share learning and discuss challenges.

Arrangements have been made with external face fitters to provide face fitting across the Trust. This arrangement has finished on the 31st of March 2023 and an options appraisal was submitted to the Director of Infection Prevention and Control (DIPC) to decide on the way forward, to ensure face fitting continues in a sustainable way. There needs to be a wider discussion around these arrangements since at the present moment, the coverage of staff face fitted is still poor, mostly under 50% (please see table fourteen on next page for details).

The Trust has 5 powered hoods (one of the hoods in Juniper Centre has a damaged screen and not available to use). Two are currently located at Juniper Centre , and the remaining at the ECT suite. The powered hoods have been previously prioritised to the ECT suite, since most AGP procedures on the Trust are undertaken there. Regardless of this, any other department can request these hoods if necessary (except in secure care where these are not to be used due to concerns the hood might be weaponised). It is important to understand that powered hoods are not be a replacement for face fitting, since they are not suitable for all clinical areas, and its use is dependent on a risk assessment, as well as not having enough stock to cover all clinical areas (5 available).

Continuous updated guidance has been issued to all professionals. To ensure this could be done optimally, communication channels were kept via the Deputy Director of Nursing and the COVID-19 department to ensure IPC messages could be cascaded effectively.

There is a COVID-19 SOP in the Trust, that is reviewed each quarter to reflect the most up to date guidance and whenever new guidance is released. When new guidance is released, the IPC team reviews this and communicates with the DIPC for approval. When guidance review is approved, this is cascaded to all clinical teams through comms and weekly matrons' meetings.

The Trust has always aligned with National guidance with the following 3 exceptions:

- Resuscitation procedures – FFP3 masks to be used during all stages – as per National Resus Team advice.
- Speech and Language Therapy (SALT) Assessment – FFP3 or powered hood used.
- Restrains – As per risk assessment, use of FFP3 with facemask or IIR with face mask.

8.2.1 FFP3 respirators face fitting

During the year a face fitting program has been in place with currently 3 different ,masks being used.

The Trust had the support of 2 external face fitters, but the support has now ceased, and there is no face fitting capacity in the Trust.

Currently there is one PortaCount® Respirator Fit Tester in the Trust that is held by the IPC team, but no face fitters (The PortaCount Respirator Fit Tester is a quantitative respirator fit tester). An options appraisal was prepared and sent to the DIPC to inform decision on next steps to ensure face fitting in the Trust is re-instated.

Face fitting in the Trust is a point of concern, not just for COVID exposure but other respiratory diseases like Flu, Tuberculosis, or any respiratory infection from unknown agent.

It is essential to work towards increasing not just the overall percentage of staff face fitted, but as much as possible to aim that most face fitted staff is able to use 2 different types of masks with the aim of increasing resilience in case of future struggles of supply.

The following table shows the percentage of staff face fitted:

Division	Requiring Mask Fit Test	Fit Tested	Passed	Failed	Not Fit Tested	% Fit Tested	% Passed	% Failed
⊞Acute And Urgent Care Services	657	343	282	61	314	52.2%	82.2%	17.8%
⊞Chief Executive Office	1	0	0	0	1	0.0%	0.0%	0.0%
⊞Exec Dir - Medical	100	16	15	1	84	16.0%	93.8%	6.3%
⊞Exec Dir - Nursing	55	23	16	7	32	41.8%	69.6%	30.4%
⊞ICCR	678	267	206	61	411	39.4%	77.2%	22.8%
⊞New Care Models	8	2	2	0	6	25.0%	100.0%	0.0%
⊞Secure Serv & Offender Health	794	443	367	76	351	55.8%	82.8%	17.2%
⊞Specialties	675	310	264	46	365	45.9%	85.2%	14.8%
⊞SSL Management Team	1	0	0	0	1	0.0%	0.0%	0.0%
⊞Strategy,people & Partnerships	10	2	2	0	8	20.0%	100.0%	0.0%
⊞Trustwide	1017	146	117	29	871	14.4%	80.1%	19.9%
⊞Not Mapped	26	0	0	0	26	0.0%	0.0%	0.0%

Table 13 - FFP3 face fitted staff

As can be seen in the table the percentage of staff fitted tested across the Trust is significantly low, which bring concerns from a resilience point of view, not just from IPC perspective but also from an emergency preparedness perspective.

IPC advice

- It is important that the Trust includes in its regular training a program of face fitting with a refresher at least every three years or before if needed. Organize oversight of face fitting program, including record and monitoring of compliance. Discuss ways to minimize impact in areas with lower compliance that do not have enough staff face fitted in the area in case of need. Include face fitting during induction

8. Incident Reporting

The IPC team also keeps a database of infectious incidents to ensure that those affected are reported to Occupational Health and are adequately followed up. Occupational Health reports numbers of staff injuries to IPPC.

The following table shows the reported incidents by quarter and correspondent trends.

The most significant values are related to "possible transmission risk", this particular item incorporates a very wide range of issues like spit with risk of contact with the eyes, to physical wounds with skin breach and would require a broader analysis to understand that if it is related to increase in violence in our wards and the factors contributing for it.

The second most prevalent is wards closure due to outbreaks. This is a reflex of the ongoing COVID-19 pandemic.

Type	Q1	Q2	Q3	Q4	Trend
Blood stream infections (E-Coli, MMSA, MRSA…)	0	0	0	0	
Clinical Waste Management	0	3	4	4	
Incorrect results (Specimens)	0	0	3		
MRSA Management	0	0	0	1	
Possible Transmission Risk	36	31	46	11	
Tests-Failure/Delay to undertake	6	1	7	1	
Ward Closure due to outbreak	10	2	11	6	
Wound Management	1	0	0	0	
Total	53	37	71	23	

Table 14 - Eclipse incidents reported by quarter

During Q3 there were concerns that the number of inoculation injuries reported by Oc. Health were lower than the ones detected through the eclipse incidents reports. There has been a meeting between the IPC team and Oc Health to clarify if the same definition of inoculation injury was being used by both the Trust and the Oc Health provider. The conclusion was that both were align and the difference of values on the report were due to Oc Health only reporting the inoculation injuries that after triage and advice required further follow up.
The IPC team takes part of the contract meetings between PAM and the Trust (every 2 months) to ensure any issues are resolved and/or escalated appropriately.

9. IPC Team Response to Alerts and Directives

The IPC team monitors all new alerts and directives released and ensures new guidance is adapted for the Trust. This has been particularly evident during COVID-19, since guidance for community and mental health settings has not always been available. IPC led on discussions internally and externally to ensure best practice was always adopted.

The IPC team cascaded the information to the clinical areas and other areas of the Trust through the Deputy Director of Nursing, through regular matrons' meetings and IPC champions during the training sessions.
During IPC audits adherence to IPC guidance was observed and, when appropriate, aspects of the guidance were incorporated in the auditing tools to ensure consistency.

10. Food Safety

Ward managers undertake quarterly food service audits and monthly activity kitchen audits. Findings are included in matrons service area reports to the IPPC, and checks are also included in IPCN inspections. Food safety advice and audit is provided externally.
At present, the Trust has no food expert, so the annual audit had to be externally sourced. It is recommended that the Trust contracts a permanent food safety expert to allow continuous monitoring and training of staff.
The Food Safety Report is attached to this document.
On the next table we can see the summary of food related incidents eclipsed across the year. The number of reports is low and we have not seen an increase across the year.

Type	Q1	Q2	Q3	Q4	Trend
Food From unnaproved supplier	0	0	1	0	
Foreign Body identified in food	0	0	0	1	
inappropriate storage of food	1	1	1	0	
No appropriate Ethnic/dietary option	3	2	0	7	
Other catering issues	1	0	4	1	
Other food safety issues	1	0	1	0	
Out of date food	0	0	0	0	
Total	6	3	7	9	

Table 14 - Eclipsed food related incidents

11. Water Management

The water surveillance is made through the Water safety group (WSG).

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The WSG aims to ensure the safety of all water used by patients/residents, staff, and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a wide range of competencies can be brought together, to share responsibility and take collective ownership for ensuring it identifies water-

related hazards, assesses risks, identifies, and monitors control measures and develops incident protocols.

12.1 Water Safety – Positive Legionella bacteria samples

Elevated cold-water temperatures can result in Legionella bacterium present in water systems becoming active. Legionella pneumophila is a waterborne bacterium and is spread via exposure to aerosols of water containing the bacteria.

Legionnaire's diseases present as a severe pneumonia, which is caused by exposure to Legionella pneumophila. Symptoms of Legionnaire's disease include muscle aches, tiredness, headaches, dry cough, and fever.

The water management during the year was challenging, with an incident of external report by the Deputy DIPC of a positive legionnaire's disease case during November 2022. IPC confirmed with the laboratory, that the result was negative and the service user was treated accordingly.

Water concerns resulted on the closure of Forward House. By the end of the financial year, Forward house was only partially open with some areas still presenting with high counts of legionella.
Due to the water related issues, an external review was commissioned from an IPC perspective (done by the ICB) and a second review of Estates services provided, undertaken by Hydrop (Independent Consultancy Practice Specialists in the Management of Legionella and Water Quality). The findings and actions taken so far from the IPC related audit have been discussed in 5.1.

Once both reports are available, joint work should take place to elaborate an action plan, and ensure the findings are acted upon, and measures are put in place to prevent repeat of these issues. Meanwhile, and in response to the findings of the first report, the IPC team is proposing an SOP to risk assess the SUs in areas with high counts of legionella, including chain of information, to ensure that the wrong reporting incident is not repeated. This document will be presented to the IPCC for consideration.

12. Cleaning Standards

IPC team along with Facilities carried out a trust clinical cleaning roadshow for all clinical staff in inpatient areas. Providing information on the following:

- NHS Cleanliness Standards.
- Trust Cleaning Policy 2022.
- FR3 Charter & Ratings
- Efficacy Audits.
- Trust Chemicals.
- IPC standard precautions.
- Cleaning Methods.
- Water Safety.

The Estates and Facilities report details activities undertaken to promote and maintain standards required to meet the Code of Practice and other regulatory standards.

Of note were the consistently high cleaning scores reported to IPPC. Cleaning scores can be seen on estates report attached.

13. Capital Developments

The IPC team has worked with Estates and clinical staff to ensure that standards to meet the requirements of the document Health Building Note 00-09: Infection control in the built environment have been incorporated into refurbishments and works undertaken.

15 Annual Programme of Work

The Annual Programme of Work document will be attached to this report. After analysing the past year's activity, the IPC team advises on the following:

- Revise team scope, capacity and structure.
- Audit ownership monthly into clinical areas and aggregated in IPC dashboard.
- Monthly IPPC meetings.
- All policies to be reviewed and have included auditing criteria/KPI.
- IPC audits planning to include monitor implementation/adherence to IPC policies (according to policies KPI).
- IPC team to target areas of concern instead of blanket auditing all Trust areas and sites.
- Full review of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (commonly known as the "Hygiene code") to be continued and discuss plan of action to overcome the gaps with the deputy DIPC/DIPC.

Infection Control Doctor – Annual Statement for April 2022 - March 2023

Dr Gemma Winzor. Consultant Microbiologist, UKHSA Laboratory, Birmingham

ESTATES & FACILITIES INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2022-23

1. CORONAVIRUS (COVID) PANDEMIC

- **Estates & Facilities COVID Programme of Works 2022/2023**
  With collaborative support from Matrons, Ward Managers, and Estates Teams, Estates & Facilities continued to run a programme to assist in maintaining a safe environment for all staff, Service Users, and 3rd party visitors for example contractors across all sites by:

  - Enhanced Touchpoint Cleaning in accordance with the guidance provided by Infection Prevention & Control Team
  - Weekly Isolation Returns (to capture any COVID related issues and communicate to all parties involved). This has now stopped but will be re-started should covid number/outbreaks start to increase again.
  - Provided Post Infection cleans and deep clean of sites when requested by Infection Prevention & Control Team and Clinical Staff.

2. DOMESTIC & HOUSEKEEPING MANAGEMENT

- **Estates & Facilities**
  All domestic services continue to be provided by SSL with the North PFI sites; B1 Trust HQ services being provided by a third party outsourced provision. This means that all Estates and Facilities domestic service provision across the Trust is outsourced for 2022/2023 reporting period.

- **NHS England –National Standards for Healthcare Cleanliness**
  NHS England National Standards for Healthcare Cleanliness were implemented in April 2022. The Trusts Cleaning Policy was updated and ratified to align with the National Standards. The cleaning policy is currently being revised to take into account the change in Functional Risk category for Dementia wards. This will be completed in Q1 of 2023/2024.

- **SSL Domestic and Housekeeping Operational Manual**
  SSL Domestic and Housekeeping Operational Manual operations manual contains Domestic and Housekeeping COSSH safety data documentation (in line with the Trust COSHH Policy), task-based risk assessments and method statements, task-based standard operating

procedures, cleaning method statements, Trust Infection Prevention & Control policies and procedures, and operating instructions for departmental electrical equipment.

- **SSL Facilities Rapid Response Team**
  During 2022/2023 SSL Facilities Rapid Response Team continued to undertake a programme of deep cleaning across the Trust.

3. CLEANLINESS

- **Cleanliness Audit & Inspection Programme**
  During 2022/23 the programme of cleanliness inspections and audits was undertaken. Cleanliness scores and reports were provided to the Trust Infection Prevention & Control Team each month and the Trust Infection Prevention Partnership Committee each quarter.

The programme comprises 2 levels with additional spot checks.

- Level 1 Monitoring by Domestic Supervisors
- Level 2 Trust-wide Management Audits

Cleanliness scores were reported against the thresholds in the National Standards for Healthcare Cleanliness, Inpatient building's - 90%, Outpatient and Offices 85%.

During 2022/23 the cleanliness scores throughout the Trust (BSMHFT, SSL and Amey Community Limited) averaged above 94% and were consistently above the thresholds set in the National Standards for Healthcare Cleanliness.

All special cleaning activity (including Isolation Cleaning, Post-Infection Cleaning and scheduled Deep Cleaning) was undertaken in compliance with the Trust Infection Prevention & Control Policy and was reported monthly to the Infection Prevention & Control Team and to the Infection Prevention Partnership Committee each quarter. The Trust's Deep Cleaning

Programme is an integral element of the Trust Cleaning Policy and responds to the National Standards for Healthcare Cleanliness.

Key Cleaning Performance Data for 2022/23

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	1 April – 30 June 2022	1 July – 30 Sept 2022	1 Oct – 31 Dec 2022	1 Jan – 31 Mar 2023
	Trust Cleanliness Targets & Scores			
	Trust Overall Cleanliness Target = 90% inpatient Units, 85% Outpatient Units			
Trust Average	97.77%	96.24%	94.68%	95.39%
North PFI	97.06%	92.93%	92.33%	92.57%
BNHP	97.27%	96.14%	93.70%	95.46%
Community	97.90%	97.17%	96.40%	97.62%
Secure	97.52%	97.15%	95.35%	95.92%

- **PLACE (Patient Led Assessments of the Care Environment)**
  The 2022 PLACE assessment programme took place during September – November 2022. The results have been published and we are currently in the process disseminating these.

- **Cleaning Quality Operational Group**
  The Cleaning Quality Operational Group was re-established. It is led by Infection Prevention & Control and comprises of SSL Estates and Facilities Department representatives, Matrons, and PFI Partner Amey Community Limited and reviews all issues (and implements actions) regarding cleanliness within the Trust. The group reports into the Infection Prevention Partnership Committee.

- **Cleaning Policy**
  The aim of the Trust Cleaning Policy is to demonstrate compliance with the assessment criteria detailed in "The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (DOH, July 2015) on the standards of cleanliness that facilitate the prevention and control of infections and improve the quality of health service provision by ensuring that all cleaning related risks are identified and managed.

The policy requires delivery of consistent and compliant cleaning practices and cleanliness standards Trust-wide (whether delivered through SSL or PFI providers).

Compliance with the policy is monitored through the following.

- Estates & Facilities Cleanliness Audit & Inspection Programme
- Cleaning Quality Operational Group
- Estates & Facilities monthly reports to the Infection Prevention & Control Team and quarterly reports to the Infection Prevention Partnership Committee.

➢ **Cleanliness Training**

SSL Facilities Department manage an established Facilities Training Hub at The Barberry which continues to provide accredited education and training for SSL and Trust staff, as well as external companies. The Facilities Training Hub provides dedicated education and builds awareness of the cleaning profession through accredited training. Courses are delivered by Sue Ladkin (SSL) ranging from local induction training to higher level accredited training, whilst working alongside BSMHFT's Infection Prevention & Control Team and nursing colleagues. The Hub's syllabus also includes Level 2 in the Principles and Control of Infection in Healthcare Settings, Food Safety, Legionella and Water Safety and Biohazard Decontamination Training. During 2022/23, the Facilities Training Hub delivered FM training to Trust staff, SSL (Summerhill Services Limited) and PFI Partner Amey Community Limited.

The Trust's PFI Partner (Amey Community Limited) has contracted with the Trust's Accredited Training Hub to provide training to all of their Domestic Staff and Supervisors. The Trust's PFI Partner is also using the Training Hub to provide Level 2 Food Hygiene for their Domestic Assistants and Domestic Supervisors.

➢ **Computerised Cleanliness Monitoring System**

SSL Estates & Facilities Department and PFI teams operate a computerised cleanliness monitoring system "FM First" (based on the National Standards for Healthcare Cleanliness). The system generates cleaning scores and real time reports. This system was updated in April 2022 in line with the new Cleaning Standards.

4. CATERING MANAGEMENT

➢ **Environmental Health Inspections**

During 2022/23 Inspections by Birmingham City Council Environmental Health Officers carried out a visit to Juniper Centre on 10 October 2022. Scores on doors awarded 4 - Meals for Juniper are provided by Moseley Hall Hospital. SSL also carried out internal audits.

➢ **SSL Kitchen Inspections and SSL Food Safety and Quality Audits on behalf of BSMHFT**

During 2022/23 a programme of kitchen inspections and food safety and quality audits were undertaken once a quarter across the production kitchens with scores and reports provided to the Trust Infection Prevention Partnership Committee and the SSL/Trust Food Safety and Quality Group each quarter.

- **Allergy Awareness**
  Since changes in Food Safety Legislation in the UK, food businesses must inform you under food law if they use any of the 14 allergens as ingredients in the food and drink they provide. This list has been identified by food law as the most potent and prevalent allergens. SSL staff that handle food are required to complete the FSA online training. As this training has recently been updated in line with changes to the most recent legislation. If staff have completed the training before 16 September 2020, we would advise that you re-take this version as it contains new information. It has been recommended that all staff that handle or serve food complete this training and the link has been added to the Trust eLearning food safety level 1 package.

- **Food Safety Training**
  The Trust Food Safety Policy stated that all Housekeepers and Amey food service staff should be trained to Level 2 food Hygiene and food handlers to Level 1.
  However, is a requirement for all staff who handle food to have Food Safety level 2 training. Clinical staff on the North PFI sites, serve the food to the Service Users.

- **National Standards for Healthcare Food and Drink**
  The National Standards were implemented in November 2022, there are 8 standards that all NHS organisations are required to meet:
  - Organisations must have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.
  - Organisations must have a food and drink strategy.
  - Organisations must consider the level of input from a named food service dietitian to ensure choices are appropriate.
  - Organisations must nominate a food safety specialist.
  - Organisations must invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services.
  - Organisations must be able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.
  - Organisations must monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals.
  - NHS organisations must be able to demonstrate that they have suitable 24/7 food service provision, which is appropriate for their demographic.

  The Food Group was set up in 2022.

5. WASTE MANAGEMENT

- Waste Contracts

The contract with the Violia for Domestic waste commenced 1st April 2020 and the Clinical Waste contract with Tradebe commenced 01 July 2020. These contracts were established for a period of 3 years with the option to extend on a +1 year and +1 year basis.

These contracts for Domestic and Clinical Waste have continued to deliver an effective and compliant service during 2022/23 whilst at the same time keeping costs to a minimum. The 24/7 helpline and call logging process enabling queries to be logged, responded to and tracked more effectively and in doing so improving service standards has continued to be effective. Contract Review Meetings are held regularly with a focus at each meeting of dealing with any isolated problems and seeking further service efficiencies.

- Duty of Care Audits

  Duty of Care Audits by external experts of the Trust's various waste contractors continue to be carried out on an annual basis to ensure that the Trust's waste is managed effectively and compliantly from point of consignment to final disposal. In addition, SSL has worked very closely with the clinical waste contractor Tradebe to complete many pre-acceptance audits, ensuring that waste is effectively managed, segregated and consigned by BSMHFT. Where issues have been identified the findings have been shared accordingly.

- Waste Management Policy

  The Trust's Waste Management Policy which was ratified in September 2021. This Policy places a clear responsibility on the producer of the waste (the ward / the team / the individual) to manage that waste compliantly and furthermore places a control responsibility on team / ward managers and equivalent who are custodians of healthcare within their sphere of influence to ensure that their staff manage waste safely and compliantly.

- Waste Management Training

  SSL's Estates and Facilities Department has supported clinical / healthcare colleagues by offering refresher training at their own sites this being to reduce the burden on clinical staff having to travel to 'training venues' to receive such on the job training.
  In addition, sharps management training was provided both by the Trust and its sharps supplier to the Trust's Infection Control Link Workers to allow them to disseminate best practice at their respective sites. This training will continue in 2022/23.

6. LAUNDRY & LINEN MANAGEMENT

- BSOL Laundry & Linen Consortium

  SSL Facilities Managers and SSL Procurement have and continue to work with the BSOL Laundry and Linen Consortium. The workshop is led by University Hospitals Birmingham and is attended by Midlands Trust's and Elis. The aim to retender the laundry and linen services across the BSOL consortium and have one contract specification and standards.

- Laundry & Linen Contract

  During 2021/22, Central Laundry was acquired by Elis. The service has seen a decline in standards. Weekly contract meetings held with Elis, SSL and PFI Partners. Termination warnings have been issued to Elis and there has been some improvement. The contract is in

the process of being extended as no alternative suppliers have been found. SSL and PFI Partners are currently exploring alternatives.

- Duty of Care Audits
  A Duty of Care Audit was undertaken of the Trust-wide Laundry and Linen supplier Ellis in 2022. These were to the Coventry plant and the team observed the supplier's compliance with the service contract, the Trust's Laundry & Linen Policy, and Health Technical Memorandum (HTM) 01-04 "Decontamination of Linen for Health and Social Care". The Duty of Care visit also observed standards, quality systems, risk assessments and standard operating procedures as well as Laundry Staff Training Records to ensure compliance.

7. PEST CONTROL

- Trust Pest Control Policy, drafted by SSL Facilities Management, ratified in April 2022.

Capital/Revenue Schemes/Projects 2022/23							
A full schedule of schemes and projects is available on request. The following schemes are highlighted as being particularly pertinent to Infection Prevention & Control;							
Location	**Description of Scheme**		**Location**	**Description of Scheme**		**Location**	**Description of Scheme**
Newbridge House	· Air Conditioning to Inpatient Lounge · Remedial works – Water Management Risk Assessment · Duct Work Cleaning		Eden PICU	· 8 no. anti-ligature WC's and Trovex IPS panels · 8 no. anti-ligature washbasins and Trovex panels · Remedial works – Water Management Risk Assessment		Trustwide - North PFI In-Patient Areas	· Remedial Works - Trust IPCT Audit - Risk Assessment · Replacement Flooring non-compliant with IPCT Policy and HTM 64:01 · Refurbishment of sanitaryware (across all WC's/bathrooms)
Ardenleigh	· Coral Ward Seclusion Suite · Heating & Ventilation System Works · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings · Recommission the mechanical ventillation system · Recommission the mechanical ventillation system		Reaside	· Works to heating, ventilation & water distribution systems · Extract canopy to Main Kitchen Pot Wash · Various flooring works · Main Kitchen - Air-conditioning internal wall mount replacement · Various Wards - Shower Room upgrades · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Tamarind	· Various flooring works · Various air-conditioning system replacements · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings
Endeavour Court	· Creation of Clinic Room & External Fencing · Anti-ligature WC's & En-Suites to Ward		Warstock Lane	· Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Dan Mooney House	· Upgrades to internal fabric etc
David Bromley House	· Upgrades to internal fabric etc		Uffculme Centre	· Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Lyndon Centre	· Various Environmental Improvements · Upgrades to internal fabric etc
Mary Seacole 2	· Convert 1 no. Assisted bathroom to multi-functional Activity Room…		Larimar Ward - Ardenleigh	· Upgrade 1 no, Assisted Bathroom to full anti – ligature specification · En-Suite upgrades		Maple Leaf Centre	· Lagging uninsulated sections of pipework and replacement of damaged lagging · Upgrades to internal fabric etc
Forward House	· Creation of Clinic Room		Hillis Lodge	· Upgrades to internal fabric etc		Northcroft	· Flooring Works
Longbridge Centre	· Upgrades to internal fabric etc and Risk Assessment works		Rookery Gardens	· Redecoration Works		Juniper Centre	· Flooring and redecorations, improvements to internal fabric, fixtures and fittings
LBC	· Flooring Works · Remedial works – Water Management Risk Assessment, · Hot and Cold Water System Distribution Works		William Booth Centre	· Upgrade Unisex WC to anti-vandal/anti-ligature standard · Hot Water Cylinder to provide HTM compliant water temperature		Small Heath Health Centre	· Remedial works – Water Management Risk Assessment · Hot & Cold Water Systems Distribution 24 hr - 1 x Andrew 63/321
George Ward	· Remedial works – Water Management Risk Assessment,		Eden ACUTE	· Remedial works – Water Management Risk Assessment,		Northcroft	· Remedial works – Water Management Risk Assessment,

Summerhill Services

Annual Water Safety Report 2022/23

April 2023

- **Operational Water Management Group: - NOTE! The newly re written WSP enhances the below but it not yet fully ratified.**

  - This is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP. The aim of this group is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens and other risks such as scalding, chemical contamination and the risk of disruption to the water supply. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

The following is a typical list of tasks assigned to the OWMG

1. To work with and support the Infection Prevention and Control (IPC) team
2. To ensure effective ownership of water quality management for all uses
3. To determine the particular vulnerabilities of the at-risk population
4. To review the risk assessments
5. To ensure the WSP is kept under review including risk assessments and other associated documentation
6. To ensure all tasks indicated by the risk assessments have been allocated and accepted
7. To ensure new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required water standards
8. To ensure maintenance and monitoring procedures are in place
9. To review clinical and environmental monitoring data
10. To agree and review remedial measures and actions, and ensure an action plan is in place, with agreed deadlines, to ensure any health risks pertaining to water quality and safety are addressed which may include balancing the risks related to water safety and other safety risks such as ligature risks
11. To determine best use of available resources
12. To be responsible for training and communication on water related issues
13. To oversee water treatment with operational control monitoring and to provide an appropriate response to out-of-target parameters (that is, failure to dose or overdosing of the system)

14. To oversee adequate supervision, training and competency of all staff
15. To ensure surveillance of both clinical and environmental monitoring
16. To review areas/rooms taken out of commission, to ensure adequate provisions are made for flushing/draining the water systems as appropriate

Membership will include:

1. Head of Facilities Management (SSL) – Chair
2. Head of PFI
3. Senior Estates Manager – North PFI
4. Senior Estates Manager – South PFI
5. Senior Facilities Manager - Community
6. Senior Facilities Manager – Secure
7. Senior Facilities Manager South PFI
8. Senior Infection Prevention and Control Nurse or nominated Person
9. Authorising Engineer
10. Capital projects representative
11. Sector Specific Nominated Contractors
12. Deputy Director of Nursing or nominated representative

Regular meeting will be held quarterly. Agenda items will include the following:

1. Review of previous minutes. - Chair
2. Review of Action Plan - Chair
3. Community update (by exception) - Senior Facilities Manager (community)
4. Secure update (by exception) - Senior Facilities Manager
5. North PFI update (by exception) - Senior Estates Manager (North PFI)
6. South PFI update (by exception) - Senior Estates Manager (South PFI)
7. Capital works update - Capital Team
8. Service Provider Update
9. AE update / comments / policy / audits - AE
10. AOB

Quorum - attendance to be no less than 40% of membership (Senior Infection Prevention and Control Nurse or Microbiologist/Infection Control Doctor must be present at all meetings). If the chair of the OWSG is unable to attend, the chair will nominate a deputy dependant on current ongoing issues.

- **Strategic Water Safety Group: - NOTE! The newly re written WSP enhances the below but it not yet fully ratified.**

The Committee comprises of but not limited to the below and is held on a quarterly basis:

1. Responsible Person (or Deputy Responsible Person)
2. Sector Specific Nominated Persons
3. BSMHFT's Infection Prevention and Control representative (where applicable)
4. BSMHFT's Nursing department representative
5. BSMHFT's Health and Safety Manager
6. External Independent AE
7. Consultant microbiologist
8. Trust / SSL Authorised Persons

Committee's responsibilities include:

1. Provide a forum of discussion and sharing of information pertaining to Legionella Management & Control and Safe Hot Water Management across the Trust.
2. The ratification of appointment of Responsible and Nominated persons.
3. The preparation of all relevant Documentation, Works Specifications, PPM Programmes, Policies etc. (may be prepared by the team or by others for the team).
4. The ratification of all relevant Documentation, Works Specifications, PPM Programmes, Policies etc.
5. The monitoring and reporting upon the efficacy of all implemented PPM Programmes and all other relevant procedures.
6. The monitoring and reporting upon the efficacy of all contractors commissioned on Legionella related projects.
7. The monitoring and reporting upon the efficacy of all training Programmes implemented for associated staff.
8. The implementation of arrangements for managing an outbreak or suspected outbreak of Legionella.
9. The liaison between all other official bodies particularly in an outbreak situation.

Authorising Engineer:

SSL has appointed the Water Hygiene Centre to provide professional advice on water management issues.

The AE is an independent professional advisor whose primary role is to assist the Trust in managing the risks from exposure to legionella bacteria in water systems and also from other waterborne organisms associated with such systems such as pseudomonas and stenotrophomonas.

As a specialist, the AE will act as an independent professional advisor on water safety matters, and will work closely with both the Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG).

The role of the AE is to provide:

1. Advice to the appointed duty holders, responsible persons and their deputies on regulatory compliance, communication, management procedures, procurement etc
2. Make recommendations for the appointment of the RP[W], DRP[W]/AP[W]. Certificates of appointment will be issued detailing areas of responsibility and limitations.
3. Monitor the performance of employees and contractors with regards to their tasks in legionella management
4. Conduct regular compliance audits of single or multi-site facilities.
5. The AE will also become involved in developing staff training plans, reviewing commissioning works, construction design appraisals, mothballing of unused premises, and the development of specialist water safety policies and procedures etc.

The AE will also provide the following services:

1. Attend quarterly Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG) meetings.
2. Carry out annual audit of the Trust's control of legionella policy to ensure operational and management systems are in compliance with ACoP L8 and HTM 04-01; produce an audit report indicating areas of non-compliance; recommend actions and suggested improvements or amendments to policy and procedure documentation
3. Provide two half-day training sessions which include an update on the key principals of legionella risk management and associated legislation/codes of practice; two sessions to be targeted at trade maintenance staff, two at estates management staff; provide training workbooks and certificates of attendance for all delegates (BSMHFT Trust will provide the training venue and refreshments within the Birmingham locality)
4. Provide additional one day's refresher training for the Trust's infection control team
5. Provide on request ad hoc and technical expertise for all legionella risk management and other related matters via telephone, fax, letter or email; provide regular updates on any changes to legislation/codes of practice which may impact on the Trust legionella risk management system
6. Annual review of water safety plan.

- **Water Safety Plan**

The WSP has been developed in order to comply with the requirements of HTM 04-01: Safe Water in Healthcare Premises.

The purpose of the WSP is to assist with understanding and mitigating risks associated with waterborne hazards in distribution and supply systems, together with associated equipment. The WSP also provides a risk management approach to the safety of domestic hot and cold water and establishes good practice in local water usage, distribution and supply systems. The

WSP will also identify potential water related hazards, consider practical aspects and detail appropriate control measures.

The content of the WSP includes management and governance arrangements, together with details of training, professional support, maintenance regimes and supporting documentation.

The water safety plan was updated in August 2021 with Appendix 10 (Legionella Sample Result Action Levels Flow Chart) reviewed and updated March 2022 so we have consistency in approach (see below).


Water safety plan 09.08.21.docx


Appendix 10 Rev A.docx

A full re write of the WSP is underway taking lessons learned and actions from the independent review on the closure of Forward House, the updated WSP is currently out for consultation.

- **Legionellosis Management and control Policy**

Legionellosis Management and control Policy was reviewed, updated and ratified in September 2021 with the next anticipated review in 2024.


Legionellosis management and con

- **Training (Estates):**

Water Safety RP and AP Courses attended and completed across the SSL FM and PFI departments as per the below:

Water RP's

- Lee Gough – Head Of Facilities Management.
- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).
- Tarnjit Singh – Estates Manager (Ardenleigh).
- Paul Tranter – Estates Manager (Tamarind).
- Martin Spiers – Estates Manager (Reaside).
- John Mead - Senior Estates Manager – PFI South.
- Martin Germaney - Senior Estates Manager – PFI North.
- Gary Stanton – Estates Contracts Officer – PFI North.
- Nicky Bowen – Senior Contracts & Commercial Services Manager – PFI North.
- Clive Round – Contracts Officer – PFI North.
- Yvonne Kelly - Contracts Officer – PFI South.

Water AP's:

- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).

Water CP's:

Refresher training is scheduled for all Estates maintenance teams for April 23 as per the below:

	19th April (Plymouth Room, Uffculme) 08:30 – 16:30			**20th April (Butterleigh Room, Uffculme) 08:30 – 16:30**			**27th April (Conference Room 2, Reaside Clinic) 08:30 – 16:30**	
	Name	Site		Name	Site		Name	Site
1	Michael Reid	Tamarind		Kevan Lewis	Tamarind		Mohammed Ifzal	Ardenleigh
2	Malcolm Linton	Tamarind		John Johnstone	Reaside		Tyrone Williams	Reaside
3	Stan Millwood	Reaside		Liam Crowe	Reaside		Lisa Flavell	Reaside
4	Mark Seymour	Reaside		Mark Barrett	Hillis Lodge		Asif Quayam	Tamarind
5	Oliver Higgins	Ardenleigh		Adrian Flanaghan	Hillis Lodge		Kevin Richards	Hillis Lodge

6	Derek Harley	Hillis Lodge		Daniel Wise	Hillis Lodge		Howard Moore	Hillis Lodge
7	David Bromley	Hillis Lodge						

- **Risk Assessments:**

Retained Estate:

Legionella Risk assessments have been carried out at the below sites with all remedial works completed:

Ref	Property	Postal Address	Gross internal floor area (m2)	Date of Last Survey
1	Adams Hill	190 Adams Hill, Bartley Green, B32 3PJ	180	17/08/2021
2	Ardenleigh inc Thomas Telford and Training Centre	385 Kingsbury Road, Erdington, B24 9SA	8,598	20/07/2021
3	B1	Unit 1 B1, 50 Summer Hill Road, B1 3RB	3,039	29/07/2021
5	Dan Mooney House	1 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
6	David Bromley House	2-4 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
9	Grove Avenue	32 Grove Avenue, Moseley, Birmingham, B13 9RY	397	28/07/2021
10	Hertford House	29 Old Warwick Road, Olton, Solihull, B92 7JQ	484	27/07/2021
11	Hillis Lodge	Hollymoor Way, Northfield, B31 5HE	1,095	25/07/2021
12	Juniper Centre	Moseley Hall Hospital site, Alcester Road, Moseley, B13 8JL	5,246	29/07/2021
13	Longbridge Health & Community Centre	10 Park Way, Birmingham Great Park, Rubery, B45 9PL	1,414	17/08/2021
14	Lyndon Resource Centre	Hobs Meadow, Solihull, B92 8PW	888	27/07/2021
15	Maple Leaf Centre	2 Maple Leaf Drive, Marston Green B37 7JB	1,752	17/08/2021
18	Newington Resource Centre	Newington Road, Hamar Way, Marston Green, B37 7RW	850	16/03/2021
19	Orsborn House	55 Terrace Road, Handsworth, Birmingham, B19 1BP	1,659	18/08/2021
22	Rookery Gardens	385 Kingsbury Road, Erdington, B24 9SA	1,239	03/08/2021
23	Shenley Fields	15 Shenley Fields Drive, Northfield, B31 1XH	487	25/07/2021
24	Tamarind	165 Yardley Green Road, Bordesley Green, B9 5PU	8,261	29/07/2021
25	Uffculme Centre inc (Main Building, Tall Trees / Estates, Staff Support, Gate House	52 Queensbridge Road, Moseley, B13 8QY	2,166	20/09/2021
26	Uffculme site (Tall Trees)	52 Queensbridge Road, Moseley, B13 8QY	628	28/07/2021
27	Warstock Lane	Warstock Lane, Billesley, B14 4AP	577	28/07/2021

North PFI:

All WRA's have been updated in 2022 with remedial works completed, these are not due a refresh until 2024 unless works are carried out which materially impact the water systems on site.

South PFI:

Property	Address	Gross Area	Date of Last Survey

Barberry	25 Vincent Drive, Edgebaston, B15 2SY	8,913m2	Q4 22
Oleaster	6 Mindlesohn Crescent, Edgebaston, B15 2SY	7,200m2	Q4 22
Zinnia	100 Showell Green Lane, Sparkhill, B11 4HL	4,331m2	Q4 22

Remedial works are currently being reviewed / undertaken across all sites.

- **Authorising Engineer Audits:**

Audits have recently been carried out by water AE across the following areas – audits being finalised before distribution.

- South PFI.
- Community Sites.
- Secure Sites.

- **Water Sampling Results and General Overview**

- Combined Sampling results are now collated into a single spreadsheet including actions taken (see below)

Combined Results.xlsx

Retained Estate:

Reaside:

Throughout the year Reaside has only seen 2No positive results as per the below:

- G64 Estates Cold (25 CFU's).
- G280 Severn Ward Kitchen Hot (500 CFU's).
- Current results are all clear.

Newington:

After sampling post installation of the new water heater we received 2 low positive results of 25 and 100 CFU's to the cleaners cupboard sink – a full clean and disinfection was carried out to the outlet with sampling weekly until 3 ND's – currently all clear.

Orsborn House:

As part of routine sampling by the landlord a count of 4 CFU's was detected within our demise to the 2nd floor kitchen sink (cold) – a full clean and disinfection of the outlet along with weekly sampling was carried out unit 2ND's – currently all clear.

General:

As part of a robust RFQ exercise from July 2023 the contractor that we use for legionella management and control will be changing from IWS to Acquiesce Environmental Compliance.

North PFI:

General: - see combined results spreadsheet for latest sampling results.

On the North PFI sites there have been numerous positive readings throughout the year but robust action plans have been put in place following the Action flow chart and discussions with the Strategic Water Safety Group.

Over the year the main sites where we have seen positive results continue @ Eden Acute & PICU, Forward House, William Booth & George Ward, the estates team have a clear action plan in place with Amey which includes:

- Reviewing risk assessments including carrying out actions in a timely manner.
- Following the action flow chart including chlorination's, installing POU filters, reviewing flushing frequencies, servicing TMV's, descaling outlets and aerators.
- Installing a Copper and Silver ionisation dosing plant @ Eden.
- Replacing pipework, TMV's and balancing the system at Forward House.

- Installing an independent localised hot water system @ William Booth to enable the hot water temps to be better controlled.

It must be noted that there has been in excess of £1,000,000 spent on water management across the North PFI sites over the last financial year.

Independent Review of Forward House:

Due to the closure of Forward House SSL commissioned an independent review of the Water safety processes used by BSMHFT/ SSL and their Supply Chain, this was carried out by Hydrop. The Audit included include both Operational and Governance Audits along with analysis of specific actions on Forward House and the North PFI premises in particular.

The report generally notes the below, with any actions included in the re written WSP.

- **General summary** - This detailed review did not identify a single acute incident which caused the identified Legionella contamination within Forward House. Instead, a building, typical in its management of Water Quality Risk Management regimen was observed. Whilst improvements can be made, to ensure tighter control of identified failures in control measures, can be instigated, it is doubtful that such improvements in the overall control measures would have prevented the incident.
- **Usage evaluation and flushing** – The process for the identification / notification to estates by the clinical teams of infrequently used outlets needs to be improved with the clinical teams taking ownership.
- **Sampling –** Carry out a review of the sampling process including which outlets and frequency of sampling inc methodology for when filters are installed – the full methodology has been reviewed and incorporated into the latest WSP.
- **Training of Trust Staff –** Training of all none estates members of the Strategic Water Safety Group is to be reviewed as in recent months we have had some new members. – The Trust water AE is going to carry out reviews and review training needs.
- **Formal suitability assessment and appointment of Responsible and Competent Persons -** Review and complete suitability assessments for all key Amey / Severn Trent personnel. – The Trust AE is going to carry out suitability assessments.
- **Water Safety Group (WSG) –** Review the attendees of the Strategic water safety group including TOR. – A revised TOR and attendance list has been included in the latest WSP.
- **Water Safety Plan –** An existing water safety plan is in place but this has been enhanced from lessons learned over the past 12 months.

South PFI

The South PFI sites have continued to show clear results over the past year, below are the quarterly reports / sampling results formulated / taken by Equans.

Quarterly Reports below:


MH Quarterly Report Nov 22.docx


MH Quarterly Report Aug 22.docx


MH Quarterly Report May 22.docx

Quarterly Sampling Results below:


MH Results Tracker Nov 22.xlsx


MH Results Tracker Aug 22.xlsx


MH Results Tracker May 22.xlsx


MH Quarterly Overview Feb 23.xlsx

The CLO2 systems in Barberry, Oleaster and Zinnia were replaced in 2022. Careful adjustment and monitoring of the levels saw no significant change in sampling results.

Capital projects of note:

Location:	Description of works:
Ardenleigh	Coral Seclusion Suite
Ardenleigh	Various isolation valve and TMV replacement works
Lyndon Centre	Various environmental improvements
Reaside	Various works to heating and water distribution systems
Newington Centre	Replacement of hot water cylinder
Hillis Lodge	Replacement of boiler
Longbridge	Replacement of boilers and hot water cylinders
Eden	Installation of Copper / Solver Ionisation unit / various water safety works
George Ward	various water safety works
Newbridge	Heating System Controls - 15 x Actuator Valves, Heating System Pumps - 10 x sets twin head, Calorifiers - 1 x Andrews (Max Flow), 2 x state SBT 75
Willaim Booth	Hot Water Cylinder to provide HTM compliant water temperature
Forward House	Various Water safety works

LEE GOUGH

Head Of Facilities Management

Food Safety Report – Sue Ladkin

Birmingham and Solihull Mental Health
NHS Foundation Trust
Uffculme Centre
52 Queensbridge Road
Birmingham
B13 8QY

Main switchboard: 0121 301 0000
Website: www.bsmhft.nhs.uk

8.4. Safeguarding Annual report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**8.4**		
Paper title	Safeguarding Adults and Children Annual Report, April 2022-March 2023		
Date	4th October 2023		
Author (s)	Jane Wilkinson, Interim Head of Safeguarding September 2023 update from Mel Homer, Head of Safeguarding.		
Executive sponsor	Steve Forsyth		
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?	
What data has been considered to understand the impact?	

Executive summary & Recommendations:

This year's annual report provides an overview of safeguarding activity for the period April 2022 – March 2023. It summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how BSMHFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and Care Act 2014.

The report outlines the requirements from all health providers in regard to effective safeguarding arrangements for children and adults. The Head of Safeguarding provides evidence against these requirements through submission of the Section 11 and Care Act 2014 compliance audit and is monitored by the Safeguarding Management Board (SMB) with oversight by the Chief Nurse/Executive for Safeguarding.

Safeguarding Training compliance, BSMHFT's training needs analysis (TNA) outlines the levels of training staff require to be compliant and frequency of training which incorporates safeguarding children, adults, domestic abuse and Prevent training. An additional 1,147 individuals now require Safeguarding Adults level 3 and additional 1,108 individuals now require Safeguarding Children Level 3, this is due to a change in compliance being mapped against job role. Additional training sessions have been provided to meet this demand.
September 2023 update- we are currently compliant for level 3 safeguarding children training and aim to be compliant for safeguarding level 3 adult training by end of October 2023.

Safeguarding supervision training has been funded by the safeguarding team for 32 delegates from across the trust to support embedding a supervision culture. A further 2 cohorts have been funded with 36 delegates having signed up. A Safeguarding Supervision Policy will be ratified and compliance with supervision for children subject to child protection planning will be monitored and reviewed at the Safeguarding Management Board and the local ICB.

Prevent referrals remain low, with good overall compliance with training. The Trust Prevent Lead submits a quarterly return to NHS England via NHS Digital and to the local ICB.

Domestic Abuse, BSMHFT continues to contribute to the Multi Agency Risk Assessment Conference (MARAC) in both Birmingham and Solihull. The local ICB is developing a model to provide a one health system to support the sharing of information to MARAC and BSMHFT is exploring this opportunity.

External Reviews (DHR's, SAR's an CSPR's) BSMHFT has supported Community Safety Partnerships in one DHR for this reporting period and continues to share learning from previous reviews with the wider trust which is incorporated into all safeguarding training.

During the reporting period, BSMHFT has also participated in seven CSPRs where the children or adults have been known and have contributed to the consideration of one SAR which did not meet the threshold.

BSMHFT is launching its **Think Family** strategy in the summer of 2023. The Safeguarding team will monitor the uptake of the guidance, support a Think Family approach through reflective supervision and offer targeted support through local clinical governance committees.
September 2023 update: Think Family launch has been delayed until beginning November 2023 due to vacancies' / changes in the team of Head of Safeguarding and Named Nurse. These posts are now filled, and we are on track as a team to launch in November.

MASH (Multi Agency Safeguarding Hub) has continued to see a rise in enquires with only 10% being known to BSMHFT. The ICB funds three nurses which work as part of the BSMHFT safeguarding team to cover MASH across Birmingham and Solihull.
September 2023 update: The MASH model from a Health perspective is undergoing change in the commissioning and representation at the MASH, which will be serviced by BCHCT for both Birmingham and Solihull moving forward. The Head of Safeguarding is working closely with the ICB and BCHCT to ensure safe transition and any gaps and issues identified of an operational nature are shared promptly to enable a solution focused approach to ensure safety and reduce risk.

Incident reporting data: There were 217 adult safeguarding referrals raised by BSMHFT staff in 2022/23 compared to 183 in 2021/22. There were 168 children safeguarding referrals raised by Trust staff in 2022/23 compared to 158 in 2021/22. This year the referral rate is higher which could indicate an increase in Trust staff awareness of safeguarding issues.
September 2023 update: Whilst there has been an increase over the quarters, referral numbers are low compared to the size and scale of the City and Solihull as a borough and the deprivation and poverty of our local areas. The safeguarding team will continue to promote messages via comms for making good quality referrals to the relevant local authorities and promote this in training and supervision. The Safeguarding advice and support duty line was increased back to 4pm from 11th September to support staff who wish to access specialist support from the team.

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

The committee is asked to note the contents of the Safeguarding Annual report prior to

submission to Trust Board in August 2023.

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)

At which other meetings has this report been previously discussed or presented?

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)*

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

Equality impact assessments:

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

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

Defining levels of assurance:

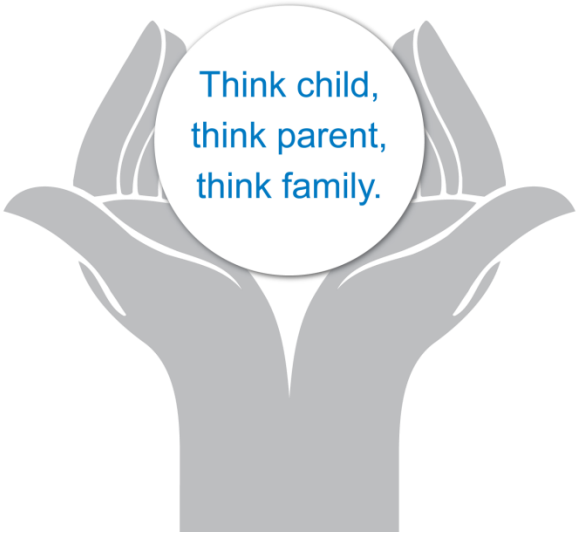
Level of assurance	Definition
Substantial Assurance	The evidence provided demonstrates there is a sound system of governance, risk management and that internal and existing controls are operating effectively and are consistently applied to support the achievement of objectives in the Division or Department.
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).	

Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham & Solihull Mental Health
NHS Foundation Trust

Safeguarding Adults and Children Annual Report

April 2022 – March 2023



Jane Wilkinson, Interim Head of Safeguarding
April 2023

Contents

1.0 Background/Introduction

All safeguarding work across the Trust is underpinned by our Trust Values.

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

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

1.3 The Trust operates across Birmingham and Solihull and works closely with our local safeguarding partners.

2.0 Governance and Accountability Arrangements

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

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

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

2.4 The Safeguarding Strategic Plan (see Appendix 1) is routinely presented at the quarterly Safeguarding Management Board (SMB) and to the Integrated Care Board (ICB).

3.0 Quality Assurance

3.1 All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and their commissioners that these are working and

effective. (*Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2019.)*

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults.
- Safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competencies for safeguarding children and adults.
- Effective supervision arrangements for staff working with children, families, or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture.
- Identification of named safeguarding professionals.
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

3.2 The Head of Safeguarding provides evidence against these requirements through submission of the Section 11 and Care Act 2014 compliance audit and is monitored by the Safeguarding Management Board (SMB) with oversight by the Chief Nurse/Executive for Safeguarding.

4.0 Assurance Framework

4.1 The Trust has an internal assurance process. This includes a quarterly Safeguarding Management Board (SMB) which reports to the Quality, Patient Experience and Safety (QPES) committee. The SMB has a performance and quality assurance role and monitors the annual work plan and safeguarding risk register.

4.2 Each directorate has a lead manager representative at the SMB to ensure that safeguarding priorities are embedded at an operational level and this feeds back to their local clinical governance committee.

5.0 Partnership Working

5.1 The Trust is committed to working in collaboration with all partners to protect adults and children from harm. As part of these arrangements, the Trust is represented at Birmingham and Solihull Safeguarding Adult Boards and Safeguarding Children Partnerships to cover the two local authorities where the Trust provides services. These representatives attend and contribute to strategic development regarding local priorities, accountability and assurance. These priorities and deliverables are reported to the SMB.

5.2 Named professionals contribute to multi-agency audits in the local safeguarding adult boards and safeguarding children's partnerships.

5.3 The Trust safeguarding team has supported safeguarding adult reviews; child safeguarding practice reviews; domestic homicide reviews; channel panel and Prevent/ Contest boards throughout the reporting year.

6.0 Safeguarding Training Compliance

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

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

6.3 The TNA has been updated in line with the Adult Safeguarding Intercollegiate Document 2018 and reviewed against existing Children Safeguarding Intercollegiate document 2019. Compliance has been mapped to job role rather than Agenda for Change banding to meet this standard. An additional 1,147 individuals now require Safeguarding Adults level 3 and additional 1,108 individuals now require Safeguarding Children Level 3. To meet the increased demand, additional in-house face to face and webinar training sessions have been provided and an e-learning option has been created to provide additional training opportunities. Staff are required to be fully compliant by December 2023.

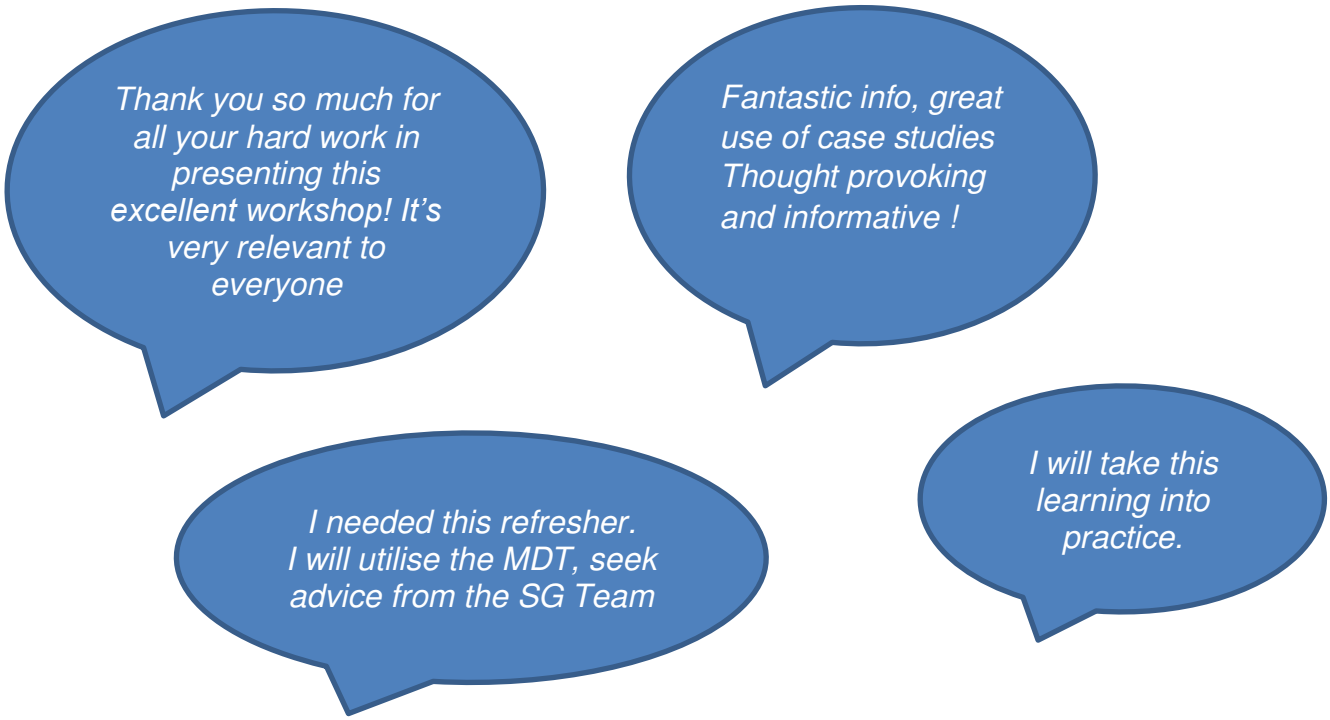
6.4 Level 1 and Level 2 Safeguarding Adult and Children training is completed via an online package and is compliant.

6.5 Level 3 Safeguarding Adult training is delivered face-to-face, by webinar and via online learning. Compliance is monitored weekly by the Head of Safeguarding and the Executive for Safeguarding. Reports are provided at the quarterly Safeguarding Management Board (SMB) and compliance is steadily improving.

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

6.7 The safeguarding adult boards and safeguarding children's partnerships also provide multi-agency training. BSMHFT staff are encouraged to attend and we have seen a greater number of staff attend this training during this reporting period.

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



6.9 Chart showing training compliance for the period 2022/23.

NB: expected drop in compliance following realignment of staff to intercollegiate documents.

Safeguarding Training 2022/23 Compliance Target 85%	Q1	Q2	Q3	Q4
Safeguarding Children L1	95%	96%	96%	94%
Safeguarding Children L2	95%	95%	95%	94%
Safeguarding Children L3	84%	83%	85%	64%
Safeguarding Adults L1	94%	95%	96%	95%
Safeguarding Adults L2	95%	93%	96%	96%
Safeguarding Adults L3	83%	84%	84%	65%
Prevent	91%	94%	95%	89%

The training compliance is monitored weekly and is showing an upward trend. A trajectory is not available due to the inability to predict e-learning but it is expected that compliance will be achieved by the end of December 2023. The Trust is monitoring the risk and has mitigations in place.

7.0 Safeguarding Supervision

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

7.2 The Trust is committed to embedding a culture of Safeguarding Supervision and in 2022 funded Safeguarding Supervision training with an external provider for 32 staff members within BSMHFT. Following the success of the course, a further two cohorts have been funded and 36 professionals have signed up for the training throughout summer 2023. Service areas that did not secure places in the initial training sessions have been targeted with success.

7.3 Those who completed the training in 2022 have an identified person to support them with delivering their safeguarding supervision. This includes offering regular catch ups to explore how the supervision is going, discuss the use of supervision models and any challenges that may have arisen.

7.4 Safeguarding supervisor network meetings are held bi-monthly. There has been three so far covering topics such as neglect and all age exploitation, where we have had professionals from external agencies attend to present. The hope is that the safeguarding supervisors will be able to use the knowledge and resources shared within their supervision and disseminate to their wider team. The upcoming meetings plan to have focus upon self-neglect and domestic abuse, which were suggested by the network.

7.5 During the reporting period there has been a focus on developing the model and training supervisors. A Safeguarding Supervision Policy will be ratified and compliance with supervision for children subject to child protection planning will be monitored and reviewed at the Safeguarding Management Board and the local ICB.

8.0 Prevent Duty

8.1 Prevent forms part of the Counter terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised and drawn into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person being radicalised.

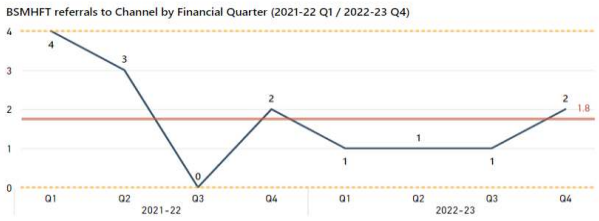
8.2 The purpose of Prevent is for staff to identify and report concerns where they believe children, young people or adults may be vulnerable to radicalism or exploiting others for the purpose of radicalisation.

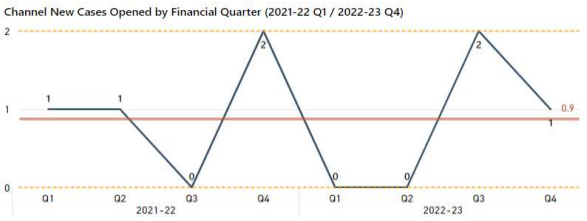
8.3 The Trust Prevent Lead submits a quarterly return to NHS England via NHS Digital and to the local ICB.

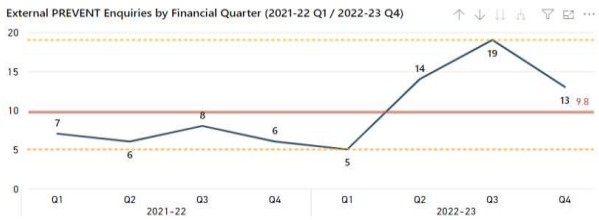
8.4 The Trust Prevent Lead attends Channel and represents the Trust at Prevent Operational Groups for Birmingham and Solihull and associated Prevent Delivery Groups.

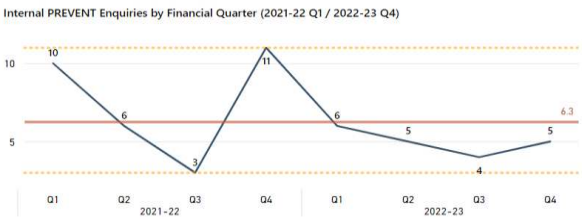
8.5 SMB and QPES receives a six-monthly assurance report.

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









Referral rate remains low, however compliance with training is good and the Prevent Lead supports discussion with Trust staff regarding Prevent. The data shows an increase in the number of external enquiries in this reporting period, however there is no known explanation for this.

9.0 Domestic Abuse

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

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

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*

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

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

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

9.3 There are plans to deliver bespoke domestic abuse training for identified teams that will focus on Think Family and Routine Enquiry.

9.4 The Domestic Abuse Policy has been updated to reflect the changes in the Domestic Abuse Act 2021.

9.5 The Trust continues to contribute to the Multi Agency Risk Assessment Conference (MARAC) in both Birmingham and Solihull. The local ICB is developing a model to provide a one health system to support the sharing of information to MARAC and BSMHFT is exploring this opportunity.

9.6 The Trust Named Nurse for Domestic Abuse chairs Birmingham MARAC meetings and represents the Trust at the Domestic Abuse Priority Board, Birmingham and Solihull Governance Committee and supports a review of the Birmingham Domestic Abuse Strategy.

10.0 Domestic Homicide Reviews (DHRs)

10.1 A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence or neglect by:

- A person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship, or:
- A member of the same household as himself or herself.

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

10.3 During the reporting period there was one DHR commissioned by the Community Safety Partnership and BSMHFT has supported the process.

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

11.0 Safeguarding Adult Reviews (SARs)

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

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

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

11.4 A SAR is commissioned when there is reasonable cause for concern about how Safeguarding Adult Board (SAB) members or other agencies providing services worked together to safeguard an adult if:

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

11.5 The Head of Safeguarding is a member of the SAR subgroup in Solihull and contributes to the reviews.

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

11.7 During the reporting period BSMHFT was involved in the consideration of one case for a SAR, which did not meet the threshold.

12.0 Child Safeguarding Practice Reviews (CSPRs)

12.1 A CSPR takes place after a child is seriously injured and abuse or neglect is thought or known to be involved. It looks at lessons that can be learned to help similar incidents from happening in the future. The reviews are recommended at a local level and then reviewed by the national panel that decides if learning should be disseminated at a local or national level.

12.2 Birmingham and Solihull Children Partnership sub-groups are attended and represented by a member of the Safeguarding team and reviews are supported by the Safeguarding team and clinical teams who are involved with the case, to support the process.

12.3 During the reporting period, BSMHFT has participated in seven CSPRs where the children or adults have been known.

12.4 A rapid review meeting is held in all cases to gather facts about the case, ensure immediate safety of any children involved, consider potential for any safeguarding improvements and decide on next steps. As well as participating in rapid reviews for the above cases, the Safeguarding team was involved in a further eight rapid reviews in which it was identified the threshold for a CSPR was not met, that learning had been gained from the rapid review process or that any learning is being actioned by the partnership already.

12.5 The Safeguarding Management Board receives updates on all learning reviews and actions are monitored by the Local Safeguarding Children Partnerships.

12.6 The Safeguarding team has worked with Solihull Safeguarding Children Partnership to address the findings from the national review into the murder of Arthur Labinjo-Hughes. The review recommended that mental health trusts develop a Think Family approach. BSMHFT has developed a Think Family Strategy and associated delivery plan which is monitored at its Safeguarding Management Board.

12.7 BSMHFT is launching its Think Family strategy in the summer of 2023. The Safeguarding team will monitor the uptake of the guidance, support a Think Family approach through reflective supervision and offer targeted support through local clinical governance committees.

13.0 Learning from External Reviews

13.1 BSMHFT Safeguarding team participates in external reviews, such as DHR, SAR and CSPR. Learning from these reviews - which includes our own single agency learning and wider lessons - is important to develop practice and to reduce the risk of similar issues arising.

13.2 Emerging themes are considered and as a result policies, guidelines and training are updated.

13.3 Assurance that learning has been embedded into practice is key to providing evidence and this is achieved by audits related to specific areas of practice.

13.4 Themes that are emerging from reviews this year are consistent with national findings and include: lack of professional curiosity; sharing information with safeguarding partners in a timely manner; thinking about children in the home and any associated risks; the impact of cannabis use on parenting capacity and gender bias.

13.5 To address these themes, BSMHFT has developed training packages which are delivered by the Safeguarding team to clinical staff including the medical team.

The Think Family strategy has been adopted and will be launched in the summer of 2023. The Domestic Abuse Policy has been updated to remind staff that domestic abuse occurs across all genders, identities and sexuality. Safeguarding supervision will be rolled out across all directorates to facilitate reflective discussions and promote professional curiosity. Additional guidance will be written to support effective information sharing across agencies to support safety planning and identification of risk.

13.6 Audits have been undertaken in specific services to provide assurance that domestic abuse is considered, Think Family principles are applied and referrals are made where safeguarding concerns exist.

14.0 Multi-Agency Safeguarding Hub (MASH)

14.1 BSMHFT is commissioned to provide mental health information into both Birmingham and Solihull MASH. In Solihull, BSMHFT provides information about adults and children and in Birmingham for adults only.

14.2 Information is shared in line with statutory guidance to safeguard children. (Working Together to Safeguard Children 2018). Effective sharing of information between practitioners and local agencies is essential for the early identification of need to keep children safe. Serious Case Reviews have highlighted that missed opportunities to share relevant information in a timely way can have serious consequences for the safety and welfare of children (Triennial analysis of serious case reviews (SCRs) 2022. Learning for the future: Messages for child and family social care from SCRs conducted 2017-19 (Research in Practice and University of Birmingham).

14.3 The number of enquiries is monitored quarterly and reported to the Safeguarding Management Board and local Integrated Care Board (ICB). The number of enquires has significantly increased this year across Birmingham and Solihull with an average of 10% of all enquires having service users known to BSMHFT. The ICB funds three nurses to work in MASH across Birmingham and Solihull.

15.0 Safeguarding Adult Incident Reporting Data

15.1 All service user safeguarding incidents are reported on the internal incident reporting system (Eclipse). The incidents are reviewed and screened by the Safeguarding team to identify cases where suspected abuse or neglect has been indicated. This supports staff in their decision-making to consider any safeguarding concerns and to make the appropriate local authority safeguarding referrals.

15.2 There were 217 adult safeguarding referrals raised by BSMHFT staff in 2022/23 compared to 183 in 2021/22. This year the referral rate is higher which could indicate an increase in Trust staff awareness of safeguarding issues.

15.3 The nature of safeguarding referrals is recorded with physical and psychological abuse having the highest number followed by financial and domestic abuse.

15.4 The Dementia and Frailty team raised the highest number of safeguarding incidents (54) followed by Acute Care (43).

15.5 In areas where there are low numbers of reporting, the Safeguarding team is doing targeted safeguarding awareness work.

16.0 Safeguarding Children Incident Reporting Data

16.1 There were 168 children safeguarding referrals raised by Trust staff in 2022/23 compared to 158 in 2021/22. This year the referral rate is similar to last year which indicates continued awareness of child safeguarding issues.

16.2 The nature of safeguarding referrals is recorded with emotional abuse and neglect being the highest reported, which is in line with local themes.

16.3 Urgent Care and Recovery raised the highest number of safeguarding incidents (36 each). Solar - BSMHFT's Emotional Wellbeing and Mental Health Service for Children, Young People and Families in Solihull – raised 32 incidents.

16.4 In areas where there are low numbers of reporting the Safeguarding team is doing targeted safeguarding awareness work.

17.0 Citizen Story

17.1 BSMHFT had considered adding a citizen story to this annual review but was unable to meet this wish within the timescales and will be included in next year's annual review.

18.0 Conclusion

18.1 In the reporting period, the Safeguarding team has promoted the importance of safeguarding supervision and Think Family being a standard operating process in all aspects of service delivery.

18.2 BSMHFT is committed to building safeguarding capacity throughout the Trust which incorporates 60 safeguarding supervisors and additional recruitment to the corporate Safeguarding team.

18.3 Links between the Patient Safety and Safeguarding teams have strengthened in this period and BSMHFT will continue to prepare for the implementation of the Patient Safety Incident Reporting Framework (PSIRF) in the coming year, where safeguarding is an integral component.

18.4 Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. There are a great number of committed staff who work impeccably to support and serve our service users and their families and the Safeguarding team would like to acknowledge them all.

Safeguarding Team Annual Plan 2022/23

Workstream	Objective	Action Required	Responsible Person	Timescale	Evidence / Progress
1. Quality Assurance Provide a comprehensive Quality Assurance Framework which monitors standards and improve outcomes					
	Safeguarding dashboard to reflect quality standards for services and the Trust including Think Family Standards	Review current dashboard and agree what needs to be included	Head of Safeguarding HOS	Dec 22	G
	Improve the link between learning from safeguarding reviews and organisational quality goals to drive improved clinical effectiveness	Review current tracker to ensure outstanding actions are completed	HOS		G
		Audit programme to be developed to provide assurance	HOS and Named Professionals		G
		Support Learning from incidents and SI's using framework such as After-Action Reviews	HOS		G

	Embed Think Family Strategy	Linked to delivery plan for Think Family	SG Team and Heads of Nursing AHP's		A
		Quality Improvement Framework to include Think Family	HOS		A
2. Domestic Abuse Work in partnership with our local partners to identify victims of domestic abuse and protect them from harm					
	Ensure BSMHFT actively supports and provide information to MARAC to safeguard service users	Work with the ICB IVT nurses to ensure mental health information is shared at MARAC	Named Nurse DA		A
		Develop a supervision/ practice standard for service users who are discussed at MARAC	Named Nurse DA		A
	Support the development of IDVA role within BSMHFT	Develop a collaborative approach with BWA to evaluate the pilot	Named Nurse DA		A
	Review themes from DHRs to ensure learning has occurred	Review previous learning events and identify gaps	Named Nurse DA		A
3. Safeguarding Adults					

Develop a comprehensive programme to support teams to identify safeguarding incidents and report					
	Accurately report numbers of BSMHFT referrals to Adult Safeguarding	Remind staff to use Eclipse and explore ways to obtain this data from the Local Authority – link with designated nurses and raise at Birmingham and Solihull operational group	Safeguarding Adult Lead		G
	Understand and review how BSMHFT supports section 42 enquiries to make safeguarding personal	Identify service users who are subject to S42 and develop RiO alert and data capture mechanisms	Safeguarding Adult Lead	Dec 22	A
	Support the introduction of Liberty Protection Safeguards with our Mental Health Legislation Colleagues	Review policies and SG training to include new guidance	Safeguarding Adult Lead and LPS lead		G
		Develop links with Mental Health Legislation colleagues to ensure that the link between safeguarding and mental capacity is better understood	Adult Safeguarding Lead	June 23	A

	Report numbers of PiPoT	To link with HR to ensure SMB is cited on these numbers	HOS and HR Lead		G
4. Safeguarding Children Develop a comprehensive programme to support teams to identify safeguarding incidents and report.					
	Develop our contribution to MASH in Solihull and initiate a MASH rotation of staff	Recruit to CCG funding	HOS and Named Nurse children	Dec 22	G
		Support development of the "Health Offer" within MASH	HOS and Named Nurse children		G
	To provide the children workforce with a SG SV model to ensure SG concerns are identified early	Develop a Children SG SV Policy/Standard	HOS and Named Nurse children	Dec 22	A
		Evaluate the Medic Supervision pilot in Perinatal MH Teams and consider how to roll this out to Solar	Named Doctor SG Children	Dec 22	G
	Accurately report numbers of BSMHFT	Remind staff to use Eclipse and explore ways to obtain this data from the Local	Named Nurse SG Children		G

	referrals to Children Safeguarding	Authority (LA) – link with designated nurses and raise at Birmingham and Solihull Operational Group			
	Report numbers of LADO referrals to the LA	To link with HR to ensure SMB are cited on these numbers	HOS		G
	Develop a system to identify children who are subject to CP plan LAC	Develop links with the LA to obtain these numbers weekly and update the RiO system	HOS and Named Nurse children		G
	BSMFHT to monitor attendance of staff at CP meetings	BSMHFT to receive all invites to meetings and monitor attendance	Named Nurse children		G
5. **Training and Development** Provides a comprehensive training programme designed to meet the requirements set out in the Intercollegiate documents and to meet the Trust targets					
	To ensure BSMHFT staff have access to Safeguarding training relevant to their role	Safeguarding HUB to publish the available courses and provide booking information	HOS and Training Facilitator		G

	Accurately report compliance of SG training to commissioners and address deficits with a focus on FCAMHS and Solar	Identify staff who are not compliant and request Head of Nursing and AHP ensure compliance	HOS and Training Facilitator		G
	Develop resilience in the team to deliver training alongside Jason	Review Partnership and SAB offers and ensure these are available to staff and attendance is logged with L&D	Training Facilitator		G

8.5. AHP Strategy update

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**8.5**		
Paper title	AHPs at BSMHFT – Delivering personalised recovery and optimizing well being		
Date	4th October 2023		
Author (s)	Jane Clark, Alison Jowett		
Executive sponsor	Steve Forsyth		
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?	Staff survey, local and Trust wide clinical audit

Executive summary & Recommendations:

This report presents a current overview of the AHP workforce, and the achievements of the AHP Strategy 2020-2023.

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

e.g. The committee (FPP, QPES, People Committee etc) or Board is requested to:
1. ***NOTE*** *this report to recognise the contribution of the AHP workforce and the delivery of the strategy.*

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)

CLINICAL SERVICES: Transforming how we work to provide the best care in the right way in

the right place at the right time, with joined up care across health and social care.
Financial Implications *(detail any financial implications)*

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Equality impact assessments:
Engagement *(detail any engagement with staff/service users)*
Staff survey deep dive project
Acronyms *(List out any acronyms used in the report)*
AHP – Allied Health Professions

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 organisation." (HM Treasury – 2012).	

Allied Health Professionals in BSMHFT

Delivering personalised recovery and optimising wellbeing

compassionate inclusive committed

Purpose of the report

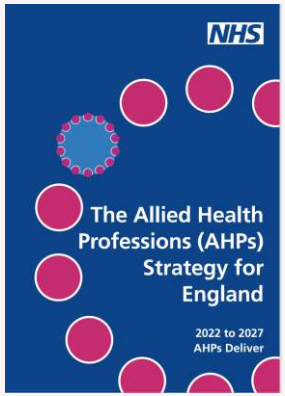
- Brief overview of Allied Health Professionals (AHP) Workforce and Services
- Share the highlights of AHP Strategy Impact Report and collaboration with Trust Strategy objectives
- Outline opportunities and challenges for the future

Workforce Overview

- 14 profession under the AHP workforce group – at BSMHFT we have Occupational Therapists, Physiotherapists, Dietitians, Speech & Language Therapists and Arts Therapists.

  (Arts Therapists align with Psychological Therapies)
- Embedded in nearly every service across BSMHFT – some as non-traditional roles.
- Total numbers are circa 195 including aligned clinical support workers and apprentices
- Represents 4.89 % of total clinical workforce. Ambition target is to reach 10% of workforce - mirroring levels seen by CQC Outstanding organisations.
- Overall % position is static – impacted by overall increase in staff in clinical staffing, revision of model in Acute, corporate budget challenge, barriers within person specifications.

Local and national strategic drivers



BSol ICB AHP Strategy
In consultation

2020

2021

2022

2023

compassionate inclusive committed

Transition from AHP Strategic Priorities to Trust Strategy

Birmingham and Solihull Mental Health NHS Foundation Trust

1. To deliver a high quality, recovery focussed AHP service in all areas of the Trust.
2. To support and achieve an exceptional and valued workforce.
3. To collaborate with Experts by Experience.

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

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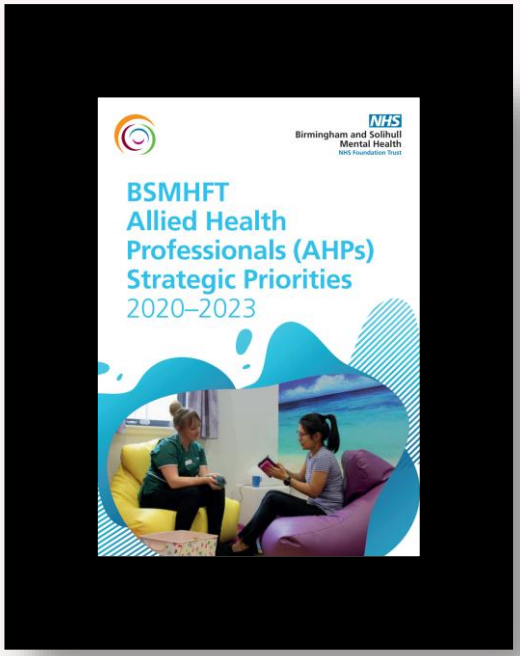
NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Allied Health Professionals Strategy Impact Report 2020-23



Doing, Being, Belonging, Becoming

AHPs develop relationships with service users and carers to enable full and active lives at home and within their communities. Rooted in holistic origins of personalisation and empowerment the AHPS in BSMHFT use their specialist interventions to support individuals towards their own version of living well.

compassionate inclusive committed

1. To deliver a high quality, recovery focussed AHP service in all areas of the Trust.

- Promote and embed clinical outcome tools across the services including a) development of PAGS a bespoke multi-professional measuring and b) the digitisation of MOHOST and the INSIGHT dashboard.

- Inpatient and HTT pathway to incorporating reasonable adjustments and neurodiversity **(Occupational Therapy – A&UC)**

- Partnership with West Midlands Autism and sensory integration **(Occupational Therapy Specialities)**

- Delivery of Moving Lives, Healthy Minds collaboration with Sports Birmingham and Newman University. **(Health Instructors)**

- Working proactively across the BSol system to support transitions from our services into the community and settings

2. To support and achieve an exceptional and valued workforce.

- Active professional forum - AHP Advisory Committee - cross representation and attendance with an engaging agenda
- National trailblazer for AHP degree apprenticeships for registered staff, third cohort now in progress - expanding on range of professionals and we now have fifteen Level 6 (BSc) and 7 (MSc) in training or about to start, and three Level 3 apprenticeships being established.
- Promoted equitable access to national CPD funding for ongoing skill development and professional career pathways
- Implementation of Job Planning in line with NHS Long term Plan mandate
- In depth follow up of Staff Survey results to explore the feedback and develop actions to improve the recognition and working experience of AHPs
- Implementation of retention strategies – establishing 12 month AHP Preceptorship Lead post to improve our early career support, commencing a 3 year cohort analysis of new graduate starters, annual trust AHP conference last held 21.3.23

3. To collaborate with Experts by Experience.

- The Perinatal EBE programme celebrated 10 years of excellence
- Perinatal Peer support workers embedded into community and inpatient teams
- Co production of discharge support packages from Acute Inpatient wards
- Active and expanding Recovery College programme including -Perinatal support, Health Diet, and Exercise
- EBEs undertaking ward based sensory environment assessments in Acute Care

Delivering the Trust Strategy

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

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.

Use job planning data to support service equity and capacity and demand.

Have clear effective clinical pathways in each service area – supported by evidence and ongoing audit.

Regular reviews of service design to ensure model of delivery is inclusive and effective.

Work with local system provider partners to guarantee seamless transitions and appropriate level mental health skills of *all* clinicians.

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.

Implement e- Job planning to define roles and CPD.

Focus on early careers staff and provide additional support and development opportunities.

Complete the role essential training workstream to provide a clear pathway for each role/profession depending on grade and specialism.

Support nontraditional career routes and cross professional leadership.

Expand the clinical support workforce to create a source of local talent.

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.

Collate clinical effectiveness and outcome data as part of the Quality Management system.

Expand the skills and application of the QI approach across all service development activities.

Use a data informed approach to focus on health inequalities and access to services and interventions.

Sustainability

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

Progress with carbon net zero projects inc. single use plastics, combines delivery routes and equipment re-use.

Optimise travel times with use of agile working.

Build on existing successful partnerships for joint working and service design.

Opportunities for the Future

- Review leadership structures and roles across the Directorates
- Increase the profile and recognition of AHP
- Become a national exemplar of AHPs in mental health services
- Active engagement in Bsol AHP Council and ICB programmes

8.6. Guardian of Safe Working Reports

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Trust Board October 2023		
Agenda item	8.6		
Paper title	Annual Report on Rota Gaps and Vacancies: Doctors and Dentists in Training (2022-23)		
Date	04 October 2023		
Author (s)	Dr Shay-Anne Pantall		
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:

Annual 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.

The number of vacant shifts has remained persistently high throughout the year 2022-23, over half of which were due to post vacancies. Only three shifts went unfilled. The vast majority were filled with internal locums.

Vacancies were fairly evenly distributed across most rotas, with the highest number of gaps on the ST North rota and the lowest on the ST Forensic rota.

The on call rota structure continues to be reviewed with the aim of reducing rota gaps and improving working hours. 12 new ST doctor posts were created from August 2023; however not all of these were filled during the national recruitment process.

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. This report is for assurance to the Board that there is oversight of junior doctor vacancies and rota gaps within the Trust, and that appropriate actions are being taken to encourage recruitment and cover vacant shifts, ensuring patient safety.

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)*

Vacant shifts have been covered by locums at agreed 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)*

- Doctors in training have bimonthly Trainee Council meetings. The meeting is open to all doctors in training in the Trust. Vacancies and rota gaps are discussed in this meeting and issues can be escalated directly to the Deputy Medical Director (Professional Practice, Legal and Transformation) and Associate Medical Director for Education and Training.
- The AMD for Education and Training and DMD are invited to attend the Junior Doctors Forum and provide updates regarding the junior doctor workforce, recruitment and expansion of training posts.

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

GoSW – Guardian of Safe Working
AMD – Associate Medical Director
DMD – Deputy Medical Director
FY – Foundation Year
GPVTS – General Practice Vocational Training Scheme
CT – Core Trainee
ST – Speciality Trainee
JDC – Junior Doctor Contract
JDF – Junior Doctor Forum

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).	

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING (2022-23)

High level data (from August 2022 onwards)

Number of doctors / dentists in training (total): 187

Number of doctors / dentists in training on 2016 TCS (total): 187

Annual vacancy rate among this staff group: 34.8%

Annual data summary

Foundation and GPVTS (* 6 month rotations prior to August 2022)

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Apr-22	FY1	14	14	n/a	0	2
	FY2	7	6	0	1	1
	GPVTS*					
Aug-22	FY1	14	14	0	0	1
	FY2	7	7	0	0	1
	GPVTS	25	20	0	5	1
Dec-22	FY1	14	14	n/a	0	0
	FY2	7	7	0	0	0
	GPVTS	25	9	13	3	0

Core Psychiatry

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Aug-22	CT1	19	19	n/a	0	3
	CT2	9	8	0	0	2
	CT3	19	16	1	2	3
Feb-23	CT1	19	13	4	2	1
	CT2	9	9	0	0	2
	CT3	19	12	3	4	3

Higher Training

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Aug-22	ST GA	20	13	0	7	2
	ST OA	4	4	n/a	0	1
	ST Forensic	12	9	0	3	2

	ST CAMHS	2	1	0	1	0
	ST Psychotherapy	2	2	n/a	0	0
Feb-23	ST GA	20	13	0	7	2
	ST OA	4	4	n/a	0	1
	ST Forensic	12	9	0	3	2
	ST CAMHS	2	1	0	1	0
	ST Psychotherapy	2	2	n/a	0	0

Rota gap summary

Rota	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)	Number of shifts uncovered (over the year)
1	46	37	27	43	2.9	0
2	35	43	28	55	3.1	0
3	31	25	34	85	3.4	0
4	67	61	39	43	4.0	0
5	73	54	32	54	4.1	1
6	38	22	30	75	3.2	0
ST North	97	95	64	46	5.8	2
ST Forensic	28	24	29	25	2.0	0
ST Solihull and East	61	43	49	60	4.1	0
ST South	50	53	50	23	3.4	0
TOTAL	**526**	**457**	**382**	**509**	**37.5**	**3**

Reason for rota gap	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)
Vacancy	270	272	250	391	22.8
Sickness	48	34	43	27	2.9
COVID-19	28	26	4	4	1.2
Parental Leave	0	0	0	25	0.5
Off Rota	173	102	59	39	7.2
Compassionate Leave	3	1	3	5	0.2
Industrial Action	0	0	0	17	0.3
Acting Consultant	0	5	18	0	0.4
New Intake	4	14	5	0	0.4
Special Leave	0	2	0	0	0

Issues arising

The number of vacant shifts has remained persistently high throughout the year 2022-23, with an average of 37.5 vacant shifts per week. 63.1% of these shifts were due to post vacancies. A sharp increase in vacancies was noted in Q4.

High vacancy rates are multi-factorial in cause. Training post recruitment is via a national rather

than local process. There has been an increase in unfilled posts for trainees on the GPVTS training scheme. In the December 2022 – April 2023 rotation, 16 of 25 (64%) of GP Trainee posts were unfilled. There are also a high number of trainees 'off rota'; the majority are because of occupational health recommendations.

Despite 1874 vacant on call shifts across the year, only three shifts went unfilled. The majority were filled with internal locums.

Actions taken to resolve issues
Additional recruitment has taken place to appoint Trust Doctors and Locums Appointed for Service. A proposal for an additional 12 Higher Training posts was successful for introduction in August 2023; 10 posts in General Adult Psychiatry, one in Forensic Psychiatry and one in Older Adult Psychiatry. Due to the number of vacancies arising from unfilled GPVTS posts, five posts have been converted to posts for Foundation doctors. BSMHFT continues to support local trusts including Black Country Healthcare NHS Foundation Trust and Coventry and Warwickshire Partnership Trust to provide placements to trainees from their region. A business case has been developed for expansion of the PGME department to provide more capacity not only to support the increased number of posts and to allow greater focus on recruitment of locum doctors to vacant posts.

Due to the high volume of exception reports, work schedule reviews and fines levied, the ST North and South on call rotas are being revised with consideration given to merging rotas from three to two General Adult rotas during weekdays. This would reduce the number of shifts required and hence reduce vacant shifts across General Adult ST on call rotas.

With regards to trainees currently 'off rota', Medical Workforce are currently seeking up dated advice from occupational health for some trainees that have been unable to work on the rotas for over one year.

Summary
The number of vacant shifts has remained persistently high throughout the year 2022-23, over half of which were due to post vacancies. Only three shifts went unfilled. The vast majority were filled with internal locums.

Vacancies were fairly evenly distributed across most rotas, with the highest number of gaps on the ST North rota and the lowest on the ST Forensic rota.

The on-call rota structure continues to be reviewed with the aim of reducing rota gaps and improving working hours. 12 new ST doctor posts were created from August 2023; however not all of these were filled during the national recruitment process.

Questions for consideration:
Whilst vacancy numbers and rota gaps were high in 2022-23, action has been taken which aims to remediate some of these issues and the impact of these should be monitored. The Board is requested to note this report.

Appendix 1: Locum Bookings By Rota

Locum bookings APRIL 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	16	16	148.50	148.50
Rota 2	7	7	63.00	63.00
Rota 3	10	10	98.50	98.50
Rota 4	20	20	167.00	167.00
Rota 5	22	22	221.00	221.00
Rota 6	12	12	116.00	116.00
ST4-6 North	38	38	525.50	525.50
ST4-6 Rea/Tam	10	10	184.00	184.00
ST4-6 Sol/East	21	21	374.50	374.50
ST4-6 South	20	20	272.00	272.00
Total	176	176	2170.00	2170.00
Locum bookings MAY 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	13	13	134.00	134.00
Rota 2	14	14	139.00	139.00
Rota 3	8	8	89.00	89.00
Rota 4	18	18	148.50	148.50
Rota 5	17	17	152.50	152.50
Rota 6	9	9	93.00	93.00
ST4-6 North	35	35	503.50	503.50
ST4-6 Rea/Tam	6	6	120.00	120.00
ST4-6 Sol/East	19	19	352.00	352.00
ST4-6 South	16	16	233.50	233.50
Total	155	155	1965.00	1965.00

Locum bookings JUNE 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	17	17	176.00	176.00
Rota 2	14	14	139.50	139.50
Rota 3	13	13	135.00	135.00
Rota 4	29	29	290.50	290.50
Rota 5	34	34	328.50	328.50
Rota 6	7	7	84.00	84.00
ST4-6 North	34	34	473.00	473.00
ST4-6 Rea/Tam	12	12	216.00	216.00
ST4-6 Sol/East	21	21	376.00	376.00
ST4-6 South	14	14	190.50	190.50
Total	195	195	2409.00	2409.00

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

Locum bookings SEPTEMBER 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	2	2	25.00	25.00
Rota 2	9	9	93.00	93.00
Rota 3	2	2	24.50	24.50
Rota 4	21	21	199.50	199.50
Rota 5	9	9	101.50	101.50
Rota 6	5	5	45.00	45.00
ST4-6 North	25	25	369.50	369.50
ST4-6 Rea/Tam	8	8	136.00	136.00
ST4-6 Sol/East	18	18	328.00	328.00
ST4-6 South	16	16	240.50	240.50
Total	115	115	1562.50	1562.50

Locum bookings OCTOBER 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	0	0	0	0
Rota 2	6	6	50.50	50.50
Rota 3	4	4	33.00	33.00
Rota 4	11	11	111.50	111.50
Rota 5	7	7	63.00	63.00
Rota 6	10	10	91.00	91.00

ST4-6 North	31	31	422.00	422.00
ST4-6 Rea/Tam	10	10	208.00	208.00
ST4-6 Sol/East	11	11	216.00	216.00
ST4-6 South	22	22	297.00	297.00
Total	112	112	1492.00	1492.00
Locum bookings NOVEMBER 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	6	6	49.50	49.50
Rota 2	11	11	109.50	109.50
Rota 3	15	15	167.50	167.50
Rota 4	6	6	72.00	72.00
Rota 5	12	12	123.00	123.00
Rota 6	2	2	9.0	9.0
ST4-6 North	14	14	209.00	209.00
ST4-6 Rea/Tam	8	8	144.00	144.00
ST4-6 Sol/East	17	17	296.00	296.00
ST4-6 South	12	12	177.00	177.00
Total	103	103	1356.50	1356.50

Locum bookings DECEMBER 2022 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	21	21	203.00	203.00
Rota 2	11	11	95.50	95.50
Rota 3	15	15	143.50	143.50
Rota 4	22	22	222.00	222.00
Rota 5	13	13	133.50	133.50
Rota 6	18	18	164.50	164.50
ST4-6 North	19	19	257.00	257.00
ST4-6 Rea/Tam	11	11	208.00	208.00
ST4-6 Sol/East	21	21	400.00	400.00
ST4-6 South	16	16	223.00	223.00
Total	167	167	2050.00	2050.00

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

Appendix 2: Locum bookings by grade

Locum bookings APRIL 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	87	87	814.00	814.00
ST4-6	89	89	1356.00	1356.00
Total	176	176	2170.00	2170.00

Locum bookings MAY 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	79	79	756.00	756.00
ST4-6	76	76	1209.00	1209.00
Total	155	155	1965.00	1965.00
Locum bookings JUNE 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	114	114	1153.50	1153.50
ST4-6	81	81	1255.50	1255.50
Total	195	195	2409.00	2409.00

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

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

Locum bookings OCTOBER 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	38	38	349.00	349.00
ST4-6	74	74	1143.00	1143.00
Total	112	112	1492.00	1492.00

Locum bookings NOVEMBER 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked

CT1-3	52	52	530.50	530.50
ST4-6	51	51	826.00	826.00
Total	103	103	1356.50	1356.50
Locum bookings DECEMBER 2022 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	100	100	962.00	962.00
ST4-6	67	67	1088.00	1088.00
Total	167	167	2050.00	2050.00

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

Appendix 3: Locum Bookings by Reason

Locum bookings APRIL 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	89	89	1075.50	1075.50
Sickness	11	10	91.50	91.50
COVID 19	17	17	216.50	216.50
Off Rota	53	53	721.00	721.00
Compassionate L	2	2	25.00	25.00
NEW INTAKE	4	4	40.50	40.50
Total	176	176	2170.00	2170.00

Locum bookings MAY 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	85	85	1060.50	1060.50
Sickness	21	21	261.50	216.50
COVID 19	5	5	73.00	73.00
Off Rota	43	43	557.50	557.50
Compassionate L	1	1	12.50	12.50
Total	155	155	1965.00	1965.00

Locum bookings JUNE 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	96	96	1163.50	1163.50
Sickness	16	16	186.50	170.50
COVID 19	6	6	59.00	59.00
Off Rota	77	77	1000.00	1000.00
Total	195	195	2409.00	2409.00

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

Locum bookings AUGUST 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
New Intake	14	14	100.50	100.50
Vacancy	81	81	1077.00	1077.00

Sickness	8	7	97.00	84.50
COVID 19	3	3	48.00	48.00
Off Rota	15	15	191.00	191.00
Comp Leave	1	1	16.00	16.00
Acting Up Consultant	5	5	61.50	61.50
Total	127	126	1591.00	1578.50

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

Locum bookings OCTOBER by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	77	77	1079.50	1079.50
Sickness	7	7	78.50	78.50
COVID 19	1	1	12.50	12.50
Off Rota	26	26	317.00	317.00
Comp Leave	1	1	4.50	4.50
Total	112	112	1492.00	1492.00

Locum bookings NOVEMBER 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	59	59	829.50	829.50
Sickness	19	19	206.50	206.50
COVID 19	0	0	0	0
Off Rota	12	12	142.50	142.50
Comp Leave	2	2	9.00	9.00
Acting Up Consultant	11	11	169.00	169.00
Total	103	103	1356.50	1356.50

Locum bookings DECEMBER 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
New Intake	5	5	38.50	38.50
Vacancy	114	114	1428.00	1428.00
Sickness	17	17	190.00	190.00
COVID 19	3	3	36.00	36.00
Off Rota	21	21	241.50	241.50

Acting Up Consultant	7	7	116.00	116.00
Total	167	167	2050.00	2050.00

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Trust Board October 2023		
Agenda item	8.6		
Paper title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2023-24 Q1)		
Date	4 October 2023		
Author (s)	Dr Shay-Anne Pantall, Guardian of Safe Working		
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.

- No immediate safety concerns were raised during this quarter.
- 12 exception reports were raised during this quarter, of which 2 reports were duplicates. All related to working hours. 90% of exception reports were raised by Higher Trainees.
- A new ST Tutor, Dr Helen Campbell, was appointed from May 2023.
- Only 1 (10%) exception report raised during this quarter was closed within 7 days. Delays in the process were due to delays in arranging review meetings, need for clarification by the supervisor from the Guardian of Safe Working as to outcome and outcomes not being accepted promptly by the postgraduate doctor in training.
- 6 fines were levied against the Trust for breaches in safe working hours overnight. A change to on call working patterns continues to be discussed with Higher Trainees.
- The number of vacant shifts continues to be high (452). The majority of gaps were due to post vacancies. 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 6 occasions in this period, covering 11 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 data from Q1 was tentatively presented at the meeting in July 2023. The meeting planned for 4 October 2023 will be cancelled due to planned industrial action by consultants and junior doctors.
- 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 met with postgraduate doctors in training at their Trust induction on 3 August 2023 as part of the presentation about raising concerns.
- I have met with postgraduate doctors in training 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

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

April – June 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

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	1	1	0
CT1-3	4	0	0	4
ST 3-6	16	9 (+ 2 duplicates)	11	14
GPVTS	0	0	0	0
Total	20	10	12	18

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	3	1	3	1
ST South	11	8	7	12
ST Solihull/East	0	0	0	0
ST Forensic	2	0	1	1
Total	20	10	12	18

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	1	0	0	0
CT1-3	0	0	0	4
ST3-6	0	0	11	14
GPVTS	0	0	0	0
Total	1	0	11	18

b) Type of exceptions in the quarter:

All 10 exception reports in this quarter related to working hours, including overtime, breach of overnight rest requirements and difficulties achieving natural breaks. There were no reports relating to educational opportunities. There were no immediate safety concerns raised.

c) Work Schedule Reviews

Status (7 exception reports - figures include 4 exceptions carried forward);

Work Schedule reviews by grade	
F1	0
F2	1 (1 L1; 1 completed)
CT1-3	4 (1 L1, 3 L2; 4 pending)
ST3-6	3 (3 L1; 1 pending, 2 completed)
GPVTS	0
Total	0

5 reviews were pending at the end of Q1; four relate to the same postgraduate doctor in training and are carried forward from previous quarters preceding the tenure of the current Guardian of Safe Working. Of the pending reviews, 3 exception reports have been escalated for L2 review and 2 for L1 review.

d) Locum bookings and vacancies

Locum bookings APRIL 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	70	70
Rota 2	13	13	134.50	134.50
Rota 3	34	34	338.00	338.00
Rota 4	15	15	144.00	144.00
Rota 5	22	22	220.50	220.50
Rota 6	29	29	284.50	284.50
ST4-6 North	10	10	135.50	135.50
ST4-6 Rea/Tam	12	12	248.00	248.00
ST4-6 Sol/East	24	24	464.00	464.00
ST4-6 South	6	6	82.00	82.00
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	51.00	51.00
Rota 2	15	15	158.50	158.50
Rota 3	19	19	172.00	172.00
Rota 4	12	12	122.50	122.50
Rota 5	12	12	108.50	108.50
Rota 6	28	28	286.00	286.00
ST4-6 North	19	19	276.00	276.00
ST4-6 Rea/Tam	8	8	152.00	152.00
ST4-6 Sol/East	24	24	456.00	456.00

ST4-6 South	6	6	78.50	78.50
Total	160	160	1861.00	1861.00

Locum bookings JUNE 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	5	5	60.50	60.50
Rota 2	5	5	45.50	45.50
Rota 3	25	25	256.00	256.00
Rota 4	9	9	78.50	78.50
Rota 5	16	16	163.50	163.50
Rota 6	21	21	201.50	201.50
ST4-6 North	12	12	163.00	163.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	23	23	416.00	416.00
ST4-6 South	5	5	64.00	64.00
Total	130	130	1616.50	1616.50

Locum bookings APRIL 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	120	120	1191.50	1191.50
ST4-6	52	52	929.50	929.50
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	93	93	898.50	898.50
ST4-6	57	57	962.50	962.50
Total	150	150	1861.00	1861.00

Locum bookings JUNE 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	81	81	805.50	805.50
ST4-6	49	49	811.00	811.00
Total	130	130	1616.50	1616.50

Locum bookings APRIL 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	110	110	1368.00	1368.00
NEW INTAKE	23	23	271.50	271.50
COVID	6	6	113.00	113.00
Sickness	9	9	96.00	96.00
Maternity Leave	3	3	36.00	36.00
Off Rota	16	16	140.50	140.50
Emergency Leave	1	1	16.00	16.00
Acting Up Consultant	4	4	80.00	80.00
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	114	114	1432.50	1432.50
Sickness	6	6	57.50	57.50
COVID 19	0	0	0	0
Off Rota	14	14	125.00	125.00
Emergency Leave	4	4	38.00	38.00
Acting Up Consultant	12	12	208.00	208.00
Total	150	150	1861.00	1861.00

Locum bookings JUNE 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	91	91	1142.50	1142.50
Sickness	7	7	69.50	69.50
COVID 19	2	2	24.00	24.00
Off Rota	15	15	158.50	158.50
Emergency Leave	6	6	69.50	69.50
Acting Up Consultant	9	9	152.50	152.50
Total	130	130	1616.50	1616.50

Data specifically relating to locum bookings to cover periods of industrial action has not been provided.

Fines levied

Rota	April 2023	May 2023	June 2023
ST North	0	0	1
ST South	3	1	1
ST Solihull	0	0	0

6 fines have been levied in Q1, totaling 11 hours at enhanced rates. All 6 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 the Guardian of Safe Working fund is now established. As of the end of Q1, the total in the fund from fines levied was £3658.04. Ideas for disbursement will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The number of exception reports raised within this period remains high, demonstrating positive engagement with exception reporting particularly by ST doctors. The majority of exception reports related to breaches of core rest requirements overnight during non-resident on calls. All 6 of the fines levied in Q1 were relating to this contractual breach, 83% of which were to postgraduate doctors in training working on the South ST rota. This suggests a higher workload overnight for doctors working in the South, compared to North and Solihull rota areas.

Given the persistence of this issue, and the number of fines levied and work schedule reviews triggered, a meeting was held on 16 May 2023 attended by ST rota representatives, Dr Giles

Berrisford (Deputy Medical Director), Angela West (Senior People Partner) and Dr Shay-Anne Pantall (Guardian of Safe Working). In this meeting, alternative rota patterns were proposed including changing from non-resident on call to a full shift pattern and reducing number of rotas from three to two during weekdays to reduce on call frequency. Discussion remains ongoing with regards to the proposed changes including how the geographical area will be divided and governance of on call consultant supervision of higher trainees, with the most recent meeting on 8 September 2023. Additional rest facilities have been identified. Implementation is planned for 1 February 2024.

There were 18 outstanding exceptions by the end of Quarter 1, 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, although much of the previous backlog has now been cleared since the appointment of new ST Tutor, Dr Helen Campbell. Reminders are sent by Medical Staffing to the supervisors and doctors involved with open exceptions. Common causes for delays include further information being required, delays in arranging review meetings due to trainee or supervisor leave, need for clarification from the Guardian of Safe Working and delay in doctors accepting the outcome of the review discussion on Allocate.

There continues to be a high number of shift vacancies, although reducing over the course of Q1 from 172 in April 2023 to 130 in June 2023. The largest proportion of the vacant shifts have been due to post vacancies. Industrial Action by junior doctors took place in April and June 2023; data specifically relating to locums required to cover during the strike period has not been provided by Medical Workforce. Vacant 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. Information relating to raising concerns and the exception reporting process is part of the Trust induction for junior doctors. The information available on Connect is currently being updated and vignettes have been developed by the Exception Reporting Working Group working as part of the Trust-wide trainee-led QIP addressing Trainees Raising Concerns.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. 10 unique exception reports were raised during this quarter, of which 60% were related to breaches of overnight rest requirements for non-resident on call working. 6 fines were levied against the Trust for breaches in safe working hours. A change to on call working patterns is still being negotiated with Higher Trainees.

Only 1 (10%) exception report raised during this quarter was closed within 7 days. Delays in the process have arisen as a result of delays in arranging review meetings, need for clarification as to outcome from the Guardian of Safe Working and outcomes not being accepted promptly by the postgraduate doctor in training.

The number of vacant shifts continues to be high (452 compared to 508 in 2022-23 Q4). The majority of gaps were due to post vacancies. 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:
Ongoing support from senior leaders in encouraging raising concerns through use of exception

reporting system is appreciated.

9. GOVERNANCE & RISK

9.1. Review and update of the BAF – Cover sheet

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	9.1		
Paper title	Review and update of the Board Assurance Framework		
Date	4th October 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
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:

King IV Corporate Governance Code 2016 states that "the Board should govern risks in a way that supports the organisation in setting and achieving its strategic objectives". While the Board and its committees are responsible for risks governance; oversight and scrutiny, management team are responsible for operationalising and implementing effective risk management plans across the organisation and creating space for accountability. Hence, the role of the Board and management in ensuring the effective implementation of robust risk management arrangements across the Trust is symbiotic and complementary.

The Board Assurance Framework (BAF) is thus one of the critical tools within the Board`s arsenal to enable it to gain assurance that risks to the delivery of the Trust`s strategic objectives are effectively, efficiently and robustly monitored, mitigated and managed in line with the Trust`s Risk Management Policy and best practice.

The review of the BAF builds on the previous review and scrutiny that had been provided by each Board Committee, however, much hasn`t happened since then the BAF was received as set out below. i.e. People Committee, QPES and FPP reviewed their cut of the BAF on 21st June while the Audit Committee received and scrutinised the entire BAF at its meeting on 13th July 2023. Comments and inputs from these committees and additional updates from the BAF risk leads with signed off by the relevant Executive Directors have been incorporated into this final version of the combined BAF.

By receiving, reviewing, scrutinising and approving this final version of the Trust BAF, the Board is fulfilling one of its fundamental functions with regards risk management i.e.

oversight, scrutiny and gaining assurance.

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

The Board is requested to:

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE and APPROVE*** *the content and structure of the updated BAF.*

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)

This final version of the updated BAF has previously been considered at the following Board Committees: -

- People Committee
- FPP
- QPES
- Audit Committee

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)*

Not applicable.

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)*

N/A

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

BAF – Board Assurance 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).	

1. Introduction and Context:

1.1 The Audit Committee Handbook defines the BAF as “the key source of evidence that links strategic [goals] to risks and assurances, and the main tool that the board should use in discharging its overall responsibility for internal control”.

1.2 However, failure to adequately managed BAF risks in an organisation can be caused weaknesses such as: -

- Inadequate recognition and appreciation of BAF risks.
- Lack of engagement and exemplary risk aware attitudes and behaviours from senior managers.
- Insufficient analysis of significant operational risks and linking these to the BAF.
- Failure to identify suitable risk response activities/mitigation plans.
- Lack of a robust risk training and development programme to ensure shared understanding and consistency in risk description and quantification.

1.3 However, to be successful in effectively and robustly monitoring, mitigating and managing risks on the BAF, risk management initiatives that are implemented must be: -

- Aligned, comprehensive, embedded, dynamic and responsive to the changing business landscape faced by the Trust.

2.1 Baker Tilly and the NHS Providers emphasise the importance of the BAF in providing assurance to the Board by issuing a Board Assurance toolkit in 2015 entitled “Do we really know what we think we know?” in which they are argue that: -

> Assurance mapping as a key part of developing and maintaining board assurance arrangements and producing a BAF should provide an organisation with improved ability to understand and confirm they have assurance over key controls and “really know what they think they know”.

Hence, it is important that Board members draw sufficient assurance from the BAF in ascertaining that they “really know what they think they know”.

3. Conclusion:

3.1 In addition to providing assurance, an effective BAF should translate into tangible gains for patients through improved quality of care, enhanced patient experience, better decision-making and more efficient prioritisation and allocation of scarce resources.

3.2 An effective BAF is a confirmation that management and the Board have clearly identified and defined the Trust`s strategic goals, are aware of the principal risks to their delivery and are assured that there is a clear plan in place for monitoring, mitigating and managing the Trust`s principal risks.

9.2. Updated combined Board Assurance Framework (BAF)

OUR VALUES

Compassionate. Inclusive. Committed.

VISION

Improving mental health wellbeing.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board, we are willing to take decisions that are likely to bring scrutiny of the organisation.
We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

NB All risk scores detailed in Appendix I – BAF Risk Scores September 2023

Table 1a: QPES BAF summary showing movements in risks since last review:

Risk Ref.	Title of Risk	Executive Lead	Oversight Committee	Lead or Doer	Current risk score	Movements in risk score
			QPES BAF			
BAF01/ QPES	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/Lead, recovery, service user, carer & family experience/AD for Allied Health Professions & Recovery.	12	⟷
BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance.	From 12 to 16	↑
BAF03/ QPES	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/ AD of Clinical Governance.	16	⟷
BAF04/ QPES	Potential failure to implement a recovery focus model across our range of services.	Executive Director of Operations	QPES	Assoc. Dir. for Allied Health Professions & Recovery/ Lead, recovery, service user, carer & family experience / AD of Operations	12	⟷
BAF05/ QPES	Potential failure to be rooted in communities and tackle health inequalities.	Executive Director of Operations.	QPES	AD of EDI/ Head of Community Engagement/ ADs of Operations.	16	⟷
BAF06/ QPES	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	Executive Director of Operations	QPES	ADs of Operations	16	⟷
BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental	Executive Director of Operations	QPES	Head of Strategy, Planning and Business Development/	16	⟷

	health services across our systems			ADs of Operations		
FPP BAF						
BAF01/ FPP	Failure to focus on and harness the wider benefits of digital improvements.	Executive Director of Finance	Chief Information Officer (CIO) Joint Dir ICT & Programmes	Finance, Performance & Productivity Committee.	12	⟷
BAF02/ FPP	Potential failure in the Trusts care of the environment regarding implementation of the Green Plan	Executive Director of Finance	Dir. of Operations SSL	Finance, Performance & Productivity Committee.	6	⟷
BAF03/ FPP	Failure to operate within its financial resources.	Executive Director of Finance	Deputy Dir. of Finance	Finance, Performance & Productivity Committee.	16	⟷
BAF04/ FPP	Potential failure to comply with the requirements of Good Governance.	Executive Director of Finance	AD Corporate of Governance	Finance, Performance & Productivity Committee.	15	⟷
BAF05/ FPP	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Executive Director of Finance	Deputy Dir. of Commissioning & Transformation	Finance, Performance & Productivity Committee.	16	⟷
People Committee BAF						
BAF01/ PC	Potential failure to shape our future workforce.	Executive Director of Strategy, People & Partnerships	People Committee	AD OD	16	⟷
BAF02/ PC	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI & OD	16	⟷
BAF0 3/PC	Inability to modernise our people practice.	Executive Director of Strategy, People & Partnerships	People Committee	Head of People & Culture	16	⟷
BAF04/ PC	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI	16	⟷

1b. BSMHFT BAF Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic			BAF04/FPP		
4 Major			BAF01/FPP	BAF02/QPES BAF03/QPES BAF05/QPES BAF06/QPES BAF07/QPES BAF03/FPP BAF05/FPP BAF01/PC BAF02/PC BAF03/PC BAF04/PC	
3 Moderate		BAF02/FPP		BAF01/QPES BAF04/QPES	
2 Minor					
1 Insignificant					

Appendix 1: Details of BSMHFT BAF

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	Quality, Patient Experience and Safety Committee	
Title of risk	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	**Current Risk Rating**	3	4	12		
		Target Risk Score	3	2	6	**Date added**	**02nd June 2023**
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF01/QPES	**There is a risk that the Trust may fail to explore and respond to incident data in appropriately optimising the role and benefits that EBEs, patient safety partners and driving improvements in service user experience of care.** This may be caused by: -				
	• Inability to effectively collate and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover. • An overwhelmed workforce unable to embrace new and innovative ways of working. • Lack of a cultural shift required to capture the needs of families and carers.	• Community transformation • The design of a Community engagement Framework being led by the ICB. • QI Programmes with our EBE`s. • Ongoing work around preventative needs and stigma. • The developing Participation and experience team is	• Changes in the Policy landscape and the creation of ICBs and system working. • Challenges around workforce as genuine engagement requires	• Quarterly reports on participation and engagement presented at Trust Clinical governance and QPES. • QI Reports • Executive oversight of the engagement activities.	• Lack of regular and frequent governance reporting and oversight. • Inability to integrate and effectively use data in reporting. • Lack of EBE Strategy • Patient safety partners are new to the organisation and

	• A stretched workforce that hasn`t always got the capacity to make these relationships. • Difficulties with sharing good practice and duplicating it. • The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services. • The diversity of our communities means Communities can find us hard to reach. • Lack of consistency and burnt-out workforce in some of the services. • High use of bank and agency staff can impact on our capacity to build relationships with families.	providing support on the wards. • Review, development, and implementation of a Family Pathway. • Recovery College • Community engagement programme. • Community transformation and working with the Third Sector. • An asset-based Community approach. • Patient Carer Race Equality Framework • Synergy Pledge. • Recruitment of 5 Patient Safety Partners	sufficient and consistent staff.		at early stages of implementation – there is an absence of defined strategy for how they will be utilised.
	This may or result in: -				

	• A reduction in quality care. • Service users not being empowered. • Services that do not reflect the needs of service users and carers. • Service provision that is not recovery focused. • Increased regulatory scrutiny, intervention, and enforcement action. • Failure to think family. • Inequality across patient population. • Workforce that is not equipped or culturally competent to support populations and colleagues. • Failure to provide resources that support health, wellbeing, and growth. • Lack of engagement. • Reactive rather than proactive service model. • Increased service demand.

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/QPES /001	Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	
	BAF01/QPES /002	Better integration of Community engagement and patient experience.	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	

	BAF01/001 QPES	Identify a clear strategy for the next 12 months on how we will use EBE's to inform improved patient experience outcomes	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	
	BAF01/002 QPES BAF02/ QPES	Ensure a robust Induction and education package that enables our New Patient Safety Partners to feel fully prepared for role.	AD for AHP and Recovery/ Head of Community Engagement with support from Head of Patient Safety.	31st Dec 2023	New action	
	BAF01/003 QPES BAF02/003 QPES	Identify a clear strategy for the next 12 months on how we will use Patient Safety Partners to inform improved patient safety outcomes	AD for AHP and Recovery/ Head of Community Engagement with support from Head of Patient Safety.	31st Dec 2023	New action	
	BAF01/003 QPES BAF02/003 QPES	Identify a clear strategy for the next 12 months on how we will use EBEs to inform improved patient safety and experience outcomes	AD Clinical Governance with support from Head of Patient Safety.	31st Jan 2024	New action	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
15.05.2023	We have been doing some engagement with refugees which has resulted in the Therapeutic model. Community engagement team have a well-developed a creative Art development programme in partnership with the Art programme across the city.
30.6. 2023	A quarterly report from the Participation and Experience team is now being reported to both Trust Clinical Governance and QPESC.

27.09.2023	Five Patient Safety partners have now been successfully recruited and are undergoing induction currently. With the implementation of PSIRF in the next few weeks there will need to be a clear strategy for the implementation of the role including phased inclusion at relevant meetings, input into learning responses and ensuring the voice of the SU is understood and considered. Action Leads have been identified and a meeting with leads will be arranged to discuss requirements and agreed timescales.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	3	4	12	Quality, Patient Experience and Safety Committee	
Title of risk	Failure to focus on the reduction and prevention of patient harm and at enhancing its safety culture.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	2	6	**Date added**	02nd June 2023
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF02/QPES	***There is a risk that the Trust may fail to focus on the reduction and prevention of patient harm and at enhancing its safety culture.*** ***This may be caused by: -***				
	• *lack of implementation of a quality improvement process* • *unwarranted variation of clinical practice outside acceptable parameters* • *insufficient understanding and sharing of excellence and learning in its own systems and processes*	<u>Internal</u>: • Mortality Reviews • Rapid Improvement Week. • Mortality Case Note Reviews. • Structured Judgement Reviews. • Physical Health Strategy and Policy. • Learning from Deaths Group. • Clinical Effectiveness Advisory Group. • SI oversight Group • Patient Safety Advisory Group (PSAG). • patient satisfaction	<u>Mortality</u>: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Learning from Deaths Reports. • Community Deaths Reports. • Medical Examiner Reports.	<u>Learning for improvement</u>: • Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board. • Legal Quarterly Report • Never Events Reports • Commissioner and NED quality visits	<u>Learning From Improvement</u> Analysis and triangulation of data across different sources needs to be strengthened and made more consistent. Gaps in assurance: Safe staffing data for medical and nurse staffing. Gaps in assurance re adherence to duty of

		Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Clinical audit prog • CQC Bi-monthly Engagement Meetings <u>External</u>: • CQC Insight Data • CQC Alerts • Public View • Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme) • Coroner's Reports • QSIS compliance	• NHS Digital Quarterly Data. • Commissioner and NED quality visits. • Gap in MHA Action Plan oversight arrangements from CQC inspections	• Organisational Safety Bulletins. • Safety Summits <u>Third level assurance</u>: • CQC planned and unannounced inspection reports. • Internal and External Audit reports.	candour for moderate harm incidents. Gaps in assurance audit and NICE compliance to QPES and Board. Embedding learning from Sis, complaints, and incidences. Development of Trust Quality Strategy.
	• *lack of self-awareness of services that are not delivering.*	Clinical Governance meetings Directorate/Specialty governance meetings Improvement Programme.	Improvement Plans oversight Inconsistency in approach of local CGC arrangements	Standardized QPESC agenda item enabling escalation reporting to Trust CGC Triple A reporting to QPES from CGC	Inconsistency in what type of information is reported/escalated to Trust CGC by local CGCs

	• *poor management of the therapeutic environment.*	Capital prioritisation process SSL Service Agreement Forum CQC well-led and unannounced visits.	Gap in MHA Action Plan oversight arrangements from CQC inspections Absence of Mental Health Committee.	Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting Health and Safety committee reporting and oversight of Ligature and Environmental Risk Assessments Audits Results CQC Steering Group – oversight of Action Planning	Trust focus on MHA compliance at CGC is broad – no current assurance framework for how action plans following MHA inspections are monitored/completed as completely devolved to local divisions. Current CQC Report is very inspection focused and does not encompass the broader CQC/regulatory compliance agenda. Whilst reporting on Ligature and Environmental RA is in place – there is not a robust accountability framework in place for how actions from the assessments are overseen/managed at Divisional level with stratification of associated risk at trust level.

	• *insufficient focus on prevention and early intervention.*	Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation. Rich QI resource and draft strategy PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data tracking/themes and trending and adoption of a QI approach to resolution.		QMS update reporting to QPES QI reporting to Trust CGC and QPES Safety Summit Reporting is included in the Patient Safety Report to Trust CGC, QPES, and Board Independent annual assessment against the 68 NHS Core Standards for EPRR.	QMS is in its early adoption stage and requires trust-wide commitment and resource to embed Rich QI resource is currently under utilised for Priority1 QI Workstreams Safety Summit Framework requires strengthening Lack of upward reporting from PSAG to Trust CGC QI Strategy to be approved.
	• *limited co-production with services users and their families.*	Patient Safety Advisory Group Patient Stories.	PSAG do not send exception reporting to QPESC	FFT Scores Exception reports: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports Internal inspection and review reports: Data sets: • PALS contacts data	

				• Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board.	
	• *insufficient staff with the correct skill set*	Improvement Programme Improvement Plans <u>Governance Forums</u>: • Clinical Governance meetings • Directorate/Specialty governance meetings Safety Huddles Professional Codes of Conduct • NMC Code • GMC Good Medical Practice Guide. • HCPC Standards of Conduct, Performance and Ethics.			
	This may result in: -				
	• Failure to meet population needs and improve health. • Variations in care. • Unwarranted incidents. • Less safe care.				

	Linked risks on the CRR-Risk ID	**Brief risk description**
	1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/QPES /001	Implementation of PSIRF by October 2023 strengthening the wholescale approach to understanding and sharing of excellence and organisational learning.	Interim AD of Nursing & Governance	October 2023	• Includes detailed data analysis of trust wide patient safety datasets. • Identifies Safety priorities for the Trust to focus on for the last 12 months detailed analysis. • Resultant outcomes from PSIRF implementation will be a Patient Safety Incident Response Plan and Policy.	
	BAF02/QPES /002	Review of Trust processes that apply a performance management approach to key Quality/Governance KPIs at Divisional level	Deputy Director of Nursing /Company Secretary/ Associate Director of Nursing and Governance	October 2023	• Ensure robust confirm and challenge, enable meaningful escalation and support and timely intervention into local areas of required improvement.	

	BAF02/QPES /003	Comprehensive Review of Governance Arrangements from Ward to Board – TOR will be approved including methodology of approach – to be presented to ET and QPESC. (Amended Action)	Deputy Director of Nursing /Company Secretary Associate Director of Nursing and Governance	February 2024	• Standardise the approach to local governance arrangements ensuring consistent and robust assurance to Board.	
	BAF02/QPES/004	Robust oversight and assurance framework will be devised and implemented to ensure organisational oversight of actions from MHA inspections. (New Action)	Associate Director of Governance	January 2024	• Framework will provide structure and clarity around oversight of MHA implementation and related actions. This will help to prevent the risk.	
	BAF02/QPES/005	CQC Report and Trust Steering Group will be reviewed and amended to provide comprehensive assurance of compliance with CQC framework and regulatory compliance overall. (New Action)	Associate Director of Governance	Dec 2023	• Will ensure clear line of sight on CQC framework and regulatory compliance, enabling robust scrutiny, challenge, and support where required	
	BAF02/QPES/006	Draft QI Strategy to be approved. (New Action)	Deputy Medical Director for Patient Safety and Quality and Associate Director of Governance	January 2024	• Will enable QI resource to be allocated most usefully to the organisation alongside being a key function of the QMS. • Will assure the Board of QI approach and embedding QI culture into the organisation.	
	BAF02/QPES/007	Revised Safety Summit framework to be completed. (New Action)	Associate Director of Nursing and Governance	January 2024	• Forms part of the assurance to the board of a learning culture and aligns with PSIRF methodology.	
	BAF02/QPES/008	Monthly PSAG Upward Report to be shared with QPESC for noting/questions.	Associate Director of	November 2023	• Ensures oversight from QPESC of the discussions, emerging themes, and risks from PSAG	

		(New Action)	Nursing and Governance			

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

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

	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	2	2	4		
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date added**	2nd June 2023
						Date reviewed	27th Sept 2023
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
	There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance. This may be caused by: -						
BAF03/QPES	• Inability to effectively use time resource in driving improvements and safety. • Failure to use QI approaches to develop pathways to improve access to services. • Inability to develop and embed an organizational learning and safety culture.	• SI oversight Group • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity.	Limited assurance from current approach to review of quality and governance metrics at Divisional level. Limited reporting of Divisional quality reviews to QPES and Board.	• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board.		The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. The Safety Summits are in their early conception and may not be adopted	

	• Inability to review the Trust`s safety culture so as to identify and address any gaps. • Failure to identify, harness, develop and embed learnings from deaths processes. • Failure to develop and embed `Think Family Principle`. • Failure to fully address the improvements against the CQC action plan.	• Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Implementation of Learning from Excellence (LFE). • PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support. • Freedom to speak up processes. • Cultural change workstreams including Just Culture. • NHS staff survey	No organisational wide reporting of LFE metrics.	• Updates on PSIRF Implementation to QPES and Board.	well by Divisions/services.

	• Variations in safety culture across the organisational at Divisional and Service Level. • Inconsistencies in governance arrangements at Divisional and corporate level.				
	This may result in:				
	• A culture where staff feel unable to speak up safely and with confidence. • Failure to learn from incidents and improve care. • A failure to develop pathways of care within the Integrated Care System. • Increased regulatory scrutiny, intervention, and enforcement action. • Insufficient understanding and sharing of excellence in its own systems and processes. • Lack of awareness of the impact of sub-standard services. • Variations in standards between services and partnerships. • Demotivated staff. • Missed opportunities for System Engagement.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	There is no current CRR	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being	BAF03/QPES /001	Implementation of PSIRF by October 2023 strengthening the wholescale approach to understanding and sharing of excellence and organisational learning.	Interim AD of Nursing & Governance	October 2023	• Includes detailed data analysis of trust wide patient safety datasets. • Identifies Safety priorities for the Trust to focus on for the last 12 months detailed analysis.	

implemented to achieve target risk score.					• Resultant outcomes from PSIRF implementation will be a Patient Safety Incident Response Plan and Policy.	
	BAF03/QPES /002	Organisational Safety Culture Assessment will be completed, and Divisional led action plans put into place to address safety culture concerns.	Interim AD of Nursing & Governance	October 2023	• Baseline of understanding will be achieved. • Divisional level ownership and engagement will be ensured.	
	BAF03/QPES /003	PSAG Agenda and Cycle of Business will be reviewed and strengthened.	Interim AD of Nursing & Governance	July 2023	• Will support cross organisational learning across a broad suite of topics, specialisms, and services.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	PSIRF update as above. - Options appraisal to support organisational safety culture assessment has been devised for presentation to ET.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement a recovery focus model across our range of services.	**Inherent Risk Rating**	4	4	16	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF04/QPES	**There is a risk that the Trust may fail to implement a recovery focus model across our range of services.** This may be caused by: -				
	Lack of opportunities for service user participation. Lack of employment opportunities for those with lived experience. Lack of support for and involvement of families and careers.	• BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Family and carer pathway. • BSOL peer support approaches. • Expert by Experience Reward and Recognition Policy.	Family and carers pathway not consistently applied or suitable for all services.	• Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR) Group. • Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	Having a strong service user/carer voice across all of our governance forums.

		• EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Recovery training part of fundamental training			
	This may result in: -				
	• Inferior and poor care. • Lack of equity for service users across our diverse communities. • Ineffective relationships with key partners. • Lack of continuity of care and accountability between services. • Negative impact on service user access, experience and outcomes. • Negative impact on service user recovery and length of stay/time in services.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF04/QPES /001	Review and refresh of the family and carer pathway	Associate Director for Allied Health Professions and Recovery	Mar 2024	Families and carers will be routinely identified, and better supported or involved in care planning as appropriate.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Updating access to information policy by service users and carers and following a QI co-production approach.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to be rooted in communities and tackle health inequalities.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

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

	Demand for community services exceeding our capacity to deliver good quality, timely care. People having to go out of area for inpatient care due to inadequate service provision in area. Failure to have appropriate quality and modern estates and facilities	year 3 of implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work. • Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighborhood teams. • Development of community collaboratives. • Community engagement team	developments alongside day job. • Recruitment and retention	• Local FPP and CGC meetings. • Highlight and escalation reporting into Strategy and Transformation Board. • Performance Delivery Group “deep dives”. • Highlight and escalation reporting into BSOL MHPC Executive Steering Group.	
	This may result in: -				

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/QPES /001	Work ongoing to keep down capital costs of major developments, e.g. assessing potential use of a modular build.	Deputy Director of Estates / Associate Directors of Operations	Mar 2024	Affordable capital plans with identified funding.	
	BAF05/QPES /002	Quality improvement approaches being embedded to support transformation.	Head of Quality Improvement / Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF05/QPES /003	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF05/QPES /004	Support for development and implementation of divisional health inequalities plans from EDI team	Jas Kaur / Associate Directors of Operations	Oct 2023	Services will understand their current gaps and have actions in place to improve access, experience, and outcomes.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Co-produce approach with patients and carers and Voluntary Sectors and have devised a plan to integrate our patients successfully in the Communities.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF06/QPES	**There is a risk that the Trust may fail to implement preventative and early intervention strategies which can help enhance mental health and wellbeing.** This may be caused by: -				

	Demand for services exceeding our capacity to deliver good quality, timely care.
	.
	Lack of admission alternatives, including full range of crisis support services.
	Waiting times to access Solar services in Solihull.
	Waiting times to access Birmingham Healthy Minds.
	Inadequate support for our service users with mental health co-morbidities e.g.,
		• System approaches to improving and developing services.
		• Solihull Children and Young People Transformation Programme including:
		  ○ Transition workers
		  ○ Mental health support in schools.
		• Talking therapies recovery plan.
		• Urgent care transformation plan including:
			• Capacity within teams to deliver transformation and service developments alongside day job.
			• Recruitment and retention impacting delivery plans.
				• Integrated performance dashboard.
				• BSOL system mental health performance dashboard.
				• BSOL Talking Therapies Steering Group.
				• Solihull CYP Board.
				• Highlight and escalation reporting into Strategy and Transformation Board.
				• Performance Delivery Group “deep dives”.
				• Highlight and escalation reporting into BSOL
					• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.

	substance misuse, learning disability, autism etc.	○ Heartlands mental health hub ○ Additional Place of Safety and PDU capacity/staffing ○ Call before you Convey ○ Crisis house ○ Psychiatric liaison. • Partnership working re dual diagnosis processes and pathways. • LDA training for staff • Sensory friendly wards • LDA reasonable adjustments tool.		MHPC Executive Steering Group. • Clinical Effectiveness and Assurance Group.	
	This may result in: -				
	• Service users being cared for in inappropriate environments when in crisis. • Increased pressure on A&E in acute hospitals. • Increased risk of incidents. • Individuals' mental health issues escalating leading to increased need for secondary care. • Negative impact on recovery and length of stay/time in service. • Increased local and national scrutiny. • Negative impact on service user access, experience and outcomes.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			

	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc. due to the lack of AMHP availability, particularly out of hours.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF06/QPES /001	Quality improvement approaches being embedded to support transformation.	Head of Quality Improvement / Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /002	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /003	Review of MHPC provider collaborative governance, including terms of reference and reporting and escalation flows.	Associate Director of BSOL MHPC	Sept 2023	Appropriate oversight and assurance.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**26th** June 2023.
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date reviewed**	**27th Sept 2023**

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

	Not having service user voice to inform transformation and development plans	• Strategic partnerships with local authorities, VCFSE, NHS providers, primary care, police. • System wide approach to transformation e.g., community. transformation, urgent care pathway, talking therapies. • Internal project commenced scoping how we can be more integrated in our pathways and teams.			
	This may result in: -				
	• Lack of joined up pathways and care. • Service users falling between gaps. • Poor service user experience. • Poor service user outcomes. • Negative Trust reputation. • Loss of confidence in the Trust by partners. • Potential duplication of effort and services. • Poor value for money.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF07/QPES /001	Refresh Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Sept 2023	We will have a clear direction of travel, with our gaps identified and ambitions articulated to address the gaps and respond to our opportunities.	
	BAF07/QPES /002	Develop implementation plan for Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Dec 2023	We will have a coherent plan of how we are going to strengthen our partnership working.	
	BAF07/QPES /003	Commission Needs Assessment	Associate Director of BSOL MH Provider Collaborative	End Dec 2023	We will understand the needs of our core population and its diverse communities and can make sure our strategies and plans address these.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
26/06/2023	New risk which has just been added.
27/09/2023	Board session held on 6 September, led by P. Nyarumbu to discuss direction of travel for elements of the Partnerships Strategy. Further work to be undertaken following the session and feedback to be incorporated into the current draft strategy. Agreed that completion will be put back pending this. High level implementation plan is included in the draft strategy.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to focus on and harness the wider benefits of digital improvements.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023
		Risk Appetite	**Seek:** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)			**Date reviewed**	**19th Sept 2023**

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

		• Offering a one stop show to help engage around all things Digital, Data & technology. • We can help teams scope the problem and look at a myriad of solutions before settling on the right approach. • The System strategy group is the gatekeeper for all things Digital, data and technology in the Trust.			
	• *There may not be the financial support or budget to look at digital solutions.*	• All capital business cases go to the Capital Review Group, and this offers the ability for new ideas to be looked at through a lens keeping digital on the agenda. • The DOF Chairs, CIO is included in the distribution of	• Only new Business case projects go thorough the Capital Review Group, existing services are not considered unless capital investment is required.	• Minutes • Reports to FPP committee • Business cases	• Does not apply to existing or service redesign if no funding is required

		all new business cases.			
	• *Teams and services are not aware of digital solutions within the Trust.*	• System strategy group produces an annual update to the Trust (Digital newsletter). • The PMO ensures all digital projects have a case study and project on a page submitted to Connect and the staff briefing as they occur. Individual projects are discussed at FPP in the quarterly assurance update. • Strategy and Transformation Board receive a monthly update on all live projects.	• Articles, minutes, papers are predominantly digital media. • Those systems in place for a while no longer get entered into the papers or articles unless it is a significant change.	• Connect • Digital newsletters • Minutes of FPP • FPP Papers • System strategy minutes and papers. • Strategy and Transformation Board, minutes, and papers.	• Does not apply to existing products / systems.
	This may result in: -				
	• *Inability for services to innovate.* • *services do not engage with the digital first agenda.* • *Efficiencies and savings are not realised.* • *Quality improvements are not optimised.*				

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	**BAF01/FPP/001**	Wider communication across the Trust regarding the Systems Strategy Group, including its role.	James Reed / Carl Beet	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	
	BAF01/FPP/002	Raise awareness of the ability for the Systems Strategy Group to help in service redesign and re-imagining service delivery. Start with Senior Leadership Team meeting and professional user groups	James Reed / Carl Beet / Shaun Kelly	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
12/06/2023	This is a new risk which has been recently added.
19/09/2023	Updates to FPP have taken place in line with the quarterly cycle, 9 comms articles have gone out in the last quarter lifting the profile of digital projects and services featured in the weekly brief. The Digital strategy is in draft and has been shared with FPP and circulated through wider meetings as part of a general digital awareness. We have dedicated snap comms for all things digital and have used the snap comms to promote campaigns on cyber awareness, general digital updates, and system upgrades. We have expanded the use of the virtual agent / chat bot “Ask Jake” which now covers the majority of password resets in the organisation and we are looking to expand that in to other departments such as HR and Estates.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure in the Trust's care of the environment regarding implementation of the Green Plan	**Inherent Risk Rating**	3	3	9	Finance, Performance & Productivity Committee	
		Current Risk Rating	3	2	6		
		Target Risk Score	3	2	6	**Date added**	8th June 2023
		Risk Appetite	**Open:** We are willing to consider all potential delivery options, service opportunities and involvement of Trust employees in seeking to meet national and local targets.			**Date reviewed**	**12th Sept 2023**

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

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

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

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

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
	BAF02/FPP/ 001	Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	On-going	Full Action Plan schedule established, set against Regional and National objectives.	

Actions being implemented to achieve target risk score.	BAF02/FPP/ 002	Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust	tbc- circa February 2024	The development of a business case will allow the planning of lifecycle/ maintenance responses on Reaside premises and ultimately address the replacement of the premises supporting safe, and sustainable care environment.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
11/05/2023	Full review of all 31 Estates and Facilities Risks, 12 Risks accepted and closed these will be reviewed annually to ensure circumstances and mitigation remains in place. The remaining 19 Risks have been re-assessed for content, mitigation, likelihood, and impact.
12/09/2023	Strategic Trust Sustainability/ Green Meetings BAU. Works underway to draft achievement against NHS E MOU. Comms Plan for Autumn/ Winter 23 underway. Liaison with Trade Unions on information and details for Green initiatives.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Failure to operate within its financial resources.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	09/06/2023
		Risk Appetite	**Open:** We are willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward.			**Date reviewed**	**19th Sept 2023**

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

	This may result in: -	
	• *Trust not meeting its financial targets limiting available funds for investment in patient pathways.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.
	112	The Trust does not secure the growth funding we require.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF03/FPP/ 001	HFMA Sustainability Audit identified over 50 actions, that would lead to improvements in financial controls as well as savings delivery – these are updated and reported through Audit Committee.	Deputy Director of Finance	Each action has a different implementation date but expectation all completed by 31/3/24	Action will mitigate the impact of the risk were it to crystallise.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/04/2023	25 actions confirmed closed through April Audit Committee for HFMA Sustainability Audit.
01/09/2023	Communications issued to whole Trust re financial position – number of initiatives implemented to increase controls including Vacancy Control Panel and Investment Oversight Group. Work ongoing to identify further opportunities for efficiencies and work by KPMG at system level now being finalised which offers some further options

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to comply with the requirements of Good Governance.	**Inherent Risk Rating**	5	5	25	Finance, Performance & Productivity Committee	
		Current Risk Rating	5	3	15		
		Target Risk Score	4	2	8	**Date added**	25/04/2023
		Risk Appetite	**Open:** We are willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward.			**Date reviewed**	**19th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF04/FPP	There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice. This may be caused by: -				
	Lack of good intelligence on the current governance arrangements from Ward to Board. *Regulatory burden and pressures including ad hoc requests from regulators.* *A fluid regulatory landscape.* *A non-compliance mindset or mentality.* *A weak governance infrastructure.* *Excessive emphasis on compliance leading to a `tick-box` culture.* *Poor perception of compliance leading*	Regular and planned external inspections from the regulators e.g. CQC. Self-assessment, accreditation and self-certification. Setup a strong governance infrastructure to underpin compliance. Regular audits on compliance. Staff training and awareness sessions to	Operational pressures negatively impacting on staff capacity to fully implement these controls. Self-assessments, accreditation and self-certification processes aren`t strong. Governance around compliance is weak. Controls have not been embedded.	Inspection reports. Compliance audits. Self-assessment, accreditation and self-certification reports. External visit reports. Peer Reviews. Board Assurance Framework Report.	Poor learning from previous regulatory inspections. Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. Peer review not very regular. The culture of BAF not fully developed and embedded.

	compliance overload or fatigue. *Human factors, poor attitudes, human behaviours and desire to circumvent due process.* *Weak internal systems, processes and procedures.* *Lack of awareness of the added value of regulatory compliance to the business.* *Lack of openness, fairness, transparency and non-adherence to the Nolan Principles.* *Poor risk management arrangements.* *Inability to harness the benefits of good risk management in strengthening decision making.*	tackle poor behaviour around compliance. Strengthen the internal control systems and processes. Regular horizon scanning for cases of non-compliance. Awareness of the Nolan Principles Training; organisational capacity and capability building in risk management. Embedding and prioritisation of risk management. Use of intelligence from risk management in driving organizational safety culture.			
	This may result in: -				

	• *Regulatory action – penalty, notice etc.* • *Reputational damage to the Trust.* • *Poor patient care, safety and experience.* • *Loss of some business operations.* • *Legal actions in some extreme cases.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	1049	Failure to recruit and retain staff to enable safe staffing levels could result in a breach of HCSA regulation 18 (staffing). Risk of increasing reliance on agency and temporary workforce, will result in poor continuity of care and impact on safer staffing requirements.
	950	There is a risk that CMHT caseloads will continue to be above 35 which will breach regulation 18 HSCA (RA) Regulations 2014 Staffing. Caused by CMHT having 3 workstreams being: primary care talking therapies, memory drug prescribing & monitoring and core secondary mental health provision. This may result in higher risk of clinical incidents, increase in staff sickness, poor work-home-life balance, service users not receiving a quality service and increased waiting lists and waiting times for service users.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF04/FPP/ 001	To design a SOP to underpin the process for capturing, monitoring, review, scrutiny and governance oversight of external visits and externally commissioned reports registered.	David Tita	30/10/2023	The SOP will help reduce the likelihood of the risk materialising.	
	BAF04/FPP/ 002	Review of the Trust`s governance arrangements from `Ward to Board`.	David Tita & Lisa Pim	31/03/2024	This action will create a better understanding and help reduce the likelihood and impact were the risk to materialise.	
	BAF04/FPP/ 003	Review of the Trust`s Risk Management arrangements.	David Tita	20/12/2023	This action will create a better understanding and help reduce	

					the likelihood and impact were the risk to materialise.	

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	This is a new risk that has been recently added and is being appropriately mitigated and monitored.
19/09/2023	ToR for the review of the Trust`s governance arrangements have been finalised and are progressing through governance for approval and implementation. ToR also include a schedule for undertaking the governance review and an options appraisal reflecting potential options that have been considered and a recommendation of the preferred option. Timescales for delivering the various actions have been reviewed to align with the ToR.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	Oversight Committee	
Title of risk	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	2	6	Date added	2nd June 2023
		Risk Appetite	**Open:** We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.			Date reviewed	**22nd Sept 2023**

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

		• Better engagement with partners and shared governance arrangements. • Establishment of Memorandum of Understandings. • VCFSE collective and Panel embedded into governance structure in the Collaborative. • Implementation of Data Sharing Agreements.	*time to nurture, grow and mature.* • *Changes to the translation of the Procurement, Patient Choice and Competition Regs 2013.*		
	• *Poor Commissioning Committee decision-taking.*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance architecture. • Partnership Agreement • Memorandum of Understanding.	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out Commissioning Sub-Committee • Escalation and assurance reporting from Executive Steering Group • Auditable process for decision-taking • Consistent attendance at CoCo Sub-Committees	• Delays in getting signed agreements.
	• *Poor engagement with partners*	• Commissioning & Transformation Framework.	• Co-Production Strategy yet to be developed.	• Specifications which have been co-produced	• Time required to commission effective frameworks.

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/FPP/001	*MHPC Governance architecture governance meeting 23/6/23 to review accountabilities and ownership of risks.*	JW	June 2023	This action will create awareness and help reduce the likelihood were the risk to crystallise.	
	BAF05/FPP/002	Attendance at the VCFSE Collective and Panel Meetings which take place monthly	JW	Dec 2023	This action will create awareness and help reduce the likelihood were the risk to crystallise.	
	BAF05/FPP/003	Multi-agency engagement in decision forming groups for MHPC.	All Chairs Monthly	Dec 2023	This action will create awareness and help reduce the likelihood and impact were the risk to crystallise.	

	BAF05/FPP/004	Ownership of new and emerging risks and reporting within the Collaborative	JW	30/11/2023	This action will create awareness and help reduce the likelihood and impact of the risk were it to crystallise.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	Not applicable at this moment as risk has been newly identified.
28/09/2023	• There have been two workshops facilitated by Korn Ferries with the CYP Transformation Boards in both Birmingham and Solihull to support a re-set of the Boards including the positioning within the MHPC Governance Architecture. • Continued engagement with the VCFSE forum. • Multi-agency working groups have been established to take forward the commissioning of the Health Needs Assessment and Campaign to support the development of the BSOL MHPC Strategy.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to shape our future workforce.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Cautious:** We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.			**Date reviewed**	**21st Sept 2023**

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

		Health & Wellbeing offer Model Employer	Recruiting but not retaining colleagues	• Staff Survey results improving to top quartile performance.	• Staff survey results still reflect some gaps.
	• *Less attractive pay for some staff groups.*	Management of the workforce market: ICS workforce programme to manage demand and competition in the system in collaboration with partners. Membership of the ICS People Committee. Assertive recruitment to areas with chronic vacancy challenges. National payment mechanisms and banding panels. Remuneration Committee. Recruitment Policy and processes. Stabilisation Plan Retention Plan		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population • Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover • Analysis of exit interviews. • % staff who leave for a higher banded job.	• Falling to reassurance rather than assurance
	This may result in: -				
	• Failure to recruit a workforce that supports the values of the organisation. • Support the progression and development of the workforce. • An underperforming workforce. • Failure to represent the profile of the organisation within the workforce. • Sustained patterns of inequality and discrimination.				

	• High turnover • Non-compliant behaviours. • Employee relations cases.	
	Linked risks on the CRR-Risk ID	**Brief risk description**
	1058	Shrinking supply of mental health nurses nationally. Additionally, Difficulties in recruiting to and retaining Band 5 Registered Mental Health Nurse and shortage of experienced Band 6 Registered Mental Health Nurses continues to be a challenge (4x4=16)

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/PC/001	Deliver our workforce plan through: Increasing workforce supply to address workforce gaps across the organisation.	Head of Workforce Transformation	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF01/PC/002	Progressing the retention activities and improve our turnover rate.		Apr 24		
	BAF01/PC/003	Support delivery of service specific recruitment and retention plans.		Apr 24		
	BAF01/PC/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		Apr 24		
	BAF01/PC/005	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	Head of People & culture	Sep 23	Providing bespoke training packages to support managers.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*

09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Work predominately in this area is progressing as planned. Volumes in relation to INR has not been achieved as projected, however this is being addressed. Despite continuous IA around junior doctor and consultant pay, recruitment to consultant posts has increased. Retention is healthy within the Trust, priority is with attraction and onboarding. Score remains the same.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**22nd Sept 2023**

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

	This may result in: -	
	• Lack of recruitment • Reduce trust and confidence in communities. • Unmotivated workforce. • Increased bullying and harassment claims. • Increased sickness • Increased turnover	
	Linked risks on the CRR- Risk ID	Brief risk description
	N/A	N/A

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/PC/ 001	Provide continuous support to operational divisions in improving the experience of our workforce.	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF02/PC/ 002	Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme.	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF02/PC/ 003	Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional factors have been highlighted that add to the risk without increasing the score

Executive Lead	Executive Director of Strategy, People & Partnerships.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Inability to modernise our people practice.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	3	9	**Date added**	**2nd June 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**21st Sept 2023**

Reference / Risk ID or Number	Risk Description	**Controls** *Things in place to address the cause*	**Gaps in Controls** What are the weaknesses in the controls?	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** What are the weaknesses in the assurance?
BAF03/PC	There is a risk that the Trust may fail to modernise its people practice in ensuring the achievement of its operational objectives. This may be caused by: -				
	• *Inability to deliver digital solutions.* • *Inability to foster a psychologically safe environment.*	• Staff survey • Pulse check • Reflective HR casework • Transforming culture sub-committee • Systems strategy board • A range of digital platforms through which colleagues can escalate and feed in centrally. • QI Projects to address some of the	• Colleagues not completing surveys. • Capacity to undertake this work. • Low trust and confidence. • Lack of digital infrastructure.	• 360-degree feedback for senior leaders • FTSU quarterly reports to committees • HR casework tracker • Staff survey results improving in some areas. • Improved HR KPI reports. • Audit reports • Digital Staff management system.	• Falling to reassurance rather than assurance. • Lack of engagement and buy-in from staff. • Audits are not systematic as they are adhoc at the moment.

		concerns raised by staff. • Research and benchmarking against what good looks like. • Working with ICS partners to identify shared digital solutions. • Use of integrated digital solutions e.g. Digital passports.	• Lack of sufficient funding. • Lack of digital competence. • Lack of digital expertise within existing workforce resources to deliver training. • Digital solutions haven`t been embedded.		
	This may result in: - • Poor employer brand limiting recruitment. • Staff feeling vulnerable and unable to speak up resulting in missed opportunities to improve practice. • Increased retention of a valuable workforce. • Compensation costs. • Increased regulatory scrutiny, intervention, and enforcement action.				
	Linked risks on the CRR- Risk ID	Brief risk description			
	N/A	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
	BAF03/PC/	Develop a range of digital solutions to streamline or automate people processes	Head of People & Culture	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with	

Actions being implemented to achieve target risk score.	001				escalation opportunities available, locally and systemically.	
	BAF03/PC/ 002	Ensuring that ESR holds accurate and credible workforce data	Head of People & Culture	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Progress in relation to developing a range of digital solutions for our people processes has been slow due to staffing shortages, however some local work has been completed. Work is underway to address the accuracy within our ESR data and this now will be overseen by an internal workforce systems group. Score has not changed.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Current Risk Rating**	4	4	16		
		Target Risk Score	2	4	8	**Date added**	**6th July 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation and actively challenge racism and discrimination in everything we do. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**22nd Sept 2023**

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

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	BAF04/PC/ 001	Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU	AD OF EDI	31/01/2024	Action will mitigate potential likelihood of risk materialising.	
	BAF04/PC/ 002	Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust	AD OF EDI	29/02/2024	Action will mitigate potential likelihood of risk materialising.	

target risk score.	BAF04/PC/ 003	Take PCREF from pilot to full implementation	AD OF EDI	31/01/2024	Action will mitigate potential likelihood of risk materialising.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
06/07/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional assurance available from the NHS EDI Improvement plan, score remains

9.3. Commissioning BAF

OUR VALUES

Compassionate. Inclusive. Committed.

VISION

Improving mental health wellbeing.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board, we are willing to take decisions that are likely to bring scrutiny of the organisation.
We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

Assurance Committee: Commissioning Committee

NB All risk scores detailed in Appendix I – BAF Risk Scores October 2023

Table 1a: BAF summary showing movements in risks since last review: -

Risk Ref.	Title of Risk	Executive Lead	Committee oversight	Current risk score	Movements in risk score
BAF1-CoCo	Potential failure to deliver contractual responsibilities as lead provide.	Executive Director of Strategy, People and Partnerships	Commissioning Committee	8	⟷
BAF2-CoCo	Trust may fail to develop a culture and operating model to deliver collaboration.	Executive Director of Strategy, People and Partnerships	Commissioning Committee	12	⟷
BAF3-CoCo	Potential failure to ensure the required workforce capacity and capability across the collaboratives.	Executive Director of Strategy, People and Partnerships	Commissioning Committee	16	⟷
BAF4-CoCo	Failure to ensure safe, effective, equitable and quality services across the collaborative.	Executive Director of Quality and Safety (Chief Nurse)	Commissioning Committee	12	⟷

1b. CoCo BAF Heat Map:

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic					
4 Major		BAF1-CoCo	BAF2-CoCo BAF4-CoCo	BAF3-CoCo	
3 Moderate					
2 Minor					
1 Insignificant					

Appendix 1: Details of BAF - Commissioning Committee Board Assurance Framework

Executive Lead	Executive Director of Strategy, People and Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	**Potential failure to deliver contractual responsibilities as lead provide.**	**Inherent Risk Rating**	5	4	20	Commissioning Committee	
		Current Risk Rating	5	3	15		
		Target Risk Score	4	2	8	**Date**	**18th May 2023**
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.				
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
Sustainability	***There is a risk that the Trust may fail to deliver its contracted responsibilities as Lead Provider.*** **This may be caused by;**						
BAF1-CoCo	• *Inadequate service delivery by sub-contractors.*	• Effective procurement of subcontractors, including appropriate due diligence of performance and regulatory compliance. • Clear terms of contract including exit arrangements. • Regular Contract Management meetings. • Contracting Framework.	• *Delays in the commencement of CQRMs.* • *Insufficient reporting of performance and outcomes activity from 1 April 2023.*	• Due Diligence Report. • Signed sub-contracts. • ICB evidence on mandated providers. • Effective Reports to System Quality Group, System Oversight Group, People Delivery Group, and Lead Provider Oversight Group. • CQC Reports. • Regulatory Reports. • Coroner Reports.		• *Sub-contracts of the Lead Provider arrangements will not be signed until Aug/September 2023 due to delays with the Lead Provider Contract sign off.*	

		• Commissioning and Transformation Framework Contract Management Framework.			
	• *Failure to respond to health inequalities.*	• Health Needs Assessment. • Targeted service delivery to address areas of need. • Engagement with service users and co-production of service delivery. • Regular engagement with Locality Committees, HOSC, Health and Wellbeing Boards and Healthwatch.	Lack of awareness of new protected characteristics.	• Provision of report from independent consultancy in response to HNA specification. • Improved performance for key metrics, e.g., suicides, self-harm, use of inpatient beds, out of area delivery, access. • EBE attendance and collaboration across collaboratives.	• Time required to procure the HNA will impact on timeliness to respond to health inequalities. • Insufficient resources that may be available to address health inequalities identified.
	• *Inadequate internal commissioning and contracting function.*	• Commissioning and Transformation Framework. • TUPE transfer of ICB staff and financial resources to ensure capacity and capability in place. • Hub Operational Policy. • Commissioning & Transformation staffing training needs analysis.	• Insufficient resource identified and transferred from ICB into BSMHFT.	• Annual appraisals. • Completed TUPE transfer. from ICB to BSMHFT • Workforce review completed and implemented.	• Time to complete workforce consultation on proposed Commissioning & Transformation Hub.

		• Defined structure and workforce establishment across BMSHFT.			
	• *Insufficient budget*	• Joint Working Agreement. • System Financial Plan. • Mental Health Investment Standard. • Collaborative Financial Plan. • S117 Financial Plan. • Lead Provider Contract. • Risk and Benefit Framework ICB:BSMHFT. • Risk and Benefit Framework BSMHFT: Partners. • Annual planning round • Contract review milestones. • Sub-contract review milestones.	• Delays in agreement of Risk & Benefit Frameworks.	• System control total. • System development funding. • Contract review meetings. • Reports from external auditors. • Commissioning Committee Commissioning Sub-Committee and Executive Steering Group Financial Reports. • ICB and Local Authority financial reporting • Signed Lead Provider Contract • Signed sub-contracts. • Monthly Management Accounts.	• Insufficient resources protected through Risk & Benefit Framework due to unforeseen costs such as providers withdrawing from the market. • Providers demand higher inflationary amounts beyond those provided by ICB. • Delays in the sign off the Lead Provider Contract. • Delays in ICB resolving 22/23 outstanding financial payments to providers.

	• *ineffective delivery of a shared plan across health and social care.*	• Integrated Development Plan. • Mental Health Improvement Plan. • Solihull Mental Health Delivery Plan. • Long Term Delivery Plan.	• Existing Plans highlight demand outstripping supply. • Disjointed priorities and plans. • Effectiveness of plans are unknown.	• Reports from Reach Out Commissioning Sub-Committee. • Reports from Executive Steering Group. • Reports from Community Mental Health Transformation Programme. • Mental Health System Performance Report.	• Inability to effectively convey the detail of the reports and the gaps to members.
	This may result in:				
	• *Poor patient outcomes, including increased mortality and increased regulatory scrutiny, intervention, and enforcement action.* • *BSMHT default on the Lead Provider contract resulting in additional scrutiny and/or withdrawal of the contract.* • *Reputational damage.* • *Additional costs.*				

	Linked risks on the CRR-Risk ID	Brief risk description
	C10	Potential risk of poor interface with the 3rd Sector.
	C20	Potential risk of inadequate delivery against contract and service performance targets.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF1-CoCo/01	Clinical Quality Review Meetings to be set up for all sub-contracted providers regardless of contractual value. This includes alignment of a commissioning lead and contracting lead for each provider.	JW	July 2023	*Enables effective monitoring and oversight of services.*	
	BAF1-CoCo/02	Quarterly attendance at the newly established ICB Lead Provider Oversight Group as a forum which facilitates support to unblock any challenges around the delivery of the MHPC.	JW	June 23	*Enables the ICB to gain assurance on the delivery of the MHPC objectives and the*	

					MHPC to escalate any concerns or risks regarding delivery.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/07/2023	Not applicable at this moment as risk has been newly identified.
02/10/2023	BAF1-CoCo/01 CQRMs are set up for both NHS providers and are in the process of being rolled out to all remaining providers. All contracts have a named commissioner and contracting lead.
02/10/2023	BAF1-CoCo/02 Lead Provider Oversight Group meets quarterly for which the MHPC attends. Additional monthly interface meetings with the ICB have commenced Sept 23.

Executive Lead	Executive Director of Strategy, People and Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	**Trust may fail to develop a culture and operating model to deliver collaboration.**	**Inherent Risk Rating**	4	4	14	Commissioning Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	3	2	6	**Date**	18th May 2023
		Risk Appetite	**Cautious:** We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.				

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
Sustainability	***There is a risk that the Trust may fail to develop a culture and operating model to deliver collaboration.*** **This may be caused by;**				
BAF2-CoCo	• *poor contract management and insufficient engagement with sub-contractors.*	• MHPC governance architecture. • Reach Out governance architecture. • Appropriate contractual arrangements – procurement, dispute resolution, suspension and termination, decommissioning, and conflicts of interest policies. • Multi-partner Hub. • Research work with HSMC.	• *Newly established groups which are working through their interface with the various governance structures.* • *Limited number of policies in place to support contract management, ie decommissioning.* • *Changes to the translation of the*	• Procurement Plan • CQC Reports • Other regulatory Reports. • CQRMs enabling effective management, oversight and collaboration.	• *Time to mature newly developing relationships with providers requiring trust and transparency.*

			Procurement, Patient Choice and Competition Regs 2013.		
	• *poor CoCo decision-taking*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance architecture. • Partnership Agreement • Memorandum of Understanding.	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out Commissioning Sub-Committee • Escalation and assurance reporting from Executive Steering Group • Auditable process for decision-taking • Consistent attendance at CoCo Sub-Committees	• Delays in getting signed agreements.
	• *Poor engagement with partners*	• Commissioning & Transformation Framework. • Co-Production Strategy.	• Co-Production Strategy yet to be developed.	• Specifications which have been co-produced • Peer Review Framework • Minutes from Executive Steering Group.	• Time required to commission effective frameworks. • Time to build trust, faith and confidence.
	This may result in:				
	• *poor patient outcomes, including increased mortality and increased regulatory scrutiny, intervention, and enforcement action.* • *poor system engagement.* • Lack of trust, faith and confidence in BSMHFT.				
	Linked risks on the CRR-Risk ID	Brief risk description			

	C1 *C2*	Potential risk of inappropriate, inadequate or insufficient administered governance architectural for the MHPC. Potential risk of lack of engagement, contribution and trust within the system.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF2-CoCo/01	*MHPC Governance architecture governance meeting 23/6/23 to review accountabilities and ownership of risks.*	JW	June 2023	Ownership and accountability at every level of the MHPC governance.	
	BAF2-CoCo/02	Attendance at the VCFSE Collective and Panel Meetings which take place monthly	JW	Dec 2023	Transparency and openness with the VCFSE sector to ensure that we build trust, faith and confidence.	
	BAF2-CoCo/03	Multi-agency engagement in decision forming groups for MHPC.	All Chairs Monthly	Dec 2023	The MHPC needs to operate as equal partners with regards to decision forming and decision making and therefore it is important that all partners engage in the MHPC governance meetings.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/07/2023	Not applicable at this moment as risk has been newly identified.
02/10/2023	BAF2-CoCo/01 The governance meeting on 23/06/23 went ahead with further risk management meetings diarised with chairs of functional working groups.

02/10/2023	BAF2-CoCo/02 The MHPC continue to be represented at the VCFSE Panel meetings. The VCFSE have developed a document around 'Roles & Responsibilities' for informing the role of Panel members joining MHPC Governance meetings and to support with discussions around the management of Conflict of Interest. The Deputy Director for Commissioning & Transformation is meeting routinely with the Chair of the VCFSE Panel to share knowledge discuss risks and issues and progress on the development of the future commissioning and contracting vehicle.
02/10/2023	BAF2-CoCo/03 Terms of Reference for all MHPC governance groups are under review. This includes the membership and quoracy. An area for further development surrounds the inclusion of Experts by Experience (EBS's) on the groups. There has been a discussion surrounding the number of EBEs required in each meeting and the level of support for EBEs required to support attendance. There has been limited attendance from Forward Thinking Birmingham in some forums, so communication with FTB regarding attendance is underway.

Executive Lead	Executive Director of Strategy, People and Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	**Potential failure to ensure the required workforce capacity and capability across the collaboratives.**	**Inherent Risk Rating**	4	5	20	Commissioning Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	4	8	**Date**	**18th May 2023**
		Risk Appetite	**Open:** We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.				

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance What are the weaknesses in the assurance?**
People	***There is a risk that the Trust may fail to ensure required workforce capacity and capability across the collaboratives.*** **This may be caused by;**				
BAF3-CoCo	• *inadequate Workforce Strategic Plans.*	• Multi-partner workforce planning. • Alignment with NHS Long Term Plan. • Alignment with HEE Plans. • ICS workforce programme to manage demand and competition in the system.	• Workforce Plans do not identify the scale of the workforce challenges being faced across the system.	• Workforce Operational Plans delivered and costed. • Reports from Reach Out Sub-Committees. • Reports to People Delivery Group. • Shared leadership and OD models. • Co-produced Workforce Operational Plans across partners. • Collaborative based Attraction, Recruitment, and Retention Plans.	• Failure to recruit and attract a suitably qualified workforce. • competitive market for qualified staff.

				• Succession and Talent. Management Plans. • Career development pathways.	
	• *insufficient higher education places.*	• Partnership with HE establishments. • Partnership with HEE establishments.		• Training needs analysis by collaborative. • Training needs analysis by partner, by collaborative • Competency Frameworks.	
	• *inappropriate representation of the target communities.*	• Awareness of demographic profile of target community. • Assertive attraction and recruitment activities.		• Staff survey results from partner organisations. • FFT results from partner organisations. • EDI monitoring in partner organisations, e.g., WRES, WDES, Gender Pay Gap.	
	This may result in:				
	• *unsustainable services and unsafe staffing levels*				

	Linked risks on the CRR-Risk ID	Brief risk description
	C17 *C19*	Potential risk of insufficient workforce attraction, recruitment and retention and development. Potential risk of insufficient infrastructure, capacity and capabilities for the management of quality and safety issues.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF3-CoCo/001	Submisison of a joint workforce plan and joint recruitment events across the system.	Tara Conlan (Chair PLCG)	Dec 2024	Collaborative approach to recruitment and retention.	
	BAF3-CoCo/002	Building the commissioning and transformation hub.	JW	Dec 2024	Enabling the effective delivery of our MHPC responsibilities.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/07/2023	Not applicable at this moment as risk has been newly identified.
02/10/2023	BAF3-CoCo/001 Workforce Plans have been submitted. A successful joint recruitment event was undertaken at the ICC in May 2023. This event led to appointment of staff on the day for both BSMHFT and FTB. The event was supported by the VCFSE and future events are being considered.
02/10/2023	BAF3-CoCo/002 Work continues on the development of the Commissioning & Transformation Hub. The Mental Health Commissioning Team and Section 117 have both tuped into the organisation and report into the Deputy Director of Commissioning & Transformation. The Community

	Engagement Team as of 25 September 2023 also report into the Deputy Director of Commissioning & Transformation. Continued engagement with functional leads across the Trust are underway.

Executive Lead	Executive Director of Quality and Safety (Chief Nurse)		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	**Commissioning Committee**	
Title of risk	**Potential failure to ensure safe, effective, equitable and quality services across the collaborative.**	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	2	8	**Date**	**18th May 2023**
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.				

Reference / Risk ID or Number ----------	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
Quality, Patient Experience and Safety **BAF4-CoCo**	***There is a risk that the Trust may fail to ensure safe, effective, equitable and quality services across the collaboratives.*** **This may be caused by;**				
	• *lack of implementation of a quality improvement approach.*	• Professional input to planning and delivery. • Quality Assurance and Improvement Framework • QAIF alternative (Reach Out). • Quality Outcomes Framework. • Agreement to a single, codified improvement model.	• Lack of resources from ICB to deliver effective quality oversight arrangements. • Transitional Plan for Quality Oversight required	• Representative forums in place, e.g., Clinical Oversight Group. • Research undertaken with Academic Health Sciences Network. • Unified policies, procedures, and standards.	• Research areas to be identified. • Engagement with HSMC around research requirements. • Time required to unify policies, standards and procedures.
	• *unwarranted variation of clinical practice outside acceptable parameters.*	• Quality Assurance and Improvement Framework. • QAIF alternative (Reach Out). • Clinical Oversight Group.		• Escalation and assurance Reports from CoCo Sub-Committees.	• Available capacity and capability to drive forward the reduction in unwarranted variation.

		• Quality Surveillance Group.			
	• *inaccurate and/or inadequate data collection and intelligence sharing.*	• Digital Strategy and Procurement Plan. • Data Protection Impact Assessment. • Efficient method of information sharing across the system. • Business intelligence team. • Information Sharing Protocol.	• Digital Strategy yet to be defined. • BI function system opportunities to be explored.	• All partners compliant with data security and protection. • Delivery against the Data Protection Impact Assessment. • Single Electronic Patient Record. • Signed Information Sharing Protocol.	
	• *Insufficient infrastructure, capacity, and capabilities for management of quality and safety issues* •	• Individual organisations quality surveillance arrangements. • ICB Early Warning Signs Analytical Framework.		• Peer review process. • Compliance with safeguarding standards. • Embedded risk management processes. • CQC Inspection Reports. • Increase volume of low impact incident reporting.	• Time required to embed new operating model for the MHPC. • Capacity required within the MHPC to drive forward the new quality and safety requirements.
	This may result in;				
	• *poor patient outcomes, including increased mortality and increased regulatory scrutiny, intervention, and enforcement action.*				

Linked risks on the CRR-Risk ID	Brief risk description
C19	Potential risk of insufficient infrastructure, capacity and capabilities for the management of quality and safety issues.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF4-CoCo/01	Recruitment into a Head of Quality role	JW	Aug 2023	Oversight and management of quality agenda for the MHPC.	
	BAF4-CoCo/02	Workforce consultation surrounding a proposed Commissioning & Transformation Hub.	JW	Aug 2023	Provides capacity and capability to ensure grip and control of conversations around system quality and risk.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/07/2023	Not applicable at this moment as risk has been newly identified.
02/10/2023	The Head of Quality role has been out to recruitment twice. The closing date was 01/10/2023 and candidates are being shortlisted for interview. This role will sit across both the MHPC and the Reach Out Provider Collaborative.
02/10/2023	Ongoing engagement with functional leads regarding the development of the Commissioning & Transformation Hub is underway, however teams are already working together to ensure the effective delivery of activities for the MHPC.

Key:

	On track to delivery on time
	Completed
	Outstanding or delayed

9.4. Effectiveness Reports on Board Committees

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**9.4**		
Paper title	Effectiveness Report on Board Committees		
Date	4th October 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
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?	N/A
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

The NHS Code of Governance 2014 and the UK Corporate Governance Code 2006 state that the Board as a matter of principle and best practice should undertake a `formal and rigorous annual evaluation of its own performance and that of its committees`. It is in the above light that this report outlines the outcome of four self-assessment SurveyMonkey forms that were recently designed and administered to both core members and regular attendees at the Audit Committee, the People Committee, QPES and FPP.

While the number of respondents varied from Committee to Committee depending on membership and number of regular attendees, results gleaned from the questionnaires that were administered are broadly consistent and did not provide any surprises, thus confirmed what we already know about the areas of strengthen and weaknesses of our committees. Respondents were broadly satisfied that the four Board Committees which were assessed are effective in delivering their key statutory, regulatory and other responsibilities as delegated by the Board.

And although the results have limitations because of the low response rates, and lack quality inputs to enable triangulation, they have however provided some intelligence on mapping out some areas for improvement like: -

- Increasing NED membership per committee and
- Ensuring the timely circulation of papers in line with our Board Standing Orders.
- And continuous fine-tuning and embedding of the `Triple A` Report format of assurance reporting into the Trust`s governance fibre from `Ward to Board`.

The Corporate Governance team will in the next few months use the following techniques: engagement, training, publicising Committee Forward Plans and continuous

learning in tackling and making improvements in the above areas of work.

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

The Board is requested to:

1. NOTE and **APPROVE** this report.

2. GAIN ASSURANCE that the Trust Board Committees are effectively delivering their statutory, regulatory and delegated responsibilities from the Board.

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)

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)*

N/A

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

BAF04/FPP – There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice.

Equality impact assessments:

N/A

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

N/A

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

N/A

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 organisation." (HM Treasury – 2012).	

1. **Theming of questionnaires for analysis:**

The survey questionnaires were grouped into the following 6 broad themes to facilitate analysis: -

- Committee Membership and Resources.
- BAF and risk management.
- Assurance
- Visible Leadership and Stakeholder Engagement.
- Quality of information
- Effective Chairing, Constructive challenge, oversight and scrutiny.

Members of the four Board Committees surveyed, were broadly in agreement that Board Committee were effective in delivering their key core business functions, they however requested for a strengthening of the Trust`s risk management arrangements which is now being progressed at pace.

2. **Recommendations and learning:**

The followings are the key recommendations: -

1. There is need to encourage greater participation to increase the response rate in future Board Committee self-assessments SurveyMonkey in order to have rich intelligence and data from which to generate compelling analysis and learning.
2. In future different and distinct annual self-assessment SurveyMonkey forms will be designed for each Board Committee in order to encourage participation and ensure respondents have timely access to the right and relevant links.
3. The work around the defining, strengthening and sanitising the Trust`s corporate risk register (CRR) needs to be picked up at pace as committee members aren`t assured as they have no oversight of such risks which are linked to their portfolio.
4. The Trust`s Site Visit plan for governors, NEDs and EDs which was paused following a query from the CQC around Enhanced DBS needs to be reactivated at pace with risk assessments put in place to demonstrate how any identified or potential risks especially around security and patient safety will be mitigated and managed during the visit.
5. There is need to continue to strengthen assurance and the quality of papers and information provided to Board Committees, hence some training will be delivered to staff who regularly write Board reports around `what a good assurance report` or a `good report` to the Board and its committees looks like.
6. Encourage respondents in future Board Committee Annual self-assessment surveys to provide qualitative comments.
7. There is need to consider increasing NED membership per committee especially as the Trust now has a full Board considering the recent recruitment of two further NEDs.
8. Ensure the timely circulation of papers in line with the Board Standing Orders.

3. **Conclusion:**

Next step: A brief improvement plan with the view of translating the aforementioned recommendations into actions and to report back to all 4 Board Committees and the Board on progress in Q3 and Q4 of 2023/24. Above, all the expectation is that the recent review of the effectiveness of the Trust Board Committees will contribute to strengthening and embedding the Trust`s governance arrangements from `Ward to Board`.

9.5. Annual Report from Remuneration Committee

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**9.5**		
Paper title	Annual Report from the Remuneration Committee 2022/23		
Date	4th October 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
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?	N/A
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

The UK Corporate Governance Code, published in July 2018 states that `the Board should establish a remuneration Committee …with appropriate terms of reference, which should be published on the company website`. Membership of BSMHFT`s Remuneration Committee will change depending on the items on the agenda. Hence a governors-led Remuneration Committee will be responsible for deciding on the remuneration of the Chair and other NEDs while a NED-led Remuneration Committee will be responding for setting the remunerations of very senior managers (VSMs) and the Chief Executive including pay awards as well as any severance arrangements.

One remuneration Committee (NEDs-led) held within this reporting timeframe 1st April 2022 – 31st March 2023 i.e. on 17th January 2023 with a specific agenda to: -

1. To consider the salient points from the NHS England and NHS Improvement recommendation on the application of the 2022/23 annual pay increase for VSMs. The Committee also drew intelligence from how other NHS Provider Trusts within BSOL had responded to the national recommendation in setting the annual pay awards for the VSMs for 2022/23 and after some discussion members authorise the Trust to offer an annual pay increase of 3% to its VSMs for 2022/23.

   It is worth noting that in 2021/22, the NEDs-led Remuneration Committee also authorised a pay award of 3% which did not follow the national recommendation of 0%. This decision reflected and took into account the pay awards made within our ICB during that period.

2. The second key item on the agenda was to consider and authorise remuneration for the Deputy Chief Executive. As the Deputy Chief Executive was assuming the role in addition to their Executive Director duties, members received a report which presented two options for consideration.

The first option was a fixed amount on top of their Executive Director salary while the second was to place them on a salary pay band and point on the current framework for the role that corresponds to pay band 2 at the maximum point (4). And after some discussion, members agreed to authorise the first option. i.e to pay a fixed amount on top of their Executive Director salary.

In conclusion, it is worth noting that the frequency of a Remuneration Committee will vary depending on the nature, scale and complexity of the business of a company including other external regulatory requirements, however best practice recommends that it should meet at least twice a year in to order to effectively discharge its responsibilities.

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

The Board is requested to:

1. NOTE this report.

2. GAIN ASSURANCE that the Remuneration Committee is effectively delivering its statutory, regulatory and delegated responsibilities in line with its ToR.

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)

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)*

N/A

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

BAF04/FPP – There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice.

Equality impact assessments:

N/A

Engagement *(detail any engagement with staff/service users)*
N/A
Acronyms *(List out any acronyms used in the report)*
N/A

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 organisation." (HM Treasury – 2012).	

9.6. Cover sheet & BSMHFT Risk Appetite Framework

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**9.6**		
Paper title	Cover sheet & BSMHFT Risk Appetite Framework		
Date	4th October 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
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?	N/A
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

The Orange Book defines risk appetite as `the amount of risk that an organization is prepared to accept, tolerate or be exposed to at any point in time" while the CIIA defines it as "the level of risk that is acceptable to the Board or management ". The CIIA argues further in relation to defining a risk appetite that it "…may be set in relation to the organisation as a whole, for different groups of risks or at an individual risk level".

BSMHFT`s risk appetite framework is applicable to all risks identified and managed across the entire Trust including its subsidiaries and the Provider Collaborative. It thus defines the level of risk (bearing in mind each type of risk) that the Trust is willing to accept or tolerate in order to pursue its operational and strategic objectives, hence staff should always ensure the target risk score they set for each risk aligns with or falls within the accepted score range as defined on the BSMHFT risk appetite framework.

The BSMHFT risk appetite framework is the product of discussion at a Strategic Board Development Session during which members reflected on, debated and discussed the importance of a risk appetite to the Trust. Members also requested that a risk appetite survey be designed and administrated to them to enable them to explore and identify the level of risk against each type of risk, that they will recommend the Trust accepts or tolerates in pursuit of its operational and strategic objectives.

Please see appendix below for details of BSMHFT`s Risk Appetite Framework.

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

The Board is requested to:

1. **NOTE** and **APPROVE** the Trust`s risk appetite framework.

2. GAIN ASSURANCE that the BSMHFT risk appetite framework has been designed in line with the preferences of Board members and reflects best practice.

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)

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)*

N/A

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

BAF04/FPP – There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice.

Equality impact assessments:

N/A

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

N/A

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

N/A

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 organisation." (HM Treasury – 2012).	

Appendix 1: BSMHFT Risk Appetite Framework

Risk Type	Statement	Risk appetite category	Target risk score range
Quality & Safety	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	Cautious	**6 - 8**
Reputational	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Minimal	**2 - 4**
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Eager	**12**
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	**9 – 10**
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	**6 - 8**
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open	**9 – 10**
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Open	**9 – 10**
Data and Information Management	Accept need for operational effectiveness in distribution and information sharing.	Open	**9 - 10**
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	Minimal	**2 - 4**
Digitalisation/ Technology	Systems / technology developments considered to enable improved delivery. Agile principles may be followed.	Open	**9 – 10**
Transformation/ Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved.	Open	**9 – 10**

	Plans aligned with functional standards and organisational governance.		
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	Minimal	**2 - 4**
Property & Environment	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Open	**9 – 10**
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open	**9 – 10**
Partnerships & Provider Collaboratives	Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking.	Open	**9 – 10**

9.7. Cover sheet – Risk Management Policy

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**9.7.1**		
Paper title	Cover sheet – Risk Management Policy		
Date	4th October 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
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?	N/A
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

The UK Corporate Governance Code 2018 states that: -

> The board should establish procedures to manage risks, oversee the internal control framework, and determine the nature and extent of the principal risks the [Trust] is willing to take in order to achieve its long-term strategic objectives.

The Trust`s Risk Management Policy provides a structured framework which defines it aims, objectives and approach to risk management as well as set how staff across the Trust will undertake and embed a positive culture risk awareness in everything they do. Hence, the Trust`s Risk Management Policy provides guidance regarding the management of risk to support the achievement of corporate, business, operational and strategic objectives and protect staff and business assets while ensuring financial sustainability.

The Trust`s Risk Management Policy thus sets out the context and landscape which underpin risk management at BSMHFT while demonstrating the Trust`s commitment to implementing an agile, dynamic, integrated, proactive, evidence-based and intelligence-led enterprise-wide approach to risk management. Effective risk management can also leverage the opportunity for growth, expansion and above all the development and provision of high-quality patient-centred care and services.

The companying Trust`s Risk Management Policy (item 9.7.2) is a reflection and culmination of wider discussions and engagement with staff in designing a policy which can enable engagement and facilitate effective risk management while focusing minds and hearts on understanding that risk management is everyone`s responsibility from `Ward to Board`. It is a key responsibility of the Board to approve the Trust`s Risk Management Policy each time it is reviewed or updated.

Noticeable inclusions in this updated Risk Management Policy include: -

1. A BSMHFT Risk Management Flow chart.
2. A BSMHFT Risk Appetite Framework.
3. And a section (3.7) on types of control – to keep colleagues aware of the various types of risk control techniques they could draw from in setting the controls to their risks.

Please see item 9.7.2 for details of BSMHFT`s Risk Management Policy.

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

The Board is requested to:

1. NOTE and **APPROVE** the Trust`s Risk Management Policy (item 9.7.2).

2. GAIN ASSURANCE that the BSMHFT Risk Management Policy has been designed in line with best practice.

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)

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)*

N/A

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

BAF04/FPP – There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice.

Equality impact assessments:

N/A

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

N/A

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

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.
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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 organisation." (HM Treasury – 2012).	

9.7.1. BSMHFT Risk Management Policy

Birmingham and Solihull Mental Health NHS Foundation Trust

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	**RS 01**	**Risk & Safety**
VERSION NO & DATE	**17.2**	**October 2023**
RATIFYING COMMITTEE	**Board of Directors**	
DATE RATIFIED	**04th October 2023**	
NEXT REVIEW DATE	**1 year after ratification**	
EXECUTIVE DIRECTOR	**Executive Director of Finance**	
POLICY LEAD	**Associate Director of Corporate Governance**	
POLICY AUTHOR *(if different from above)*	**Associate Director of Corporate Governance**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT

The Policy applies to all staff - **including** HMP Birmingham Healthcare staff and persons engaged in business on behalf of the Trust.

POLICY REQUIREMENT

- All staff members are responsible for:
  - ensuring that risks are identified, assessed and managed.
  - highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.
- All operational service areas and Executive Directors should systematically review risks on their risk registers on a monthly basis, identify controls for mitigation and evaluate their effectiveness. All risks with a score of 15 and above will be reported to the Clinical Governance Committee on a quarterly basis. All risks with a severity impact of 5 will also be reported.
- The Risk Management Group will ensure effective working arrangements and controls are in place to proactively manage the escalation of risk. Risk moderation will take place at this Committee to determine whether any of the high scoring local risks will compromise delivery of the Trust's corporate objectives and business plan.

- An oversight report will be produced on a monthly basis for scrutiny by the Executive Team.
- All risks which could significantly compromise the Trust's ability to deliver its corporate objectives and business plan will be reviewed on a quarterly basis by the Quality, Patient Experience and Safety Committee, People Committee and Finance, Performance and Productivity Committee and will inform the Board Assurance Framework.
- The Audit Committee will review the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management and make recommendations to the Board as appropriate regarding its risk management arrangements.
- Although this Policy is set to be reviewed in 1 year, it could be reviewed earlier if significant changes occur within the Trust risk management landscape.

Contents

1 Introduction

1.1 Rationale

Risk is the chance that something will happen that will have an adverse impact on the achievement of the Trusts aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity/consequence (impact or magnitude of the effect of the risk occurring)
(Adapted from the Australian/New Zealand Standard AS/NZS 4360:1999)

Risk will always be present in the things that we do. The aim of this policy is to ensure that all staff actively understand risk, recognise risk, and know how to report, review, and manage risks to support the overall aims of the organisation. This means that we look at risk at all levels ranging from the risks to delivery of our most strategic aims, through to the day-to-day delivery of team-based objectives which in turn contribute to the bigger picture.

This is demonstrated in the pictorial diagram below: -

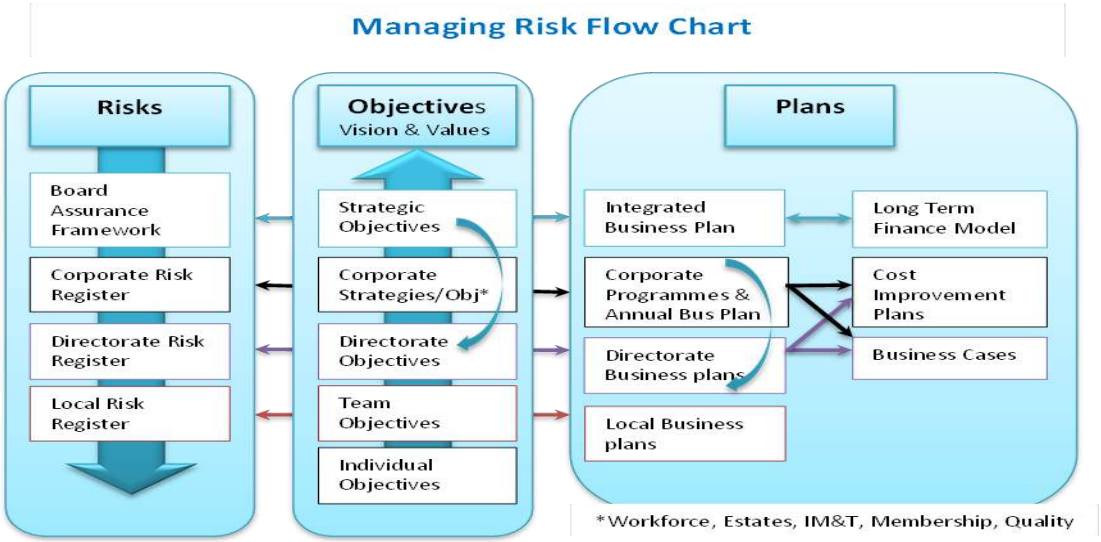


Figure 1 – Managing risks flow chart.

Good risk management is at the heart of everything we do in the Trust. We need to be open, honest, and aware of the risks we are facing on a day-to-day level as well as strategically.

In large complex organisations, managing risk can seem a daunting task. It is, however, inherent in everything that we do, and we manage risk successfully every day. It is not a new challenge and because it forms a part of our everyday work, the key is to manage risk at all levels in a simple, effective, transparent, and consistent way. Hence, the provision of healthcare entails some uncertainty, and that uncertainty brings new opportunities and risks. How we manage existing and emerging risks is important in helping us meet our objectives, improve service delivery, achieve value for money and reduce unwelcome surprises.

This Risk Management Policy provides a clear framework for the effective, proactive and timely management of risks. Sound recording and escalation mechanisms are described for departmental risks, wider locality service area risks and Trust wide risks. The policy also describes the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks.

1.2 Scope

The Policy applies to all staff, Trade Union colleagues, contractors including HMP Birmingham Healthcare staff and persons engaged in business on behalf of the Trust.

The Trust works in partnership with Birmingham Community Healthcare to ensure individuals with learning disabilities have full and equal access to the full range of mental health services. Therefore, all aspects of this policy equally apply to service users with learning disabilities.

1.3 Principles

The Trust's approach recognises:

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The implementation of the risk management arrangements must be proportionate, timely, dynamic, aligned to the delivery of the Trust`s goals, comprehensive and embedded into business as usual as well as responsive to changes within the Trust`s business environment.
- The need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create and seize opportunities in a managed way e.g. by considering alternative actions to those originally intended. Some risks will always exist and will never be eliminated; all staff must understand the nature of risk and accept responsibility for the management of risks associated within their area of authority.
- The Trust explores an integrated approach to risk management combines a top-down strategic view with a complementary bottom-up operational process.

2 Policy

All staff members are responsible for ensuring that risks are identified, assessed and managed.

All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.

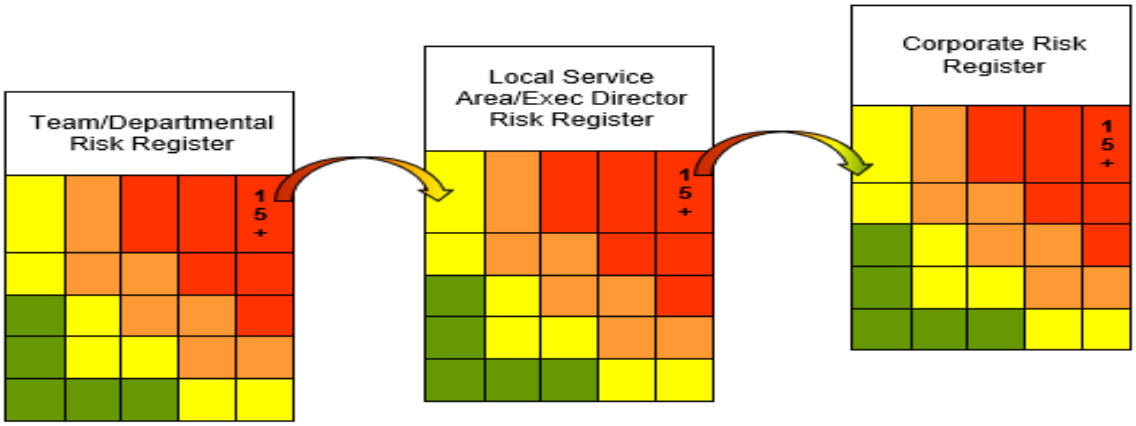
The consequence and likelihood of risk occurrence will be assessed against the Trust wide risk scoring matrix (Appendix 1). Risks will be recorded on risk registers via the Eclipse electronic risk management system.

All local service areas, managers and Executive Directors should systematically review risks on their risk registers on a monthly basis and provide assurance that the risks are being managed through their local governance arrangements. Local service areas and corporate support teams will escalate any risks with a score of 15 or above that have been approved at their local governance meeting, signed off at the Divisional level and by the relevant Executive Director and presented at the RMG for consideration, approval and inclusion onto the CRR, please see section 5 for more details on risk escalation.

Risks which could significantly compromise the delivery of the Trust's corporate objectives/business plan, once approved by the RMG, will be added onto the Corporate Risk Register (CRR). Relevant extracts of the Corporate Risk Register will be presented to the Quality Patient Experience and Safety Committee, People Committee and Finance, Productivity and Performance on a quarterly basis.

Whilst management is responsible for operationalising risk management across the Trust, Board Committees, the Board and related governance arrangements are responsible for providing scrutiny, constructive challenge and oversight. The entire CRR will be presented to the Audit Committee and Board at least once every six months alongside the Board Assurance Framework (BAF).

Figure 2 - Escalation in the Risk Register Hierarchy



3 Procedure

The Trust's overall approach to risk management is underpinned by 5 key steps:-

- Establish the Context
- Risk Identification
- Risk Analysis
- Risk Assessment/Evaluation
- Risk Control/Treatment

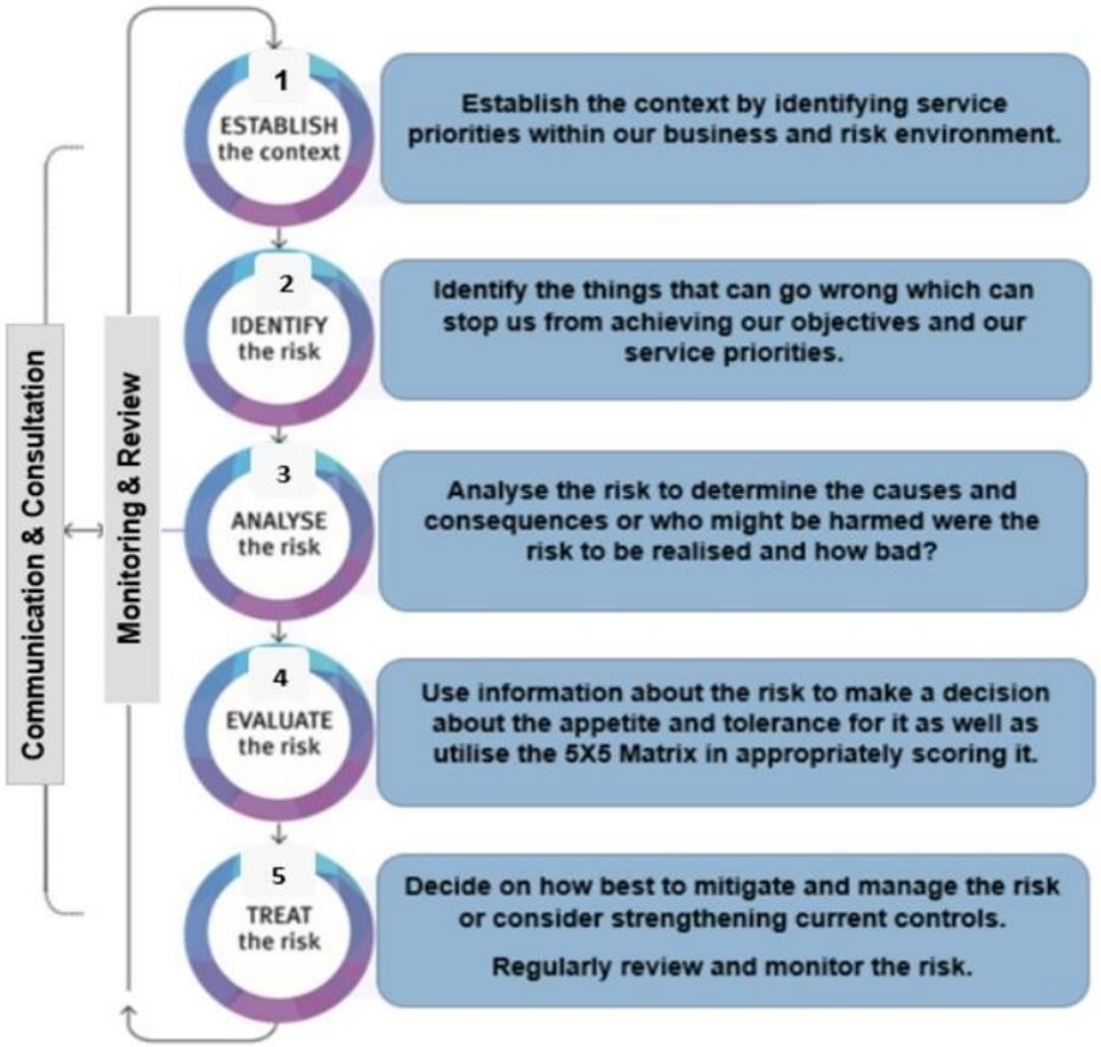


Figure 3: BSMHFT`s approach to risk management - Five steps

3.1 Step 1: Establish the context

As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priorities in order to clearly identify risks and opportunities which may impact on their achievement.

3.2 Step 2: Risk identification

The identification of risk needs to be dynamic process, which involves all staff and ensures that action is taken before incidents/actual loss or harm have occurred. Risks may be clinical or non-clinical, including financial and reputational. Risks can become apparent from many sources, included but not limited to:

- risk assessment including workplace assessment,
- clinical risk assessment,
- organisational objectives, KPI's,
- consultation of staff and patients,
- incidents, complaints, and review of litigation cases

- incident or complaint trends
- serious incident recommendations
- Family and Friends Test feedback
- internal inspections and audits,
- infection control,
- safeguarding
- information governance
- Internal audit and internal audit reports
- External sources
- Regulatory standards and inspection feedback (CQC)
- Central Alerting System (CAS),
- Mandatory and statutory targets,
- National enquiry reports
- External audit reports and findings,
- External safeguarding reviews
- Health and Safety Executive (HSE)
- National Survey Results
- NHS Improvement
- NICE
- National Benchmarking Exercises
- National Audit Office,
- National Patient Safety Agency (NPSA),
- Coroner reports
- Failings in other organisations

Any managed change generated within the Trust should be risk assessed before, during and after the change occurs. Significant projects are managed through the Project Management Office where risk & issue logs and Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams.

All projects are reviewed by the Strategy and Transformation Board which provides oversight, assurance and governance of all risks and impact assessments relating to the projects.

Staff should adhere to the Trust`s structured approach for describing risks also referred to `Cause and Effect Analysis` or the `Bow-tie` model. This model clearly identifies the event, the cause and the effect. It is helpful to frame the description of a risk into three parts by starting with these phrases:

• **There is a risk of/that/if…** (this relates to not achieving an objective as intended)
• **This may be caused by…**
• **This may lead to an impact/effect on …**

Risk description must be clear and use concise appropriate language e.g.

- *"There is a risk that patients may not be discharged promptly from the Community Hospital.*

  This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Hence the description of a risk must clearly outline the event or objective that relates to or might not be achieved if the risk were to crystallise, what could be the cause(s) and what could be some potential impacts and/or opportunities.

3.3 Step 3: Risk analysis

Determine the cause and effect and analyse what could happen, where, when, why and decide who might be harmed and how. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

3.4 Step 4: Risk Assessment/Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and if the risk were to be realised (likelihood). The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix in assessing and scoring the risk.

3.5 Step 5: Risk Treatment & Prioritisation

Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to reduce the risk and then identify further actions, which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan or risk treatment plan and decide on how best to manage it.

Hence, a decision should be made as to whether the Trust should avoid, reduce, eliminate, accept/retain or transfer the risk.

- **Avoid**: Whether a particular task can be undertaken a different way so that the risk does not occur.
- **Reduce**: Whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure.
- **Eliminate**: Whether definitive action can be taken to eliminate the risk exposure.
- **Accept/Retain**: Whether the level of risk is acceptable as no further mitigating actions can be taken, or the extent of actions to be taken outweighs the consequence of the risk occurring. Risks that are accepted will continue to form part of our review and reporting processes.
- **Transfer**: Whether the risk can be transferred to another organisation

Where further actions are required to avoid, eliminate or reduce the risk, these actions must be entered onto the risk register along with the date by which the action will be implemented and the individual responsible for assuring delivery of the action.

3.6 Risk Review and Monitoring

Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales: -

- Risks scored 15 and above should be reviewed at least monthly
- Risks scored 9-12 should be reviewed at least bi-monthly
- Risks scored 1-8 should be reviewed at least quarterly.

3.7 Types of control: Risk control techniques

Controls are measures or interventions that are implemented in order to reduce either the likelihood and/or impact of a risk were it to materialise. The following types of control are frequently used in mitigating and reducing risks: -

a. **Preventive controls** - these controls are designed to limit the possibility of a risk crystallising e.g. regular maintenance of electrical equipment.

b. **Corrective or Response controls** – These controls are designed to correct or in response to undesirable outcomes which have already been realised e.g. contingency planning.

c. **Detective controls** – these controls are designed to detect a risk before it occurs e.g. Medication reconciliation to identify potential risk of medication error or accounts reconciliation to identify potential fraud.

d. **Directive controls** – these are controls that we implement because we are directed by guidelines, regulation or legislation e.g. Requiring new staff to shadow before being allowed to work alone.

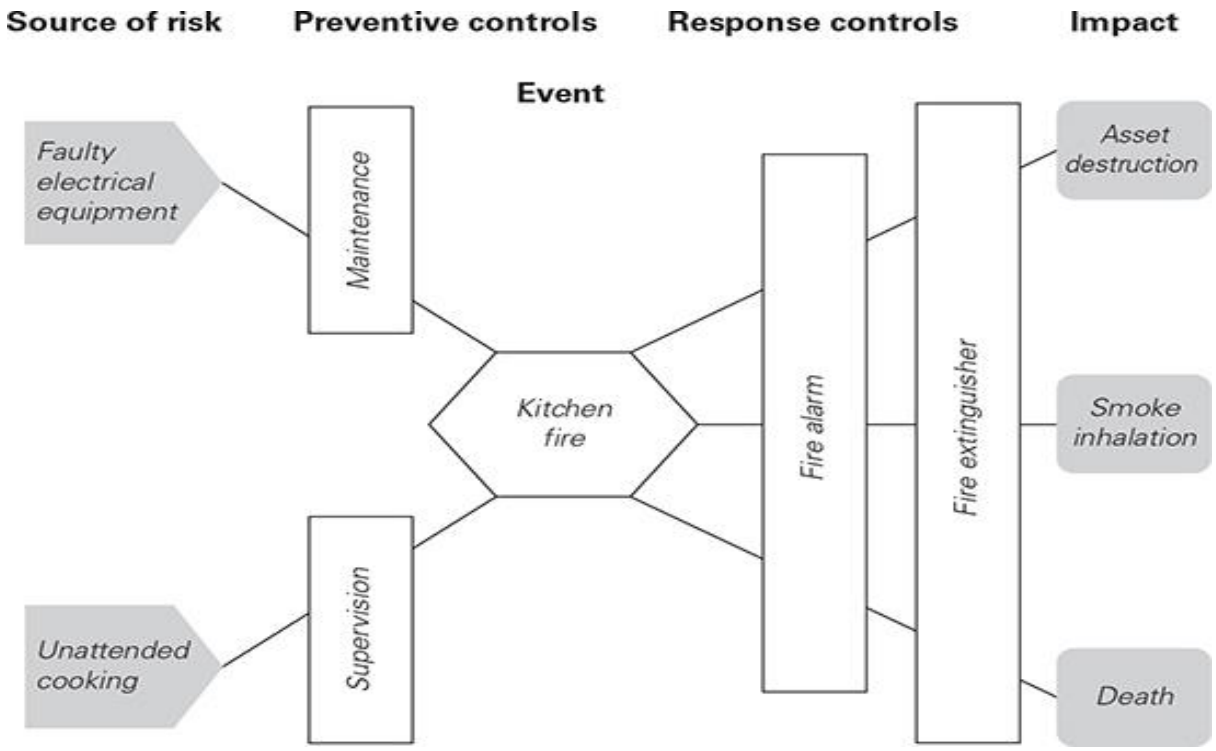


Figure 4. Types of control

4 Responsibilities

Staff/Groups	Responsibilities	Ref
All Staff	All staff should be aware of risk assessment findings and risk management measures, which affect their practice and professional needs. They must inform their line managers of risks deemed to be unacceptable and / or outside of their ability to manage. In addition, all staff (permanent and temporary) must • Report incidents/accidents and near misses in a timely manner and in accordance with Incident reporting policies via eclipse • Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business. • Comply with all Trust policies and procedures and any other instructions / guidelines to protect the health, safety, and welfare of anyone affected by the Trust's business	
Executive Director & Trust Board	The Chief Executive maintains overall accountability for risk management within the Trust but will delegate responsibility to nominated Executive Directors of the Trust Board. The Director of Finance (on behalf of the Chief Executive) is the Executive Director responsible for risk management and through the AD for Corporate Governance for co-ordinating the implementation and operationalisation of the Risk Management Policy across the Trust. The Director of Finance has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and for the effective management of risks within their portfolios. The Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning.	

	The Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning. The Director of Strategy, People and Partnerships has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships.	
Clinical Directors	Clinical Directors are responsible for ensuring that there are robust systems and processes in their Divisions to support the effective identification, assessment, mitigation, monitoring and management of risks. They are responsible for ensuring that risk management and especially high-level operational risks in their Divisions are periodically reviewed and scrutinised at their Divisional Clinical Governance Meetings. Clinical Directors will be responsible for timely reviewing and approving high operational risks scoring 15 and above from their Divisions being put forward for escalation to the RMG prior to their presentation at the RMG.	
Associate Director for Clinical Governance	The Associate Director for Clinical Governance will be responsible for ensuring all clinical and patient safety related risk are appropriately added onto the Trust risk management information system. They will liaise with the Risk Manager and the Associate Director of Corporate Governance in ensuring Services and Divisions escalating risks for consideration for the corporate risk register and/or presenting their risk registers at the Risk Management Group are appropriately supported.	
Associate Director of Corporate Governance	The Associate Director of Corporate Governance has overall responsibility for the Risk Management Policy, operationalisation of risk management Trust-wide and through the Company Secretary for the management of the Board Assurance Framework. They shall also work closely with all Directors in the implementation and delivery of the Trust's agreed approach to Risk Management, and Board Assurance Framework. They shall ensure the provision of effective risk management including risk governance structures and robust systems which assure implementation of the	

	Trust's risk and risk governance objectives through the proactive identification and prioritisation of key organisational and risks from service areas, through to Divisions and ultimately the Board. They shall ensure the development of systems, control process and risk management arrangements that comply with internal and external risk governance and best practice requirements and ensure continuous improvement of the quality of risk information, particularly in the areas of key controls. Lead of the design, development and coordination of the Corporate Risk Register and Board Assurance Framework while ensuring an effective risk management system and process is in place.	
Associate Directors	All Associate Directors have delegated responsibility for the effective management of risks within their portfolios and for ensuring that significant risks to the achievement of their local operational objectives are escalated in line with this Policy. ADs are responsible on behalf of their Executive Directors, for BAF risks that are assigned to their portfolio ensuring they are regularly reviewed, updated and all related actions implemented and evidenced.	
Senior Leaders and Managers (including the Senior Divisional Team).	• Implementing Trust policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility. • Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. • Overseeing the development and monitoring of an action plan to mitigate identified risks on the	

	risk register. • It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.	
Risk Manager	• They are responsible for ensuring the Trust has effective risk management arrangements in place, populating the Trust`s risk management policy, raising the profile, visibility and supporting Services and Divisions across the Trust to embed risk management into business as usual. • Creating space for a risk aware-culture to flourish across the Trust and the provision of risk management-related assurance to the Board and its sub-committees. • Act as an adviser to the Trust on all aspects of risk management and lead on the development of a dynamic, comprehensive, proactive, agile, sustainable Trust-wide risk management infrastructure. • Support local services and Divisions in reviewing and keeping their local risk registers up-to-date and in pulling risk registers for local governance meetings if requested including servicing the RMG. • Designing and delivering the Trust`s risk management training. • Provide admin support to the RMG including, servicing, minuting and ensuring all reports and papers are collated and timely circulated.	
Trust Board	Responsible for: - • overall risk oversight, scrutiny, gaining assurance, setting the tone and culture that underpins the Trust`s risk management approach. • ratifying the Trust's Risk Management Policy including the Risk Appetite Statement. • reviewing the Board Assurance Framework and the Corporate Risk Register.	

Audit Committee	Responsible for: - • reviewing the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management. • making recommendations to the Board as appropriate regarding its risk management arrangements.	
Quality, Patient Experience and Safety Committee	Responsible for:- • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect quality, safety, and patient experience risks and that there are effective controls, assurance and mitigation to manage these.	
Finance, Performance and Productivity Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect performance, sustainability, financial and governance risks and that there are effective controls, assurance and mitigation to manage these.	
People Committee	Responsible for • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect workforce related risks and that there are effective controls, assurance and mitigation to manage these.	
Risk Management Group	Responsible for:- • seeking assurance on the effectiveness of the Trust's risk management systems • developing and overseeing the implementation of the Risk Management Strategy and Policy. • reviewing and approving risks escalated to it and ensuring that those rated 15 or above are properly recorded in the Corporate Risk Register. • Considering evidence and approving the closure of risks on the Corporate Risk Register. • supporting the Board with the development and maintenance of the Risk Appetite Statement and the CRR.	

Strategy and Transformation Board	Responsible for: - • providing oversight, assurance and governance of all risks and impact assessments relating to change programmes and projects	
Local management and assurance groups	Responsible for: - • maintaining risk registers relating to their area of responsibility. • systematically reviewing relevant risks, seeking and providing assurance that they are being managed through their local governance arrangements. • escalating risks with a score of 15 or above through their Divisional meetings to the Risk Management Group.	

5 Criteria for escalating risks onto the CRR:

- The risk must be scored 15 and above and must be approved for escalation by the Service, Departmental or local governance meeting and/or management team, supported by the Divisional Governance meeting and/or senior management team and the relevant Exec Director.
- The risk must be appropriately assessment and all fields completed prior to presentation for escalation.
- Once a risk has been approved for escalation by the Divisional Governance meeting and/or management team, the risk Manager and/or AD Corporate Governance should be notified so they could liaise with the Service and/or Division to ensure the risk is appropriately captured on the CRR template and included onto the agenda for the RMG.

5.1 Risk Escalation:

- Timely and dynamic escalation of risks is important for effectively risk management, hence this policy identifies two pathways through which risk could be escalated to the RMG: -
- **Via Governance route**: through appropriate governance meetings as described above.
- **Via management route:** This is expedited escalation in the case where the local governance meeting isn`t due to hold for a few weeks or months, management at the local service once they have reviewed the risk and are satisfied that it has been appropriately described and scored could escalate the risk through their Divisional Senior management team for support and sign-off by the relevant Executive Director for either:-
    a. Presentation and approval at the RMG.

b. Direct inclusion on the CRR, in the case where the RMG isn`t due to hold soon. This is to ensure timely and dynamic escalation of risks; however, such a risk will need to be presented at the earliest RMG for review, scrutiny, noting, learning and minuting.

- If in doubt, services and Divisions are encouraged to contact either the Risk Manager or AD Corporate Governance for support and clarifications.

Managers from the Service escalating the risk and the Division supporting the escalation may be invited to attend the RMG to present the risk. However, if a risk isn`t approved at the RMG following escalation, the RMG will provide advice through the colleague who presented the risk and request for it to be de-escalated to the relevant service for appropriate mitigation and management or for review, amendments, and re-escalation if that is deemed appropriate.

6 Board Assurance Framework (BAF)

- The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Health Board and co-ordinating them to best effect.
- The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Trust`s strategic goals have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance.
- It thus provides a structure and process through which the Trust could focus on those principal risks which may undermine the achievement of its strategic goals as defined in the Level 1 priorities in its updated Strategy.
- Executive Directors and their ADs are responsible for ensuring that risks within their portfolio captured on the CRR and BAF are timely and regularly updated prior to presentation at the relevant Board Committees.

6.1 Linking the CRR with the BAF

- BSMHFT`s BAF and CRR are maintained distinctively separate, however, both toolkits complement each other and are symbiotically linked; inform, shape and feed-off each other. Both documents are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks are managed in accordance with this Risk Management Policy.

7 Collaborative and shared Risk Management

- BSMHFT recognises that there will be instances where the effective management of a risk will require input from other colleagues and stakeholders who may not necessarily be part of the service in which the risk has been identified. For example, a service may identify a risk, which requires inputs from Informatics, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively manage it.
- In such a situation, Services etc. should ensure that all key stakeholders who can contribute to the effective management of risks are involved in the discussions on how best to reduce and manage the risks. In other instances, such stakeholders like the Local Authority may be external; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately reducing and managing such risks.

8 Monitoring implementation of this Risk Management Policy

- BSMHFT will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 10 risks randomly selected from each Directorate risk registers and 5-10 from the Corporate Risk Register in measuring the following KPIs.

- **Compliance:** This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components: -

% of risks which are in date and/or out of date;

Evidence that services escalating risks in line with this Risk Management Policy.

- **Maturity:** This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: -

% of risks appropriately completed.

- **Data Quality:** This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -

% of risks which have been appropriately described.

8.1 Risk Management Training:

- BSMHFT recognises that developing staff capacity and capability in risk management is critical for fostering engagement and embedding its risk management culture.

- The Risk Manager with the support of the AD for Corporate Governance will design and deliver bespoke risk management training which will be available to all staff and managers as well as to contractors delivering services on behalf of BSMHFT.

9 Conclusion:

BSMHFT`s Risk Management Policy provides a comprehensive framework for staff in all Services and Divisions across the Trust to timely and proactively identify, assess, manage and mitigate any potential risks that could compromise the achievement of their local goals. It thus seeks to foster standardisation, engagement, consistency and galvanise leadership in fostering effective risk management and risk escalation from `Ward to Board`.

10 Development and consultation process

Consultation summary	
Date policy issued for consultation	July 2023
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Staff and reps from Services/Divisions - Workshops	July/August 2023
Local Governance Committees	July/August 2023
ET	3rd July 2023
Risk Management Group	
Audit Committee	13th July 2023 & 12th October 2023.
Board	2nd August 2023 & 4th October 2023

11 Reference documents

Australian/New Zealand Standard AS/NZS 4360:

12 Bibliography

None

13 Glossary

None

14 Audit and assurance

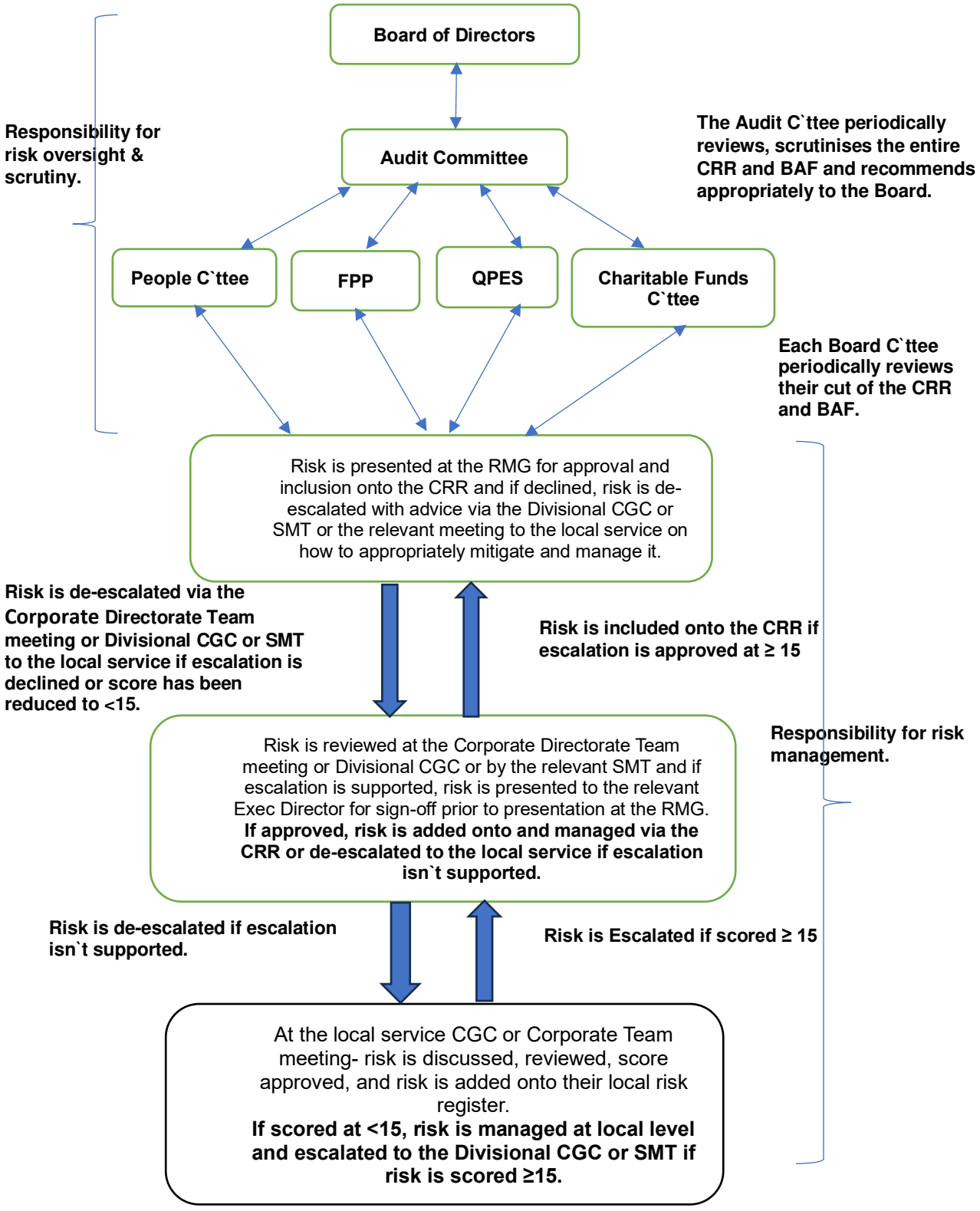
The policies, systems, framework and processes covered by the Risk Management Policy and Strategy and the Board Assurance Framework will be regularly, systematically and independently audited as required by the Audit Committee.

15 Appendices

1 Risk Management Flow Chart
2 Equality Impact Assessment
3 Risk Scoring
4 Risk Thresholds/Risk Level Monitoring
5 Key definitions
6 Risk Appetite Statement

Appendix 1: Risk Management Flow Chart

BSMHFT Risk Management flow chart - Escalation and de-escalation of risks.



NB: Responsibility for mitigating and managing risks on the CRR lies with the local service which owns the risk as escalation doesn`t exonerate them from this responsibility.

Appendix 2: Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Risk Management Policy		
Person Completing this proposal	Dave Tomlinson	**Role or title**	Director of Finance
Division	Executive Team	**Service Area**	Executive Team
Date Started	23 June 2023	**Date completed**	

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

This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Quality, Sustainability, People and Clinical Services

Who will benefit from the proposal?

The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	No/Minimal Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	✓			*please refer to note below
Including children and people over 65				

Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			*please refer to note below
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	✓			*please refer to note below
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	✓			*please refer to note below
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	✓			*please refer to note below
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	✓			*please refer to note below
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	✓			*please refer to note below
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	✓			*please refer to note below

Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	✓			*please refer to note below
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	✓			*please refer to note below
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	~~Yes~~	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				✓

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?
Refer to note below
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive impact in highlighting risks to equality and support specific approaches to close the gaps where these are identified.

Appendix 3: Risk Scoring

RISK SCORING

The prioritisation and allocation of risk

To ensure that meaningful decisions on the prioritisation and treatment of risks can be made, the Trust will grade all risks using the same tool.

- **The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) will be used to assign risk priority.**

  It is essential to have one system for prioritising and rating risks, and this will be used to prioritise risks on the Assurance Framework and Risk Registers, and for rating incidents, complaints, and claims. Risk analysis uses descriptive scales to describe the magnitude of potential consequences and the likelihood that those consequences occur.

Measures of likelihood – likelihood scores (non-financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur **at least annually**	Expected to occur **at least monthly**	Expected to occur **at least weekly**	Expected to occur **at least daily**

Measures of Likelihood – likelihood scores (financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur in the current or next year	Unlikely to occur during the current or next year	Could easily occur during the current or next year	Will probably occur during the current or next year	Definitely will occur during the current or next year

Measures of Consequence – Domains, consequence and examples of score descriptors

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work <3days Increase in length of hospital stay by 1-2days	Moderate injury requiring professional intervention Requiring time off work 4-14 days RIDDOR/agency reportable incident An event that impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work >14days Increase in length of hospital stay by >15days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
				Mismanagement of patient care with long term effects	
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if not resolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service Gross failure of patient safety if findings not acted on Inquest / Ombudsman inquiry Gross failure to meet national standards
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objectives / service due to lack of staff Unsafe staffing levels or competence	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / Inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable	National media coverage with >3days service well below reasonable public expectation. MP

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		expectation not being met		public expectation	concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget Schedule slippage	<5-10% over project budget Schedule slippage	Non-compliance with national 10-25% over budget project Schedule slippage Key objectives not met	Incident leading >25% over project budget Schedule slippage Key objectives not met
Finance – including claims	Non delivery/Loss of budget to value of <£10K	Non delivery/Loss of budget between £10K and £100K	Non-delivery/Loss of budget between £100K and £500K	Non delivery/Loss of budget between £500K and £2M	Non-delivery/Loss of Budget of more than £2M
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Measures of Consequence – Additional guidance and examples relating to risks impacting on the safety of patients, staff or public.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling – no time off work required	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information / communication on transfer of care Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation, fracture, blow to the head Loss of limb Post-traumatic stress disorder	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis Incident leading to long-term mental health problem Rape / serious sexual assault

5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)

	Almost Certain	5 Yellow	10 Yellow	15 Red	20 Red	25 Red
	Likely	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	Possible	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	Unlikely	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	Rare	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

Appendix 4: Risk Thresholds/Risk Level Monitoring

RISK THRESHOLDS / RISK LEVEL MONITORING

Level of Risk	Risk Scores	Determination of Level, monitoring of Action Plans and acceptability of risk to the Trust	Monitoring Process
Red	All risks rated 15 + (post moderation) Unacceptable level of risk exposure which requires immediate corrective action to be taken	Unacceptable risk Approved by the RMG. Action Plans approved by relevant Executive Director and RMG.	Oversight by Risk Management Working Group QPES, FPP and People Committee level monitoring of these risks QPES, FPP and People Committee to advise Board on ways of managing high risks that cannot be addressed within existing resources.
Amber	All risks rated 12+ Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	Unacceptable risk Risk scores approved by local Service and Divisional clinical governance Committees. Level determined by **Executive Director.** Action Plans managed by senior managers. Progress updates via Divisional Leads.	Included on the Risk Register and reported to local Service and Divisional Clinical Governance Committee. Action plans monitored by Executive Director.
Yellow	All risks rated 4- 10	Level determined by the **Service Manager.** Action Plans managed locally by named managers on behalf of the Director.	• Action Plans monitored by Directors Management team.
Green	All risks rated 1 - 4		

Appendix 5: Key definitions

KEY DEFINITIONS

Risk Description		There are 3 main components will need to be considered when articulating the risk description (cause, event and effect):
		- There is a risk of…if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Rating	Inherent	This is the score of a risk without taking into consideration any controls which may be in place to mitigate it. This is also referred to as gross risk, initial risk, uncontrolled risk or absolute risk.
	Current	This is the score of the risk taking into consideration the controls and mitigation measures in place. This is also referred to as net risk, residual risk, current risk, or managed level of risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is `rare` which denotes it will probably never happen, with a 5 being `almost certain` which indicates that it will undoubtedly or possibly happen.
Risk Score		Risk score is derived by multiplying the Impact by Likelihood.
Risk Appetite	Definition	Is defined as the amount and level of risk that the Trust is willing to pursue or accept in order to achieve its priorities.
Controls or risk mitigations	Definition	These are measures/interventions implemented by the Trust to reduce either the likelihood of a risk and/or the impact were it to be realised. Controls could include strategies, policies, procedures, systems, SOPs, Checklists etc being implemented to reduce either the likelihood and/or impact of the risk were it to crystallise. A control is also a measure that maintains and/or modifies risk (ISO 31000:2018(en).
Three Lines of Defence Model	1st Line of Defence	The first Line of defence refers to the service or function that owns, mitigates and manages the risk on a day-to-day basis.
	2nd Line of Defence	This refers to other functions in the in the Trust which oversee compliance or risk management e.g. HR, Risk Management team etc.
	3rd Line of Defence	This refers to functions in the trust which provide objective and independent assurance and may include Internal Audits, External Audits etc.

Appendix 6: Risk Appetite Statement

RISK APPETITE STATEMENT

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making;
- Supporting performance improvement
- Focusing on priority areas within an organisation
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

Risk Type	Statement	Risk appetite category	Target risk score range
Quality & Safety	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	**Cautious**	**6 - 8**
Reputational	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	**Minimal**	**2 - 4**
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	**Eager**	**12**
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	**Open**	**9 – 10**
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	**Cautious**	**6 - 8**
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	**Open**	**9 – 10**
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**

Data and Information Management	Accept need for operational effectiveness in distribution and information sharing.	**Open**	**9 - 10**
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	**Minimal**	**2 - 4**
Digitalisation/ Technology	Systems / technology developments considered to enable improved delivery. Agile principles may be followed.	**Open**	**9 – 10**
Transformation/ Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	**Open**	**9 – 10**
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	**Minimal**	**2 - 4**
Property & Environment	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	**Open**	**9 – 10**
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**
Partnerships & Provider Collaboratives	Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking.	**Open**	**9 – 10**

9.8. Questions from Governors and Public (see procedure below)

9.9. Any Other Business (at the discretion of the Chair)

10. FEEDBACK ON BOARD DISCUSSIONS

11. RESOLUTION

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

12. Date & Time of Next Meeting

6 December 2023, 09:00-12:30