BOARD OF DIRECTORS PART I

Schedule Wednesday 2 August 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 2 AUGUST 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
Patient Story: Valerie Theay

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

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
8.5	Summerhill Services Limited Business Report	*S. Bray*	*11:30*	*Attached*	Assurance
9.	**GOVERNANCE & RISK**				
9.1	Annual Medical Appraisal and Job Planning	*F. Aria*	*11:40*	*Attached*	Assurance
9.2	Council of Governor Minutes	*D. Tita*	*11:50*	*Attached*	Information
9.3.1 9.3.2	Review and update of the BAF – Cover sheet Updated combined Board Assurance Framework (BAF)	*D. Tita*	*11:55*	*Attached*	Assurance
9.4	Commissioning BAF	*D. Tita*	*12:05*	*Attached*	Assurance
9.5	Draft Board Risk Appetite Survey Monkey	*D. Tita*	*12:10*	*Attached*	Assurance
9.6	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:20*	*Verbal*	-
9.7	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 4 October 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.

Patient Story: Valerie Theay

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	**7 June 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	-	Director of Finance
	Vanessa Devlin	-	Director of Operations
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	Steve Forsyth	-	Interim Chief Nursing Officer
	Fabida Aria	-	Medical Director
	Linda Cullen	-	Non-Executive Director
	Anne Baines	-	Non-Executive Director
	Winston Weir	-	Non-Executive Director
	Bal Claire	-	Non-Executive Director
In Attendance	Adele Tomlinson	-	Executive PA to the Director of Operations
	David Tita	-	Associate Director of Corporate Governance
	Anna Sykes	-	Head of Communications
	Grace Holness	-	Senior Communications Officer
	Dr Shay Anne Pentall	-	Guardian of Safe Working Hours
Observers	Mustak Mirza	-	Service User Governor
Apologies	Sarah Bloomfield		

Agenda item	Staff story	Action (Owner)
	Staff stories were presented by four staff members which highlighted their personal career journey whilst at the Trust. One member of staff referred to the Reaside site and the issues associated with it. The issues were noted by the Board and agreed to continue to support those areas of issues raised. All the staff members were thanked and the Board acknowledged their personal journeys, openness in sharing their experiences.	

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 5 April 2023 were approved as a true and accurate record of the meeting with the exception of the following amendments: - • Page 1 should read Mr D Tomlinson Director of Summerhill Services. • Page 9 duplication of paragraph 6. • Page 13 item 9.4.1 last sentence should read The Chair. • Apologies not recorded for Monique Shafaq, Designated Non-Executive Director.	
3.	**MATTERS ARISING / ACTION LOG** Mr D Tita advised that this agenda item (Governance Action Plan) was to be deferred to the August Board meeting.	
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 offered out any comments or questions. The report was received and duly noted as no comments or questions were raised.	
5.	**CHIEF EXECUTIVE'S AND DIRECTOR OF OPERATIONS REPORT** Mrs R Fallon-Williams referred to the Trust's approach to the industrial action planned for the 14 to 17 June. She advised that the same approach would be taken as before and thanked those involved in the process and organising the cover arrangements to continue to provide safe levels of service. Mrs R Fallon-Williams highlighted in the Sustainability section of the report the considerable amount of funding for mental health services allocated to the new Birmingham and Solihull (BSol) Mental Health Provider Collaborative for this financial year. She advised that a large element would come to the Trust to support various services such as the transformation agenda and other pieces of work. This work would be done collaboratively to improve services with better financial efficiency. She also noted the work to reducing spend on agency and how this could be aligned and integrate services. The meeting was informed of the significant work that has been undertaken at the BSol Chief Financial Officers and Chief Executives workshop over the last few weeks. Mrs R Fallon-Williams advised that there would be a review of the financial aspects and review and also consideration of the workforce challenges. She noted that she was	

Agenda Item	Discussion	Action (Owner)
	meeting with the Chief People Officers to develop a delivery plan. Mrs R Fallon-Williams commended and thanked all who had been involved in the Integrated Health and Care Strategy with Sel Vincent, Clinical Director, undertaking a lead role in engagement people within the organisation. She confirmed that the response to the CQC action plan inspection report had been submitted and reported that all the timelines were achievable. She offered her congratulations to Birmingham City Council on their huge achievement for colleagues in the Children's Services who had been awarded "Good" by the CQC. Mrs V Devlin provided an overview of activity since the last Trust Board meeting. She noted that the Trust Value Awards which had been held recently had been a very positive event for staff, but that staffing levels continue to be challenging. However, work was ongoing to work creatively and differently, and staff remained committed to delivering as high a quality service as possible. Mrs V Devlin reported on the key areas of activities within each division. ICCR: - • The ADHD service was part of the wider BSol piece of work to review and assess the Trust's system model to ensure joined up and seamless pathways of care. Emma Brogan, Clinical Services Manager, had recently represented the organisation as part of the collaborative work and was developing some action planning. • A prioritisation of skills event had taken place based on the staff survey to ensure that staff were engaged, skilled, well supported, inclusive and listened to staff culture within the division. Secure Care and Offender: - • Support continues between sites ensuring the flexibility of staff to cover other wards. Mrs V Devlin extended her thanks to all staff working across the Multi-Disciplinary Teams • Ardenleigh Women's Services hosted a successful conference at the National Arboretum which had been a well attended and positive event. The service has received national recognition for the blended work that they have undertaken, with particular acknowledgement to Emma Watts. Acute and Urgent Care: - • Pathways continue to remain strained with a large amount of focus on "out of area". • Sensory assessment and autism training for staff has taken place throughout the months of April/May at the Oleaster as part of the Sensory Friendly Ward project and autism training requirement for staff, led by Nuala Fletcher, Head of Nursing for the division. • 'Call before you Convey' Service was reported as working well with the Community Mental Health Teams liaising with the Ambulance Service to contribute to the diversion of ambulances from the emergency departments to a Psychiatric Decision Unit (PDU) to support the reduction of attendances at Accident and Emergency Departments.	

Agenda Item	Discussion	Action (Owner)
	Dementia and Frailty • The division was developing two new posts - Pathway 2 Discharge Manager to support the discharge pathway and a Registered General Nurse/Occupational Therapist which would support falls and reduce using level 3/4 observations. • The Bipolar Service has been shortlisted for the Health Service Journal award finals for Improving Mental Health by Digital Means. • The service continues to work with senior employment advisors, particularly staff who were off sick in supporting their return to work. Finally, Mrs V Devlin offered her congratulations to Debbie Gall who had recently supported the Birmingham Pride event which she and Patrick Nyarumbu had attended. Mrs V Devlin sought the support of all the Trust Board members at next year's event. On conclusion of the report, Mrs A Baines commented on the BSol and regional work in relation to ADHD and asked if there was a timeline and how were broader partners e.g. education etc, actively involved. Mrs V Devlin advised following the ADHD workshop it had been noted that some services were struggling to meet the needs of ADHD patients and waiting lists. Therefore, the plan was of joint working to have one model and a single point of access. She went on to say that working with GPs was key as well as joint sharing and understanding and that a plan was being developed on caseloads following the workshop which had been held on the 15th May. Mrs V Devlin agreed to obtain a more detailed report and an understanding of some of the timelines. Mrs L Cullen sought clarity on whether the organisation has a sexual safety policy and sexual safety lead, and whether relevant incidents are recorded and monitored. She advised that there had been concerns raised by the CQC some years ago about the issue in Mental Health Trusts and following a recent investigation which was reported in HSJ of high levels of sexual activity and abuse in Mental Health Trusts in particular, with both staff and patients being perpetrators and victims. Mr S Forsyth advised that it had been reported as a concern by the CQC in 2017 and the guidance was subsequently published in 2018. He also noted that there was a mental health improvement programme across mental health providers and that the organisation benches itself quarterly producing quality metrics. Mrs L Cullen also asked about the investment for the high rates of domestic abuse in the inner cities which was not proportionate to the demand and was also a wider system issue. Mr S Forsyth advised that the Trust had representation on the domestic violence provider board and also a domestic abuse lead within the Safeguard Team to ensure compliance. Mr P Gayle referred to acute and urgent care services section of the report and that in April the detention of patients under Section 136 transferred to the Urgent Care Centre/Place of Safety had been the lowest since September 2022. He queried the impact of the Metropolitan Police decision that officers would only attend if there was a threat to life. Mrs R Fallon-Williams reported that the Trust had a good relationship with West Midlands Police and a member of the West Midlands Police was also a Governor on the Council of Governors Committee. She felt assured that there would be helpful discussions and an understanding perspective. Mr P Gayle also highlighted from the report the challenges of Probation Officers managing community risks in the Offender Personality Disorder and would the ongoing discussions with the Prison Probation Service be sufficient to offset the challenges. Mrs V Devlin advised that the challenges were regarding not have a full workforce but work was being undertaken to address the gaps and the relationship was much	*V Devlin*

Agenda Item	Discussion	Action (Owner)
	stronger with the Probation Service. Mr P Gayle requested that this should be kept on the radar in order to provide assurance to the board. The Board: • Noted the report and thanked Mrs R Fallon-Williams and Mrs V Devlin. • Agreed the action as above.	
6.	**TRUST VALUES – 2022/23 REVIEW AND 2023/24 GOALS** The Board received the Trust Values update report. Mr P Nyarumbu advised the purpose of the report. • Part A was to provide a summary of the delivery of goals at the end of the 2022/23 (year 2) to provide assurance to the Board for the delivery of the strategy. • Part B was seeking approval from the Board for the proposed goals for 2023/24 (year 3). Mrs A Baines commented that she was impressed by the overall structure and process but that the discussions at the Committees such as People had not been reflected within the report and that there was a risk of deliverability in terms of resource and share the evolution of the governance. It is something that can be thought about in the future of the nature of the assurance reports. Mr B Claire and Mr W Weir concurred with Mrs A Baines' comments and said that they would like to see the detail of the journey and of any risks that may make the strategy difficult to achieve. Mr W Weir queried if the 97 goals were achievable and too ambitious and what resources would be required for some of the goals detailed on page 72 of the report. In response to a comment made by Mr B Claire regarding a review and refresh of the goals, Mrs V Devlin referred to the clinical goals and of the ongoing work in the divisions and the engagements through the risks and demands which reflect what was required as an organisation. The Board: - • Agreed that this was an excellent piece of work. • Noted the comments by Mrs A Baines, Mr B Claire and Mr W Weir but were overall assured of the delivery of the strategy. • Agreed that a review of the nature of the assurance reports to reflect the discussions at Committees and the progress of the strategy within the future assurance reports with a detailed update from Abi Broderick at a 6 months and 12 months period. • Approved Part B for 2023/24 proposed goals.	*P Nyarumbu/ D Tita*
7.	**QUALITY**	
7.1	**Quality, Patient Experience & Safety Committee Chair's Assurance Report April and May 2023** Mrs L Cullen provided a summary of the key highlights within the report. She explained that April's report had been written in the old style and May had been written in the new triple A format which would be used going forward, She referred to the first report (April 2023) and highlighted that in terms of infection	

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	prevention and control (IPC), the Committee had only gained limited assurance at that point as there had not been a centralised overview of all inpatient and outpatient areas. However, the oversight process of IPC and the proposed implementation of the dashboard had been noted. Mrs L Cullen advised that the clinical audit plan 2022/23 was reviewed which included the national mandates and it had been positive to see the merging of quality, improvement and audit practice which allowed joint working in addressing the quality issues. It was noted that from all the directorates the data had been collected and shared with high priority audits and at the next meeting would focus on the lessons learned from the key audits. She drew attention to an escalation detailed in the report relating to the staff morale external message following the CQC report and that consideration should be given to the Trust communications. Mrs L Cullen went on to present the May report where she highlighted a notable increase in physical assaults and restraints and that there would be plans put in place to monitor the increase. It was also noted that there had been discussions about PREVENT training and some of the language used internally such as “Islamist”, and although it is a nationally mandated training programme for the organisation to consider and obtain some advice. Mr P Gayle concluded that this was the first report with the use of the Triple A form in terms of the content which was easier identify the key areas and that the minutes and actions were available via the reading room or on request. The Board: - • Noted the content of the report.	
7.2	**Patient Safety Report** Ms L Pim presented the patient safety report. She highlighted there were 35 live serious incidents (SIs) which was an increase of 14 since December 2022, and a further 4 SIs were agreed the previous day through the SI Oversight Group. She advised that the investigations were being worked through in a timely manner and only 4 exceeded the 60 day standard, which was a reduction of 8 since last presented to the Trust Board in March 2023. Ms L Pim also reported that the average completion of investigations was now 65 days which was a reduction of 90 previously reported due to the hard work being undertaken. However she highlighted that the increase in serious incident activity was impacting upon the workload of the Patient Safety team and although the Executive Team had approved additional resources in the interim awaiting transition to the patient safety incident response framework (PSIRF), due to the current NHSE financial arrangements an additional business case was required for final approval by the Integrated Collaborative Board and NHS England which had delayed the resource required. Ms L Pim reported that the themes of the SIs remained the same and would present the health inequalities to the Trust Board following submission to the Quality, Patient, Experience and Safety (QPES) Committee in July. She then reported on the current 112 open SIs actions dating back to 2017 and that most of the actions were within the Acute and Urgent Care division. It was anticipated a progress update would be presented at the next meeting following meetings with each divisional lead with the priority being Acute and Urgent Care. Following the previous data shared with the Board of a significant number of open	

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	incidents on the system between 2011-2023 with 708 of those incidents predating 2022. Ms L Pim reported as of the end of April this had been significantly reduced by 1753 and all incidents pre-dating 2020 have been safely closed. Ms L Pim then drew attention to the recently concluded and published external Niche reviews and their associated action plans that had been put in place to provide assurance to the Board. Further progress on the action plans would be reported through the Clinical Governance Committee and Trust level until completed. She advised of the successful safety summit approach, and a data Summit focusing on Clozapine which had been chaired by Fabida Aria. On conclusion it was reported that the overdue complaints actions were due to divisional colleagues not being sighted on those actions. An action tracker has been developed and meetings were being arranged and indicators would be considered on a quarterly basis to improve the process and understanding when reported to the Trust Board. In response from a query from Mr B Claire relating to the themes of formal complaints 34% was communication with patients and how this was being addressed, Ms L Pim advised that the themes were varied, and that there were a number of workstreams underway to address the issues. Mr B Claire suggested that it would be useful to understand what were relating to process and/or education issues. Ms L Pim agreed to provide an update around the workstreams in the next quarterly report. Mrs R Fallon-Williams remarked on the consistency of SIs and asked about the areas of work and levels of assurance. Mrs L Cullen advised it was work in progress and that reports were improving; Mr S Forsyth advised that discussions would be held at the safety summits and the strategy would be presented at the next QPES Committee. In terms of serious incidents, Mrs R Fallon-Williams noted it was pleasing to see the reduction in incidents and asked if there was a sense of trajectory. Mrs L Pim responded that this had been led by clinical governance alongside Julie Romano. The thematic reviews had been circulated to divisions for 2020 and were currently awaiting responses. Mrs R Fallon-Williams went on to mention a particular Niche report regarding ZM. She pointed out to be mindful that this would be published in July which would attract a lot of media attention. She requested that the Board were to be kept fully up to speed on the action plans. The Board: • Thanked Ms L Pim for the comprehensive and detailed summary. • Noted the content of the report.	*L Pim* *S Forsyth/ L Pim*
8.	**PEOPLE**	
8.1	**People Committee Chair's Assurance Report April and May 2023** Mrs A Baines presented the two overall reports for April and May. April's report included a deep dive into the workforce development plan and strategy and a detailed report in terms of safer staffing. With regards to the May report, Mrs A Baines referred to the future workforce, culture and staff experience assurance report. She highlighted the concerns and in depth discussions that had been held by the Committee with regards to the pressure of staffing and issues relating to vacancies, absence from work and inability to fill shifts. These were impacting on wellbeing and	

Agenda Item	Discussion	Action (Owner)
	colleagues ability to access the key information / training in particular the appraisals as the core leadership programme in order to support them effectively and which was impacting on the development of staff and the leadership of the organisation. This had been reflected in the junior doctor's staff story. She went on to point out there had also been discussions around safer staffing and the challenges with the pace of the extended implementation of the 6 weeks e-rostering. In terms of ALERTs, Mrs A Baines noted the Committee were concerned in terms of the ethnic minority community colleagues within the organisation particularly in relation to the recruitment process where currently the numbers being shortlisted in relation to appointment had reduced significantly and the Committee were considering how this could be addressed. Similarly in the number of caseloads in the process of disciplinary or policy implementation there was a proportionately higher number from those communities which again would be reviewed to ensure that policies were in line with the Trust's anti-racism approach. Mrs A Baines stated that there was an apprehension regarding the people strategic goals because a number of those had been extended into the following year and the resourcing to making those changes should be considered in relation to the Board Assurance Framework (BAF). On a positive note, it was reported there had been an increase in AVERTS training and sickness rates had continued to reduce particularly in mental health, anxiety, and wellbeing. In addition, work had been undertaken by John Travers with regards to the staff survey in developing improvement plans which would be cascaded across the organisation. On conclusion Mrs A Baines noted there had been an update on the international nurses scheme and that there would be about an additional 35 members of staff from October 2023. She also remarked that it had been positive to learn of the focus on the induction, pastoral and welcoming aspects into the organsation. In response to a question from Mr W Weir, Mrs A Baines stated that there would be an updated report in terms of e-rostering bimonthly to the Committee. Mr S Forsyth added that there would be a clinical lead from July for e-rostering which would roll out the process. The Board: • Received and noted the content of the report.	
9,	**SUSTAINABILITY**	
9.1	**Finance, Performance & Productivity Committee Chair's Assurance Report April and May 2023** Mr B Claire referred to both April and May reports which were taken as read. In summary he advised that a break-even plan had been submitted to NHS England however month one had showed a deficient of £59,000 mainly due to out of area expenditure and temporary staffing. He advised that there continued to be an upward trend in this area and it would require close monitoring going forward. Following discussions with Richard Sollars a year-on-year pre-, during and post-COVID costs in relation to commissioned activity would be provided. No significant changes were noted following the review of the performance indicators. Mr B Claire reported that the Committee had approved a new provider collaborative in	

Agenda Item	Discussion	Action (Owner)
	the perinatal services which would be live as from October 2023 with some financial considerations between now and October. He also advised that Carl Beet had provided a digital strategy update which was approved in principle and further discussions were ongoing. Mrs V Devlin commented on the bank and agency spend. She and Richard Sollars had undertaken some deep dives to establish where the challenges were which the divisions have found helpful. The divisions have asked for additional training for staff focusing on budget management and savings skills as this had not been as much of a priority during the height of the COVID period. She advised the deep dives would also be fed back into the local divisional FPP meetings and the Performance Delivery Group. The Board acknowledged the improvement trajectory but that staff sickness rates were having an impact on band and agency usage and that it would be useful to triangulate the data in relation to clarifying what was driving the demand. Mr B Claire pointed out the inappropriate out of area bed placements and how this was impacting on finances. Mr D Tomlinson clarified that there were two areas which require to be monitored – inappropriate out of area admissions were monitored within the Integrated Performance Report, but even spend against appropriate out of area admissions needed to be monitored as it was in excess of available funding.	
9.2	**Finance Report** Mr D Tomlinson provided a summary of the finance report. He advised that there was an original submission of a £3.1m deficit for the year and this was later amended to break even following receipt of additional funding from the ICB, including funding for PFI inflation. The ICB had established a negative risk reserve. At this stage the Trust has flexibility to manage the overall position although there were issues around out of area beds and temporary staff and a need to ensure improvement around each of these issues and the level of risk. Mr B Claire requested analysis of change since pre-COVID which would be helpful in this area. Capital expenditure was ahead of plan. The Trust has a bank balance of £68m but is unable to spend this on capital. University Hospitals Birmingham have even more significant cash funds. The Trust is trying to address the Reaside and Highcroft funding needs and have developed an approach re Highcroft modular build to increase capacity. Mr W Weir queried the efficiencies of £14.7m of which £2.4m was unidentified and asked if schemes could be identified. In response Mr D Tomlinson advised that it was likely to use balance sheet flexibility to cover this. The Board: • Received and noted the content of the report.	
9.3 & 9.4	**Audit Committee and Charitable Funds Chair's Assurance Report April 2023** Mr P Gayle advised that both reports were taken as read and had also been presented to the Council of Governors.	
9.5	**Integrated Performance Report** Mr P Gayle advised this report was taken as read. No further questions were noted. Mr	

Agenda Item	Discussion	Action (Owner)
	D Tomlinson advised that a more triangulated report would be presented from the individual areas which would provide the Board with a more rounded view.	
10	**GOVERNANCE & RISK**	
10.1 & 10.2	**Updates on any action plans arising from – Good governance reviews; external visits, CQC, Coroner any externally commissioned reports and investigations** The Board were advised that the CQC action plans following the external review and any externally commissioned reports were being pulled together on a spreadsheet in order for the Board to have sight of the actions on a six monthly basis.	
10.3	**Freedom to Speak Up Annual Report** Ms E Randle provided an update of the report presented. She highlighted the current activity with 89 concerns and enquiries between January and March 2023 with 33 of those going through the informal process. She noted that the majority of the concerns were raised by nursing colleagues but was confident that they were reaching all professional groups. The board were also advised of an approved expansion of the team of a band 5 who was very visible in supporting areas across the F2SU landscape. Following the CQC report working with those areas in supporting the Trust's response. Ms E Randle concluded by requesting the Board to encourage Associate Directors to and their direct reports to complete the three modules of training – Speak Up, Listen Up and Follow up by December 2023 to ensure a full understanding of the process and their role as senior leaders in setting the culture and tone of the organisation. Mrs R Fallon-Williams commented on the protected characteristics and if more could be done to encourage this information to be provided. Ms E Randle agreed to consider how this information could be increased. The Board: - • Received and noted the content of the report. • To consider the recommendations detailed within the report.	
10.4	**Quarterly Guardian of Safe Working Report** Dr S A Pantall provided a summary of the key highlights for this quarter. She reported of no immediate safety concerns although there had been an increase in exception reports compared to the previous quarter. Delays in the process was also delayed due to the need to clarify the on call working pattern for higher trainees with medical workforce, disagreement with the initial outcomes and outcomes not being accepted promptly by the junior doctor. She also advised that 10 fines had been levied against the Trust for breaches of safe working hours and as a result a change to the on call working patterns were being discussed. The number of vacant shifts continues to be high with an increase in shift vacancies compared to quarter 3, mainly due to post vacancies. On conclusion Dr S A Pantall reported that there continues to be a large amount of work to support and facilitate cultural change to support doctors in training raising issues.	

Agenda Item	Discussion	Action (Owner)
	The Board: - • Noted the reort and the progress that has been made in encouraging postgraduate doctors in training to raise concerns. • Assured that there was oversight of safe working hours for junior doctors in the Trust and that appropriate actions were being taken to response to concerns raised.	
10.5	**Questions from the Governors and Public** No questions were noted.	
10.6	**ANY OTHER BUSINESS** **10.6a.** Health inequalities (including PCREF, Blaichir & Internal work). Ms J Kaur provided an update which would be received by the Board on a six monthly basis and welcomed any questions or feedback. The Board acknowledged that the report was helpful and was pleased to see the progress made. Ms J Kaur reported that further work was being undertaken with regards to the data and that practitioners were being encouraged to use the data to challenge their own practices. The plans and outcomes were also noted from a health perspective and the joint working with the local authority councils and police. The Board agreed to the suggestion of holding a conference for the wider message of health and equalities to promote that this was a high priority for the Trust. The following were all noted by the Board: - **10.6b.** To schedule an extraordinary Board Meeting on 21st June 2023 from 14:00 – 14:35 to ratify the Annual Report & Accounts for 2022/23. **10.6c.** Ratification of Trust Constitution and associated documents. **10.6c1:** BSMHFT Constitution, incorporating Standing Orders for the Commissioning Committee **10.6c2**. BSMHFT Scheme of Delegation **10.6c3**. BSMHFT Standing Financial Instructions (SFIs) **10.6d.** HSE - NHS Chief Executive Letter and Report on MSDs and V&A Interventions - March 2023 The Board offered their congratulations to Dr Fabida Aria for her appointment as a Fellow of the Royal College of Psychiatry.	
11.	**FEEDBACK ON BOARD DISCUSSIONS** Nothing to note.	
12.	**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	

Agenda Item	Discussion	Action (Owner)
	Wednesday 2 August 2023, 09:00– 2:30	

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS – DECEMBER ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
June 2023 Item 5	**CHIEF EXECUTIVE'S AND DIRECTOR OF OPERATIONS REPORT** Mrs V Devlin agreed to obtain a more detailed report and an understanding of some of the timelines of joint working with GPs.	V. Devlin			
June 2023 Item 6	**TRUST VALUES – 2022/23 REVIEW AND 2023/24 GOALS** Agreed that a review of the nature of the assurance reports to reflect the discussions at Committees and the progress of the strategy within the future assurance reports with a detailed update from Abi Broderick at a 6 months and 12 months period.	P. Nyarumbu			Scheduled on the forward planner for December
June 2023 Item 7.2	**PATIENT SAFETY REPORT** Ms L Pim agreed to provide an update around the workstreams in the next quarterly report.	L. Pim	August 23		Noted within the report
June 2023 Item 7.2	**PATIENT SAFETY REPORT** Mrs R Fallon-Williams went on to mention a particular Niche report regarding ZM. She pointed out to be mindful that this would be published in July which would attract a lot of media attention. She requested that the Board were to be kept fully up to speed on the action plans.	S. Forsyth	August 23		Complete

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	2 August 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

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

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

1.3 I am pleased to offer a brief report to the Board in Public of my key areas of focus since the last Board meeting.

2. CLINICAL SERVICES

2.1 NEDs have started to visit our Trust services, and this is likely to increase over the coming months. Most NEDs and governors now have the appropriate level DBS certificate on file to undertake service visits.

2.2 It was a pleasure visiting our Criminal Justice Recovery Service at Perry Barr Custody Suite. I spent some time meeting staff and police colleagues and hearing about their work and some of the challenges they face, but overall staff were quite positive about their work and the service.

2.3 I visited staff the Oleaster unit based on the UHB site and met with staff across all service areas. Our staff work in often quite challenged circumstances but again they were very positive about their work and welcomed the visit. Our staff expressed that they are looking forward to other Board members visiting the Oleaster unit.

2.4 I was pleased to be able to visit our Solar services at Bishop Wilson Clinic. I met with the staff and some parents and heard about the great work they do and the effective partnership working with other children services that they have fostered. Staff felt really pleased to have members of the Board coming to see and hear about the service we provide for young people in Solihull.

3. PEOPLE

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

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

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

3.3 NED appraisals have now concluded and compliance is now 100%.

3.4 I was pleased to meet with Rebecca Farmer, Directors of Strategic Transformation, NHS England. Positive working relations continue. We have agreed to meet on a bimonthly basis.

4. QUALITY

4.1 I was honored to be able to attend the Doctor of the year awards where staff were recognised for their outstanding contributions.

5. SUSTAINABILITY

5.1 The Council of Governors received and reviewed the Membership and Governor Engagement Strategy, version two is in draft and will be reviewed in September 2023.

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 is scheduled for next week.

5.3 The elections process for the Council of Governors will be launched following receipt of its nominations and the ballot is open until the end of August 2023.

5.4 A NED Role has been advertised to following my appointment as chair. The advertisement for the role is now closed and John Travers, our Lead Governor and myself are in the process of shortlisting candidates for interview.

PHIL GAYLE
CHAIR

5. Chief Executive’s and Director of Operations Report

6. QUALITY

6.1. (a) QPES Chair’s Assurance Report June

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: QPES Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 August 2023**
Date(s) of Committee Meeting(s) reported	**21 June 2023**
Quoracy	**Membership quorate: Y / N**
Agenda	The Committee considered an agenda which included the following items: 1. CQC Update and Action Plan 2. Safer staffing Inc. MHOST update 3. Integrated Performance Report 4. Trustwide Audit Planner 5. Patient Safety & Complaints Report 6. Infection, Prevention & Control (IPC) Annual Report 7. Board Assurance Framework 8. Annual Safeguarding Report 9. Quality Account 10. Quality Structure - Next Steps for IHI and QI Strategy
Alert:	The Committee wishes to alert the Trust Board to the following CQC action plans: The Compliance team has been working closely with clinical teams to obtain the progress against actions outlined in the CQC Must and Should Do findings. Good progress being made with the first updates being provided to the CQC. Acknowledged actions that are overdue with a particular focus on supervision. Deep dive taking place as supervision is occurring noting issues with recording/uploading with the electronic system. The actions for appraisal, clinical and managerial supervision remain a concern, with the reports from Insight still showing relatively low levels of compliance. More robust monitoring of these figures is required at service level as per the action plans agreed to address the Section 29a, to enable sustained improvement. **Patient Safety & Complaints Report** Serious Incidents: Data evidences a decrease in the number of the serious incidents reported in month, with 4 incidents reported during April 2023, which is below the

mean, compared with 7 and 10 serious incidents reported in February and March.

The report noted the types of SI's at the time, there were 21 current SI's in the review process, this had increased by the time of this committee to 36, the team are applying the 60day review standard very well, with now only 5 exceed this compared when the updated reporting of 12.

It is noted that there are only a small number of serious incident investigators in the teams, additional resources have been requested and approved by the executive team, however new restrictions from NHSE means a business case which has to be submitted/ approved by ICB then up to NHSE for their approval, currently waiting feedback from ICB, the Interim Executive Director of Nursing and Executive Medical Director have contacted their ICB counterparts to stress the urgency of approval.

Prone Restraint: The figures evidence there was an increase in the number of reported prone restraints for the month of April with 88 incidents being reported, despite this being an increase of the previous month of 71. The data suggests that a small number of service users were involved in a large number of incidents due to clinical presentation and acuity.

Staff Assaults: The total number of actual assaults on staff for the month of April totalled at 80 which is a decrease in the previous month, however it is noted that some of the staff assaults have resulted in injury and psychological harm.

Complaints

Currently there are 18 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer, an increase of 4 (total 37 so 49%). This is a deteriorating position from previous month whereby 37% of complaints were pending an IO. • The average is currently 76 working days for an open complaint (this has decreased by 12 days as the team have closed down). The average time it is has taken to allocate a case to an Investigating Officer is 66 working days an increase from 57 on prior month.
Both these targets do not meet best practice standards and continued work is being undertaken by the Complaints Lead to improve these KPI's. Additional resource has been requested in a paper to the executive team. Whilst approved, the same financial restrictions remain in place for agency. An additional experienced bank person has been found more laterally in the last week that will offer additional experience to the team.

At the time of writing this report there are 32 open serious incidents in the review process, excluding infection control reviews, of which 5 exceed 60-day review deadline. The average time for completion of a review has been evidenced as being 65 days. Delayed investigation and completion of serious incidents leads to delayed learning for services and the organisation and increases the risks of a further incident of this type from reoccurring.

Restrictive practice

	A detailed conversation was held at committee regarding seclusion and that we are assured that we are not stopping urgent and emergency seclusion which may be required outside of a designated seclusion suite to protect the risk of immediate threats to life. If the decision is made to seclude someone in a room not a designated seclusion suite this is done as a clinical/professional decision with documentation in place noting all of the relevant safeguarding being in place, observations, safe environment, least restrictive, minimum amount of time e.g., monitoring etc. Dr Rowe is reviewing the policy and the Interim Chief Nurse has taken the discussion of clinical practice to a national forum. We stopped the misuse of an anti-barricade lock that had significant implications, when audits were undertaken, we found: barrels missing from locks and also malfunctioning locks, meaning the potential risk for somebody barricading in a room and then subsequently not being able to override the unbarricaded lock was so significant. Also noted seclusion is not a locked door/ or a bedroom it can take place in many forms/environments e.g., therapy room and having the staff in front of the door/ removing other individuals from an area and just remaining with the one person, seclusion is the process not where it is done. The Mental Health Act Code of Practice section 26 point 102-149 notes all of the elements relating to seclusion; we have the National PICU guidance as well but the priority is the prevention of significant harm. There is a clear plan that was discussed at the RRP steering group around a national debate that has been triggered as a result of BSMHFT instigation. This is not just an issue for our trust but for all trusts, it was noted the process of seclusion had many variances, with currently no consistent approach/guidance. The national Mental Health forum are now in the process of setting up an urgent meeting to open up the discussion on this issue. The CQC and NHSE have been invited to take part in the forum. The Interim Chief Nurse has collated all of the responses to the topic discussion to show the breadth of the feedback and current variances in clinical practice. **Learning Disability and Autism;** 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. Numerous meetings were taking including a weekly meeting with NHSE/I It was suggested more oversight took place within the local governance then reported back to QPES in July 2023. It was also noted the LDA Lead should happen immediately and perhaps look within the organisation and/or approach partners for a dedication person.
Assurance:	The committee was assured on the following: **CQC Actions**

The Compliance team has a schedule for assurance testing and will be reviewing those completed actions as part of this process. The team will also continue to work closely with the service areas to improve the efficiency of providing progress updates to enable monitoring so that we can ensure the ongoing safety of our staff and service users.
It was agreed that those services who want to give alternative dates for 'must do's'/'should do's' will bring trajectory to QPES for scrutiny/oversight/approval before we update the CQC.

Trust Wide Audit Planner 2023-24

The Committee received a report and detailed spreadsheet of the Trust Clinical Audit Programme (TCAP) for the current financial year.
The planner includes Level 1, 2 and 3 audits- Which are our Nationally mandated projects, Trust priorities from SI's, Quality objectives and other key areas trust-wide, and service area priorities, corporate department audits (Such as pharmacy and safeguarding) and Policy audits. It was noted there could be changes through the year due to national changes, Trust SIs and the organisation was still scoping for some clinical audits around policies and SI actions.

Incidents:

There are currently 2712 incidents identified as currently awaiting managers sign off. This is a reduction from 2800 on prior month • A proposed methodology for the closure of overdue incidents was presented and formally agreed by committee for closure of historical incidents and is currently being worked through and progress will be reported through each committee meeting.
The 1st phase of the roll out of this work, open incidents from 2011 -2019 has been successfully completed
In preparation for PSIRF we are currently reviewing and strengthening our processes which includes the redesign of audit tool on the Eclipse system.

86% of our incidents reported during April 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.

It was confirmed that the quarterly quality metric paper will come to this meeting next month, which will show the charts and transition over time.

Infection, Prevention & Control

The Committee received and noted contents of the report
Committee was assured that 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.

Board Assurance Framework

Committee was assured by good progress made on the review and update of the Trust`s BAF with greater ownership, alignment with strategy , involvement and leadership from Executive Directors, additional columns for gaps in controls, assurance, gaps in assurance, actions
A short discussion took place around the BAF and how it links back to the strategy so that people on the frontline understand the work that is being done and how this links to risk logs held in the divisions. Also using the language, we have in aims about being the leader in mental health, being recovery focused, being rooted in the communities and prevention and early intervention.

Thanks given to all of the colleagues who were engaged and gave input to develop the BAF, it is now moving away from being owned by an external individual to being owned by the organisation,

If approved by committee this will go to audit committee in July and then Board in August. Regarding deep dives if a deep dive paper comes to committee this can be matched to a related risk on the BAF for that triangulation.

Annual Safeguarding Report

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. 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. 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. 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. 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.
Advise	The Committee was advised of the following matters: **The Committee received an update report on Safer Staffing and MHOST tool** We have now appointed Clinical Lead for Safer Staffing; she is due to start in post on the 3rd July 2023. This new post will allow an increase in clinical engagement across the organization with a plan to work co- productively across the organization, begin work with the community teams and continue with the projects that the safer staffing team are involved in i.e., the north early adopter of having pharmacy technicians/occupational therapy assistants/psychology assistants thinking creatively/outside of the box. The report was now in a statistical process chart format, to give visual representation of each division over a 12-month period to show the changes and trends. Also included will be bed occupancy data including harm-free days. Following from the CQC request we will now show shifts captured as zero RMN working/lone RMN shifts, this data is checked for assurance. We will be triangulating the fill rate data against 4 wards with the lowest fill rate data using the trust KPIs for this. This will be a new and innovative way of presenting the report to the Safer Staffing Committee. The second MHOST cycle finished on the 28th May 2023. The data from this collection will be added into the MHOST calculator to formulate an establishment. This will be measured against current workforce data on ESR, Eclipse data and professional judgement from each of our areas. The MHOST tool measures the acuity on the ward of each service user, it considers the level of observation prescribed as well as other aspects of care including assessments, 1:1 session with staff on the ward. The Lead Nurse for Safer Staffing will be meeting with the relevant areas to go through the findings and the recommendations of what the establishment should be and how we are going to measure this against our future workforce plans. It is anticipated that the first draft paper of the review will be ready by Mid July 2023. 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 is now ready for publication and NHSE chaired a pre-publication stakeholder meeting to review its contents and associated recommendations. It is anticipated that a press conference will be held inJuly 2023 for the release of the report.

	One action has been identified in the report for BSMHFT which broadly relates to the Standard Operating Procedure for Prison Discharge being updated. A meeting has been held with the Clinical Director for this service with timelines for this piece of work currently under review. 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 The Committee noted the waiting time of 3 months for new referrals to be seen by Neuropsychiatry was quite significant. It was advised the issue had been reviewed previously and following a performance meeting deep dive a report of the finding would be feedback to QPES in the near future. It was suggested to have the Specialist Psychotherapy Services Data (SPS) on the Committee Forward Planner for presentation on a regular occurrence **Infection Prevention & Control Annual Report 2022-23** Excellent detailed report provided. The question was asked if we could share the Food Safety Expert / Decontamination Officer as a shared role with another trust i.e. Birmingham Community Heath Care Trust (BCHC). The impact of the 4 closed flats on Forward House has implications for our acute services/detox services and the flow of this was noted. **Quality Structure - Next Steps for IHI and QI Strategy** Good progress noted and committee approved plan Building the structures to support quality, Agree QI strategy including new roles, and agree ongoing development at all levels in the organisation, Develop standardised SPC charts and data reports available to all within next 6 months Ensure that all strategic workstreams have a QI approach (not necessarily a project)- including corporate Ensure that all new Board members access training to QI approaches by September 2023 Sign off QMS implementation plan at QPESC and Board June 2023, monthly updates thereafter Share plan within each Executive Director portfolio with senior team so that all teams have a common vision and goal, with clear plans for how they link in (e.g. finance, data, People) Data systems: same information ward to Board, SPC charts, easily accessible and transparent. Governance structures clarity, effectiveness, two way communication

	PSIRF infrastructure , including investment in training for all staff Investment and recruitment of key roles PSIRF, RRP lead, LDA lead, developing QI team. Creating time for leaders to lead QI – job planning. Board development of strategic QI/QMS skill set, ownership by all Execs and non-Execs Close scrutiny of progress at local and Board level monthly. Close alignment with Trust strategy. Interim Quality Lead for at least 6 months to develop processes and focus on monitoring. Development of the Transformation and Improvement Hub (TIH) and QI registration process • Life QI development • Local QI measures of success Internal structure • Structured reports for QPES, TCGC, S&T and any relevant sub board committees Committee structures • Work with leads to agree where QI sits • Work with directorates to standardise reporting • Agree where work is shared to learn lessons and share good practice • Communicate this effectively to staff Supporting and enabling EBE to co-produce projects, training and sustainable change Local QI and governance structures; work with local leadership team to agree committee structures Ensure that all strategic workstreams have a QI approach (not necessarily a project)- including corporate Increase depth and breadth of QI training, to enable staff to develop awareness of QI	
Risks Identified	The Committee agreed to the following to be added to either the Corporate Risk Register or Board Assurance Framework:	
Report compiled by:	Dr Linda Cullen Steve Forsyth	**Minutes available from:** Maggie Maher

6.1.1. (b) QPES Chair’s Assurance Report July

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: QPES**
Report presented at	**Board of Directors**
Date of meeting	**2 August 2023**
Date(s) of Committee Meeting(s) reported	**19 July 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. CQC Update and Action Plan 2. Staffing inc. MHOST update 3. Integrated Performance Report 4. Infection, Prevention & Control 5. Patient Safety (including safety alerts) &Complaints Report 6. Safeguarding actions and learning report 7. Update on risk register
Alert:	The Committee wishes to alert the Trust Board to the following (for example): **CQC SECTION 31 NOTICE** 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. **Detailed Report - Patient Safety: Complaints, SI Escalation Report and Patient Safety Alerts** This document provided the committee with an overview of the serious incidents, incidents and complaints reported during the month. At the time of writing this report there are 37 live serious incidents in the review process, excluding infection control reviews, of which 5 exceed the 60-day review deadline.

	This is a reduction from 6 on previous months and evidences a continued reduction month on month. The average time for completion of a review has been evidenced as being 85 days. As previously escalated to the committee, a business case has been submitted to the ICB and NHSE requesting additional resource to manage the current number of SI investigations in the interim period awaiting transition to PSIRF. This is yet to be approved. 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. The average age of a case is 76 working days (this has decreased by 12 days). The average time it is has taken to allocate a case to an Investigating Officer is 66 working days an increase from 57 on prior month. These average times exclude Bank Holidays and weekends. Both these targets do not meet best practice standards and continued work is being undertaken by the Complaints Lead to improve these KPI's. Similarly, to the Patient Safety Team, additional resource has been requested in a paper to the executive team. Whilst approved, the same financial restrictions remain in place for agency. An additional experienced bank staff member has been employed in the last week that will offer additional experience to the team.
Assurance:	The Committee was assured on the following: **<u>Regulatory Update Including Update on CQC Action Plans</u>** • Following feedback at the last committee, the Compliance team has been working with service areas to establish more realistic target dates for proposed actions to address Must and Should Do findings. • The Compliance team will continue with its programme of assurance testing to review those actions marked as complete. As always, the team will also continue to work closely with the service areas to improve the efficiency of providing progress updates to enable monitoring so that we can ensure the ongoing safety of our staff and service users. • Although we have seen some improvements in some teams, the actions for appraisal, clinical and managerial supervision remain a concern, with the reports from Insight still showing relatively low levels of compliance. More robust monitoring of these figures is required at service level as per the action plans agreed to address the Section 29, to enable improvement.

- The CQC have also now responded to the Trust, acknowledging the submission for the Section 29 notice that was made in January. They have requested an update on actions and the response is being developed for submission.

Integrated safer staffing report
The safer staffing report provides an overview of the inpatient workforce for May 2023. Report looks at Fill rates (overall and RMN) broken down into directorates.
Bed Occupancy average, Lone RMN shifts and 0 RMN shifts. These are for Acute Care, Secure Care, Dementia/Frailties and Specialties and Steps to Recovery. It is anticipated that from July 2023 we will incorporate how many hours we utilize on the higher levels of observations (level 3, 4, 5 (exclusive to mother and baby) and seclusion).

The report is now in statistical process chart format, so we can have a visual representation of each division. We will be triangulating the fill rate data against 4 wards with the lowest fill rate data using the trust KPIs for this.

It was noted that from May's fill rate report there had been a significant increase in the overall fill rate shifts increasing. There are concerns around RMN fill rates consistently at Sycamore, Laurel, Lavender and Larimar.

Assurance has been provided that no ward has worked without a registered nurse on duty.

It is highlighted to the committee that across the divisions there is daily huddles to discuss the staffing and any incidents that may have occurred in the past 24 hours. These meetings support acute and urgent care this enables them to discuss pending admissions. Committee were assured that in acute and secure care that there is a lead nurse on site and on call to support staffing issues.

Establishment Review
The establishment review is still being prepared, there are plans to meet with the divisions to go through the findings to explore and interrogate the results.
Further training with the MHOST will be provided from September 2023 onwards. Lead Nurse for Safer Staffing will begin work with the community teams and urgent care to review establishments.

E – Rostering Projects
We have appointed into Health Roster Implementation Officer posts. This will support with the role of out the e rostering projects that are in line with CQC Action Plan for the organisation. This will enable responsive and accurate planning to correctly assign the level of staff

required to meet acuity and skill mix and may reduce agency spend in the long term.

Infection Prevention & Control Team report
Committee gained reasonable assurance on following:

- There were no MRSA, MSSA and E.coli Bacteraemia's in the month of May.
- Hand hygiene audits evidence compliance greater than 95%
- There has been 1 COVID Outbreak this month
- The North PFI site of the trust are continuing to see counts of
- Legionella pneumophila above 100 cfu in the water outlets. Outlets have been closed, remedial works ongoing with the IPC team attending weekly catch ups to discuss plans and to monitor the situation. Forward House remains partially open, a meeting was held to discuss Forward House flat 5, due to high counts of legionella identified there.
- The monthly IPC audit dashboard has been implemented with data being collated by an IPC administrator.
- The bi-monthly Cleaning Quality Group meetings were reinstated with the first meeting taking place in this month.
- The IPC team attended the BSOL collaborative IPC meetings, to discuss a collaborative approach across the system.
- The IPC team – widely promoted World Hand Hygiene Day on 5th May.

Safeguarding actions and learning report
The New Head of Safeguarding has been made aware that BSMHFT are outstanding updates and progression on a number of actions relating to Child Safeguarding Practice Reviews (CSPRs). These are primarily in relation to three CSPRs from Birmingham and the single agency action plans / identified learning points.
Committee were provided with a report detailing these cases in more detail and identifies the risks to 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.
A template was included as appendix 1 to the report. This will enable a thematic review of learning to be undertaken where themes and trends will be identified.
A single point of contact for requests of information from our safeguarding partners will also be developed and implemented.
The action trackers will be presented to Patient Safety Advisory Group, and progress and updates will also be presented to the Safeguarding Management Board regularly.
The Head of Safeguarding is a member of Birmingham Serious Cases Sub-group and will have oversight of cases via attendance at this.

Advise	The Committee was advised of the following matters: Trust Clinical Governance Committee Chairs Escalation and Assurance Report 4th July 2023 gave QPES a good comprehensive update and good level of assurance with the following items: • Deep Dives – Patient Safety/Safeguarding • Risk Register Review • Section 136 Report • Regulatory, External & Commissioner Reports – Combined with • CQC Action Plan Update • Clinical Effectiveness Advisory Council – Including Audit/NICE • Summary from Pharmacy & Medicines Safety (from June 23) • Sub-Committee Escalation Reports (Local CGC's) • Quality Management System • Quality Account Update • Local CGC s are to be reviewed as to their processes to bring about a degree of standardisation in each CGC **Integrated Performance Report** Ongoing work to identify the most appropriate quality metrics included within the integrated report and how issues with other metrics are escalated. Discussion is in progress to address these matters. **Update On Risk Register** The following are next steps/recommendations; • Recruit a substantive Risk Manager to support the Risk Management Function. To support immediacy an interim/secondment solution should be secured. • Review the current Risk Management Policy for fitness for purpose • External Audit Recommendations and Action plan to be reviewed and addressed • All outstanding red risks to be reviewed/updated by Divisional and Corporate functions within the next 2 weeks • A risk review to be undertaken in each clinical and corporate directorate focusing on all risks populated pre 2020 to agree risk grading and requirement to remain on risk register – this will from part of the Risk Managers immediate priorities • Roll out of training across Directorate functions to support on-going understanding and management of Risk Registers.	
Risks Identified	No new risks added to risk register	
Report compiled by	Dr Linda Cullen Mr Steve Forsyth	**Minutes available from:** Lorraine Joyce

6.2. Patient Safety Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	6.2		
Paper title	Patient Safety and Complaints Report – Front Sheet		
Date	2 August 2023		
Author (s)	Lisa Pim - Interim Associate Director of Nursing and Governance		
Executive sponsor	Steve Forsyth. 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:

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

- 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.
- Duty of Candour has been applied to all of these incidents
- At the time of writing this report there are 37 live serious incidents in the review process, excluding infection control reviews, of which 5 exceed 60-day review deadline. This is sustained performance on prior month. The average time for completion of a review has been evidenced as being 85 days. This is sustained performance on previous months
- 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, the importance of strengthening the interface with external partners in care of our service users, including CGL and GP's, as well as effective communication between different services within the trust alongside medication management.
- As previously escalated to the committee, a business case has been submitted to the ICB and NHSE requesting additional resource to manage the current number of SI investigations in the interim period awaiting transition to PSIRF. This week it has been confirmed that NHSE have not approved the business case.

- 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.

- The paper gives an overview of current actions/progress against external reviews undertaken by NICHE and identifies the current progress on the new Psychological Approaches Review. Finally, the report references the advisory letter from NHSE, notifying the Trust that they have approved the commissioning of an Independent Investigation into the care and treatment for a young person who whilst on leave from one our secure care unit committed a homicide

- 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 resulted in PFD’s being issued to the Trust

- PFD1: 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

- 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.

- The Trust processes for the management of actions arising from PFD’s has now been enacted to support addressing the concerns, including setting up stakeholder groups to assess and action the specific areas of concern identified by the coroner in both cases.

- The PFD’s have also resulted in a Section 64 response from the CQC with assurance and documentation requests focused on both PFD’s. Responses have been collated with Executive sign off undertaken.

- Following a focused piece of work there are currently a total of 88 overdue actions, which includes our clinical and corporate services. This is a reduction of 12 actions from prior month.

- During the quarter 1 there were a total number of 6995 incidents reported. The majority of incidents resulted in no harm. The highest number of incidents being reported were:
  - Quality of care and compliance
  - Assaults, violence, and harassment
  - Medications
  - Self-harm behaviour

- The local Clinical Governance Facilitators have been working with the Divisional CGC’s to close the historic local incidents from 2021–2022. There is noted improved performance across both years; 2021 open incidents have reduced by 25% (235

incidents left to close), 2022 open incidents reduced by 62% (525 incidents left to close)

- The paper details prone and physical restraint figures with SPC Charts in place to support understanding of statistical importance. Whilst an increase in reporting has been over the last quarter the figures remain on or around the mean

- A new RRP dashboard has almost been completed, intended completion September, that will enable robust triangulation of data to give a more comprehensive understanding of the patterns and themes leading to restrictive interventions supporting/strengthening current and new workstreams to bring down the number of interventions where clinically reasonable

- Similarly, the paper details staff assaults which has shown variation, but continuing to rise above the mean, with astronomical reporting in May. 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

- Patient Assaults: The total number of reported assaults on service users for the quarter has shown a month on month increase with a total of 174 incidents being reported of which 66 occurred in June. The majority of these incidents occurred at our PICU services with the same service users being identified as the instigator

- The number of PALS cases has increased since the start of the year. The number of open formal complaints has increased to 40, an increase of 3 complaints on prior month. As a quarterly position, the Customer Relations Team received 28 formal complaints in Q1 (01.04.23 – 30.06.23) which is an increase to the 13 received in Q4.

- There are 25 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer (total 42 so 60% awaiting an IO an increase from 49% reported in prior month). The average age of a case is 64 working days. The average time it is has taken to allocate a case to an Investigating Officer is 73 working days.

- There has been an increase in the number of actions open in total with 43 complaints actions open with 63% of actions (27) now overdue. This is an improvement in the 71% of actions overdue in prior month.

- A themed review of complaints for Q1 has revealed that the following are the top categories for complaints; Failure to provide adequate care, Communication with patient, and Dispute over diagnosis. These categories have varied from prior quarter.

- A breakdown of Q1 complaints by protected characteristics is provided. In summary; Most of the complainants are under the age of 55. There are almost three times the number of male complainants to female. The main ethnic groups for complainants are White- British and Pakistani – Asian or Asian British. In comparison to the data in Q4, there is an increase in the age of complainants from being under the age of 44 in Q4 to under 55 in this quarter. There has been a decrease in complaints from females

and Black Caribbean – Black of Black British ethnicity with an increase from Pakistani – Asian or Asian British ethnicity. On-going monitoring of this data, its meaning, and impact will be reviewed regularly through this committee. It is anticipated that further information including Religion, Marital Status, and Sexual Orientation will be part of this review process going forward

- Safeguarding/Patient Safety Deep Dives; There has been some drift and delay in relation to actions and learning in relation to Child Safeguarding Practice Reviews (CSPRs) specifically three CSPRs from Birmingham. This has been appropriately escalated within the Trust. The Head of Safeguarding has worked with Birmingham LSCP and triangulated all the outstanding actions to ensure we are fully sighted on the outstanding areas of review

- Updates on progress on all three CSPRs have been returned to the Bham Partnership meaning the organisation is now on track

- Thematic work from all Safeguarding Reviews will be fed into PSAG with the Head of Safeguarding working closely with the Patient Safety Team to identify the common learning and themes which are applicable Trust wide

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 the Clinical Governance Committee and QPESC.

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

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

Financial Implications *(detail any financial implications)*

Note additional agency resource required within both the Patient safety Team and the Complaints Team.

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

BAF/01 Potential failure to explore incident data, EBEs and patient safety partners in improving service user experience of care.

BAF/02 Potential failure to focus on the reduction and prevention of patient harm.

BAF/03 Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and 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	**6.2**
Paper title	Patient Safety and Complaints Report
Date	2 August 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 an overview of the serious incidents, incidents and complaints reported during the quarter

The report will outline the number of incidents reported within the quarter 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.

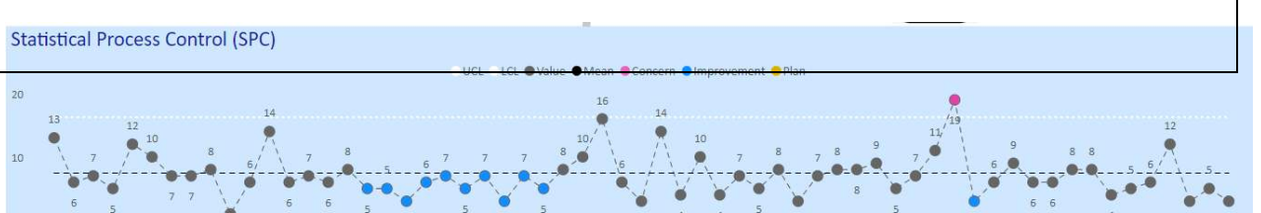
1.0 Serious Incidents

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 cause indicators of special cause variation over this period and reporting.

Duty of candour has been applied to all of these incidents.

At the time of writing this report there are 37 live serious incidents in the review process, excluding infection control reviews, of which 5 exceed 60-day review deadline. This is a reduction from 6 on previous months and evidences a continued reduction month on month. The average time for completion of a review has been evidenced as being 85 days. This is a reduction from 90 days on previous months. Delayed investigation and completion of serious incidents leads to delayed learning for services and the organisation and increases the risks of a further incident of this type from reoccurring.

Delays in completion of serious incidents have been highlighted as being due to a number of cases having been overdue as a result of capacity issues within the Patient Safety Team, delayed meetings with relevant staff or awaiting additional information from other agencies. The Patient Safety Lead and team will be working closely with the Divisional teams to work towards the 60-day KPI.



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) which is likely to be in place within 12 months following the release of the new framework in September 2022. 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, 13 reports were submitted for consideration of closure during the quarter. Prior to submission the reports were reviewed by our serious incident oversight group, a group that includes executive membership and divisional representation from senior leaders, which forms part of our PSIRF preparation.

The themes arising from Serious Incidents include family engagement and support, the importance of strengthening the interface with external partners in care of our service users, including CGL and GP’s, as well as effective communication between different services within the trust alongside medication management.

1.3 External Reviews

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%.

A response has been provided by the service areas to the learning points generated in the draft report for consideration by NICHE.

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 actions identified for BSMHFT will be governed through the local CGC.

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

We are in the initial stages of sharing information and planning meetings with the service areas.

We have also recently received an advisory letter from NHSE, notifying us that they have approved the commissioning of an Independent Investigation into the care and treatment for a young person who whilst on leave from one our secure care units committed a homicide.

1.4 Inquests

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 issues were highlighted

In July 2 Prevention of Future Deaths (PFD) have been issued by HM Coroner:

The first PFD was issued to:

- The Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, Department for Health.
- NHS England.
- NHS Digital.
- NHS Birmingham and Solihull Integrated Care Board.
- Chief Executive, Birmingham and Solihull Mental Health NHS and Birmingham City Council.

Raising the following concerns:

1. The continuation of a chronic lack of resources to treat seriously mentally ill patients in Birmingham and Solihull including psychiatric beds, access to AMHP's, care co-ordinators
2. Communication between specialised teams within BSMHFT is not effective
3. Prior to his discharge in 2012 BSMHFT Neuropsychiatry proposed Carbamazepine management for the service user to the GP, however this was not prescribed by the GP as suggested. The service user was referred to the CMHT in 2016 and it was not noted until 2022 by a consultant at BSMHFT that the service user had not been prescribed the medication, at inquest BSMHFT could not explain why this omission had not been identified sooner and there is a concern that this issue indicates a problem with process and system which needs further exploration.
4. Communication between different health organisations is not as effective as it could be, and important information is being missed as identified in issue 3
5. Lack of resources at a national level for GP's

The second PFD was issued to:

- BSMHFT
- Secretary of State for Health

Raising the following concerns:

- No safe system to communicate high levels of clozapine
- No safe system to effect medication changes
- No system for highlighting clozapine results in RIO notes which are routinely used by all clinicians
- Lack of understanding of when to measure clozapine levels, how to interpret high clozapine levels and then how to respond
- The Trust not learning from a previous for PFD issued in August 2020 where it was noted that there was no system in place ensure abnormal clozapine levels were acted upon or monitored
- Quality of the internal investigation process as the initial investigation report did not raise significant issues regarding monitoring of clozapine and if the service user had toxicity
- Pharmacy were not effective due to lack of resources

A response to both PFDs with the actions we intend to take is required by September 2023 and stakeholder meetings are scheduled in August to formulate a robust response.

1.5 SI Actions

Following a focused piece of work there are currently a total of 88 overdue actions, which includes our clinical and corporate services. This is a reduction of 12 actions from prior month. This work continues to be supported by the Clinical Governance Facilitators and the Divisional SLT's where timelines for closure have been requested.

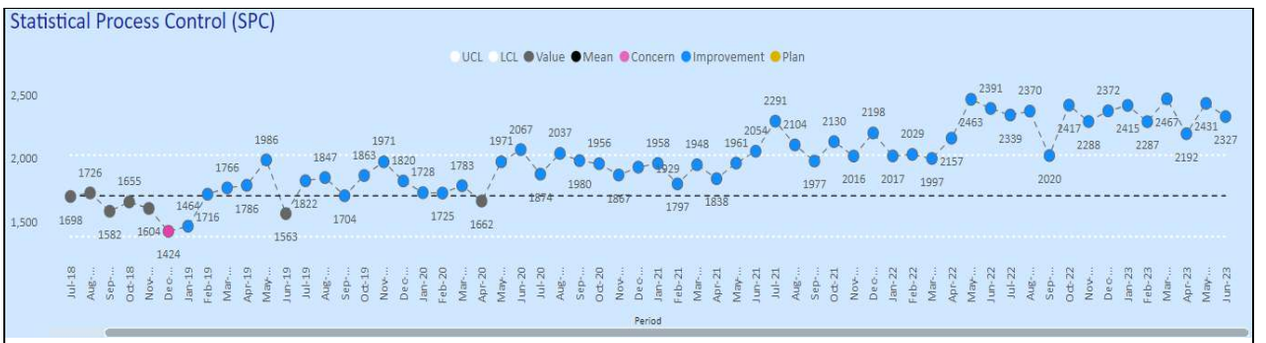
A breakdown by Division is presented within the appendix of the report.

2.0 Local Incident Reporting

During the quarter 1 there were a total number of 6995 incidents reported. The majority of incidents resulted in no harm. The highest number of incidents being reported were:

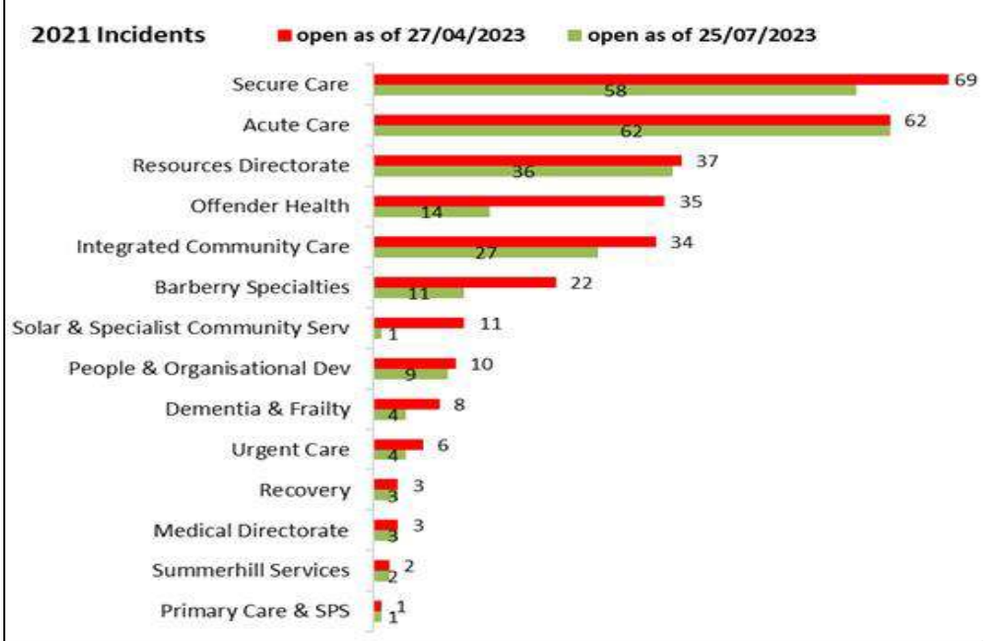
- Quality of care and compliance
- Assaults, violence, and harassment
- Medications
- Self harm behaviour

There are currently 3176 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.

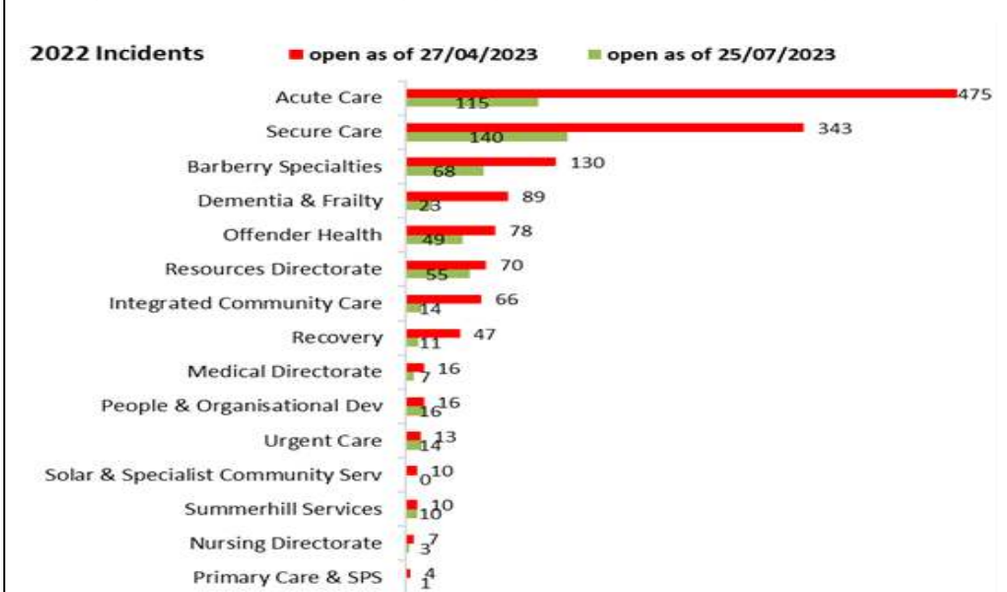


The local Clinical Governance Facilitators have been working with the Divisional CGC's to close the historic local incidents from 2021–2022. There is noted improved performance across both years;

2021 open incidents have reduced by 25% (235 incidents left to close), breakdown as below;

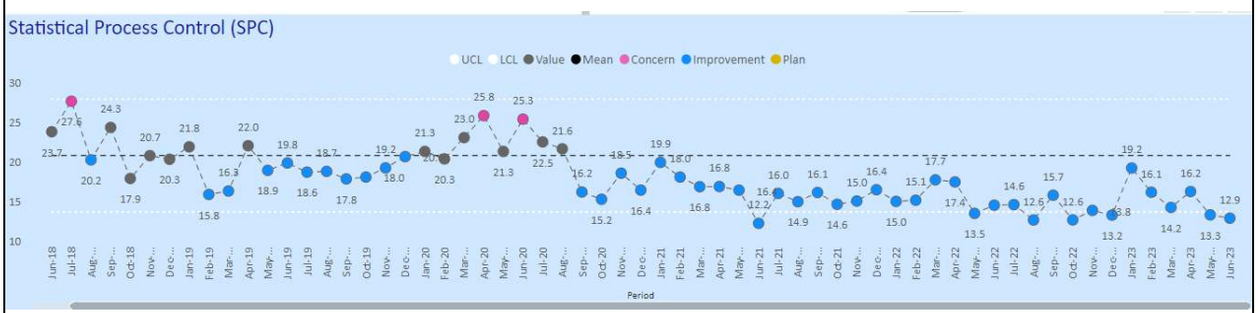


2022 open incidents reduced by 62% (525 incidents left to close), breakdown as below;



2.2 Levels of Harm

86% of our incidents reported during the quarter 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.

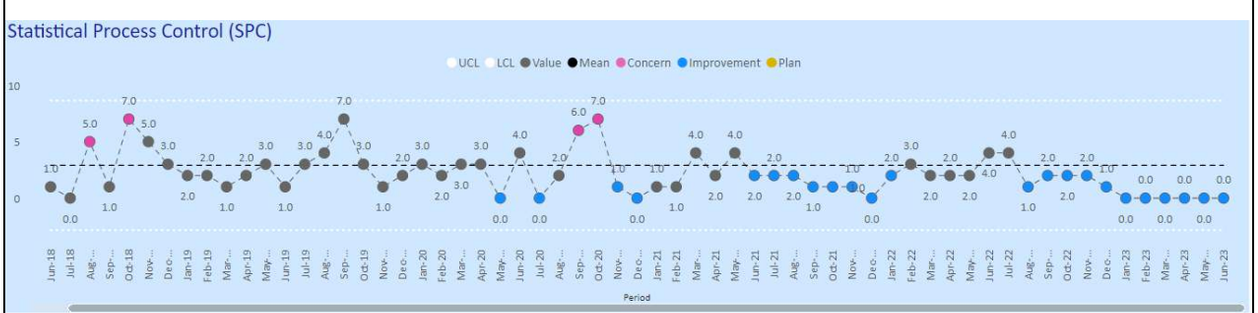


2.3 Community Suicides

In the 12 months preceding June 2023, 16 suicides have been confirmed through the inquest process. There are 9 inquests scheduled to take place for those incidents reported as a suspected suicide.

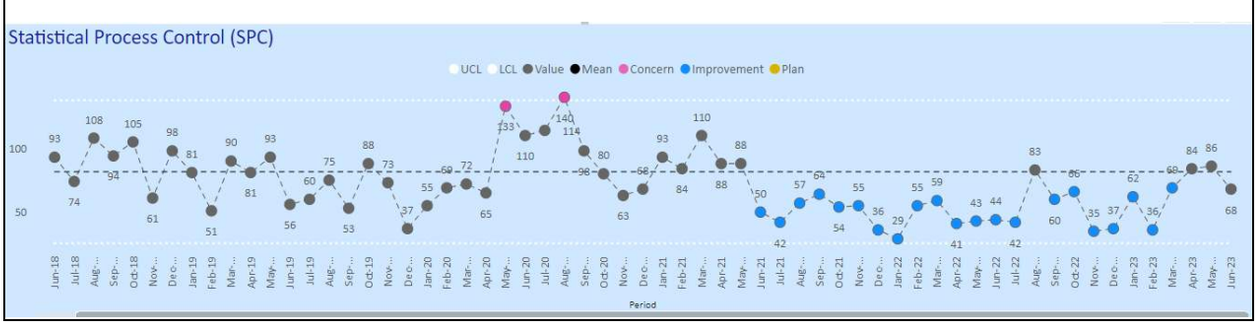
Historic information has evidenced established risk factors for suicide, such as previous self-harm, drug and alcohol misuse, multiple mental health diagnoses. The Trust has a suicide prevention strategy in place to support important work in this area with quarterly updates on this provided to trustwide committee structures.

Confirmed Suicides

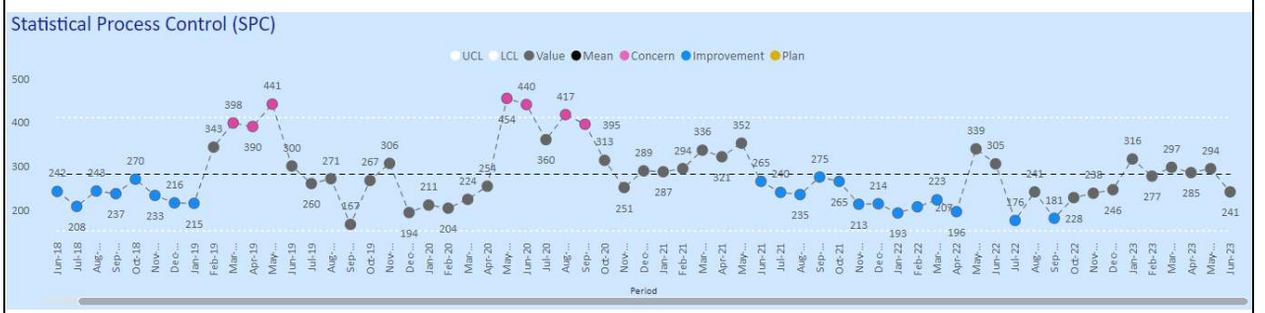


2.4 Prone and Physical Restraint

Prone: The figures evidence there was an increase in the number of reported prone restraints compared to the previous quarter, rising slightly in May above mean to 86 with a reduction noted in June to 68. Increase in reporting has been across all areas.



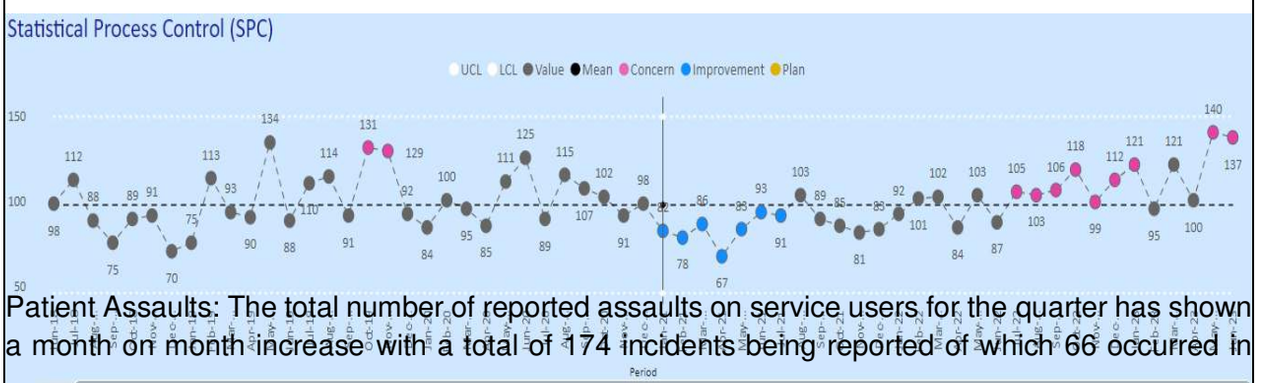
Physical: There were 241 incidents reported in the month of June totally 848 incidences of restraint for the quarter which includes the 238 prone incidents documented above. The data suggests that a small number of service users were involved in a large number of incidents due to clinical presentation and acuity



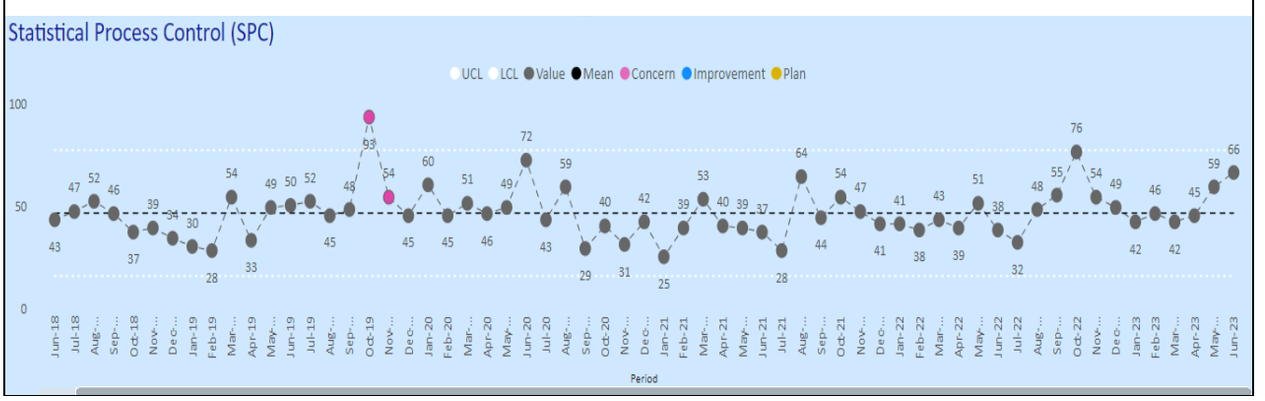
A new RRP dashboard has almost been completed, intended completion September, that will enable robust triangulation of data to give a more comprehensive understanding of the patterns and themes leading to restrictive interventions supporting/strengthening current and new workstreams to bring down the number of interventions where clinically reasonable.

2.5 Inpatient Assaults Staff and Inpatients Assaults on Patients

Staff Assaults: The total number of actual assaults on staff for the quarter has shown variation, continuing to rise above the mean, with astronomical reporting in May. 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.



Patient Assaults: The total number of reported assaults on service users for the quarter has shown a month on month increase with a total of 174 incidents being reported of which 66 occurred in

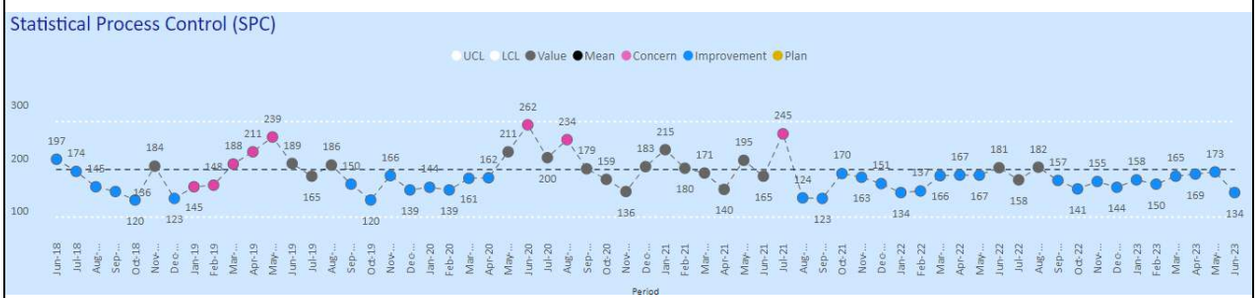


June. The majority of these incidents occurred at with our PICU services with the same service users being identified as the instigator.

2.6 Incidents of Self Harm

During the quarter the continued improvement work is evidenced with the number of incidents being reported have been consistently below the mean, this has been a continuous trend since September 2022. Most incidents occurred within the trusts acute inpatient setting. A program of works to support the prevention of self-harm incidents is being rolled out across the trust and include;

- 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

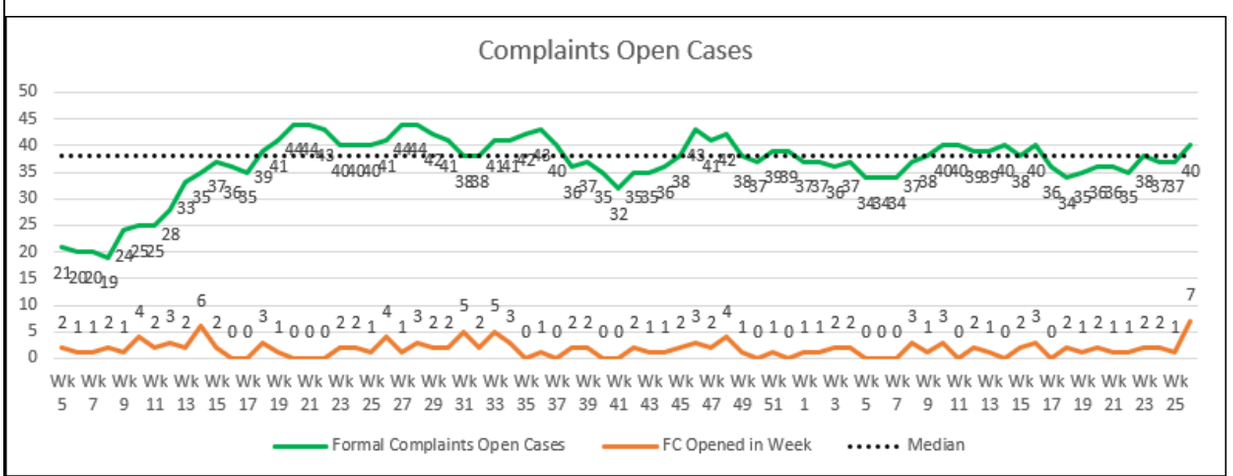


3.0 Patient Experience and Complaints

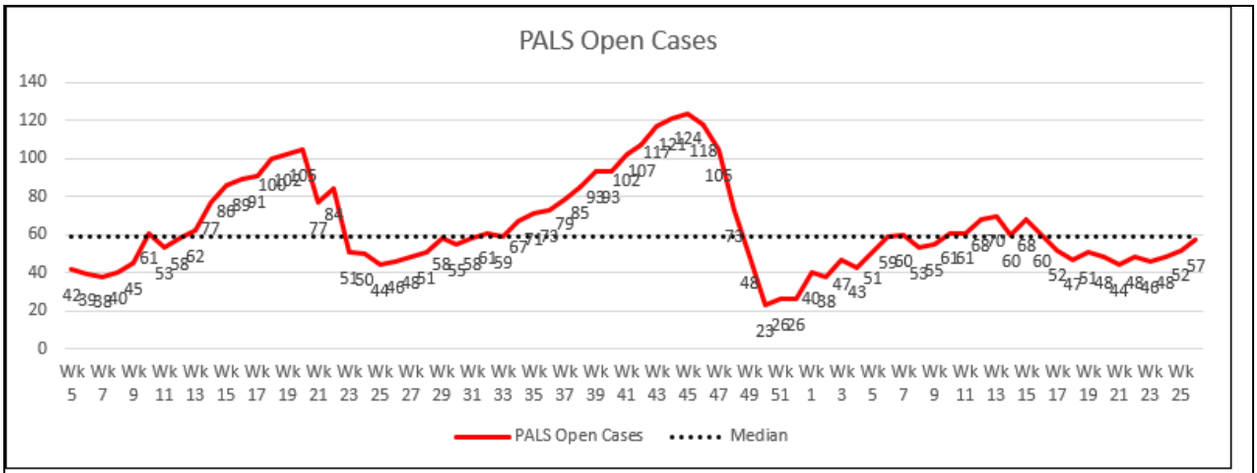
3.1 Monthly Data Complaints and PALS

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

Graph 1 Formal Complaints



Graph 2 PALS Contacts



The number of PALS cases has increased since the start of the year. The number of open formal complaints has increased to 40.

There are 25 formal complaints on the Complaints Investigation Table waiting to be allocated an Investigating Officer (total 42 so 60%). The average age of a case is 64 working days. The average time it is has taken to allocate a case to an Investigating Officer is 73 working days. These average times exclude Bank Holidays and weekends. It is understood that both of these targets do not meet best practice standards and continued work is being undertaken by the Complaints Lead to improve these KPI's. Additional temporary resource has been agreed by the Interim to the Complaints Team to support addressing the backlog, along with a successful secondee being appointed to a vacant post for 12 weeks whilst the position is advertised. It is hoped that once a full staffing establishment is in place, a revised improvement trajectory will be submitted to the Committee.

3.2 Open Complaints Actions

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

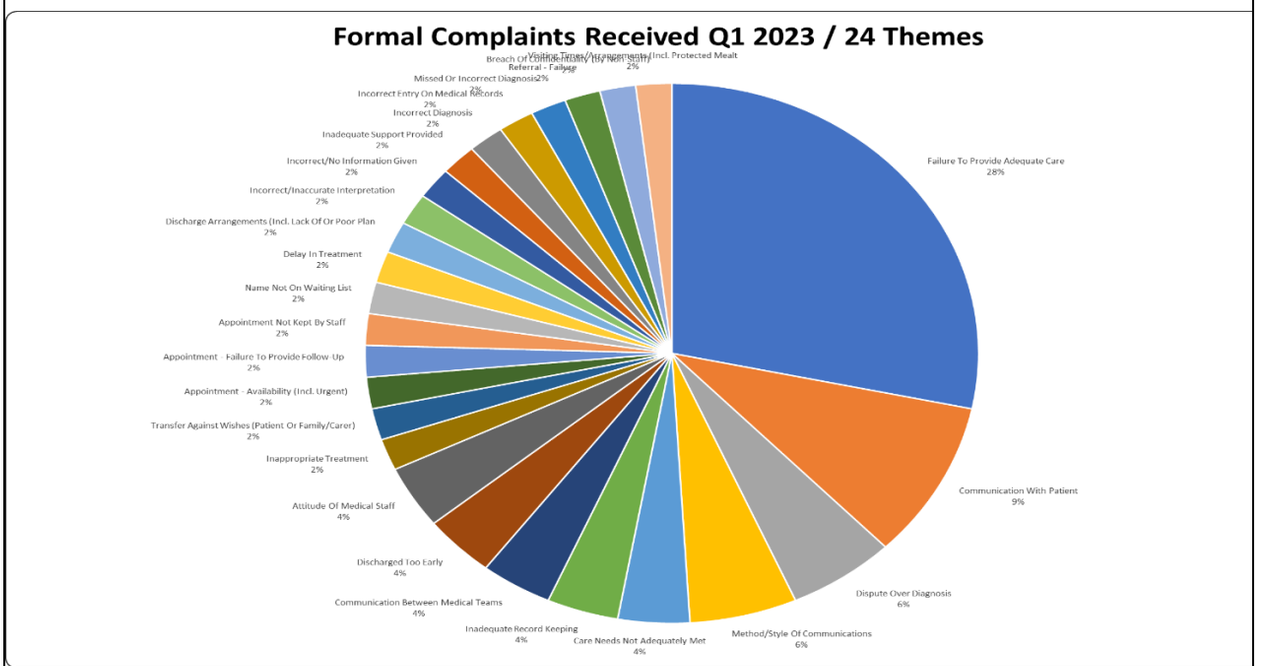
Directorate	Total	1 month	2 months	3 months +
Acute Care	7	1	0	6
Barberry Specialities	0	0	0	0
Corporate	3	2	1	0
ICCR	30	12	6	12
Urgent Care	3	1	0	2
Total	**43**	**16**	**7**	**20**

There has been an increase in the amount of actions open in total with 43 complaints actions with 63% of actions (27) now overdue. A number of these actions are identified as being over 12 months in age. Reasons identified for this have been multi-factorial in nature and include gaps in reporting transparently and effectively to Divisions and internal process around automatic allocation of timelines for actions, which can potentially appear unrealistic. Work has begun to address these areas within the complaints department and the team are working collaboratively with the Divisions and Clinical Governance Facilitators to close down outstanding overdue actions. A timescale for this piece of work has not yet been established but will be reported on through formal committee reporting.

3.3 Thematic Review

As agreed at previous Board meeting, a focused quarterly thematic review of complaints, including protected characteristics, is shared for information purposes.

The Customer Relations Team received 28 formal complaints in Q1 (01.04.23 – 30.06.23) which is an increase to the 13 received in Q4. The pie chart below details the themes for complaints received in the quarter which range from failure to provide adequate care, communication with patient and dispute over diagnosis which were the most reported themes.



3.31 Failure to provide adequate care

It is noted in 15 of the complaints in Q4 that complainants felt there had been failure to provide adequate patient care. This ranges from perceptions that clinical care has not been to a desired standard to concerns about quality of care provided, including delays in treatment, poor discharge planning/communication and lack of improvement in care.

3.32 Communication with patient

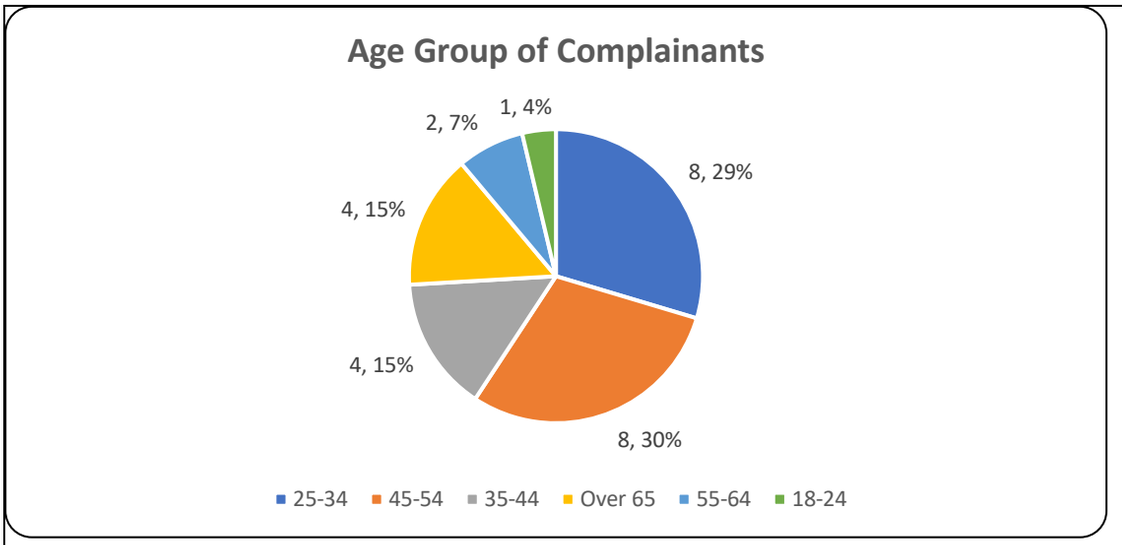
5 of the complaints cited communication concerns with patients where some felt their concerns had not been duly taken into consideration, to poor handling of communication between staff and patients.

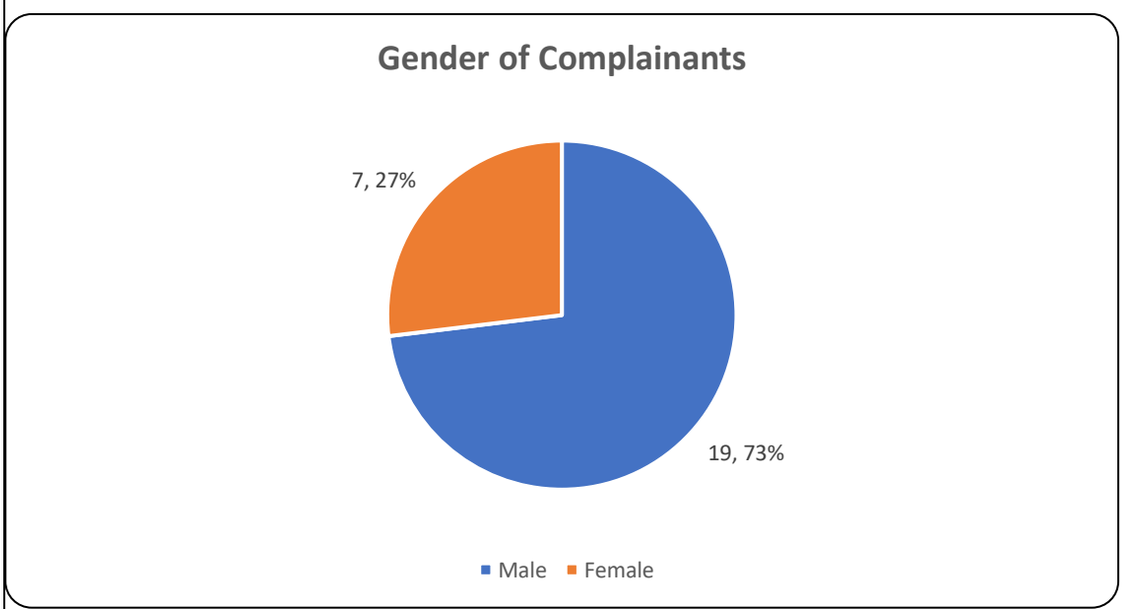
3.33 Dispute over diagnosis

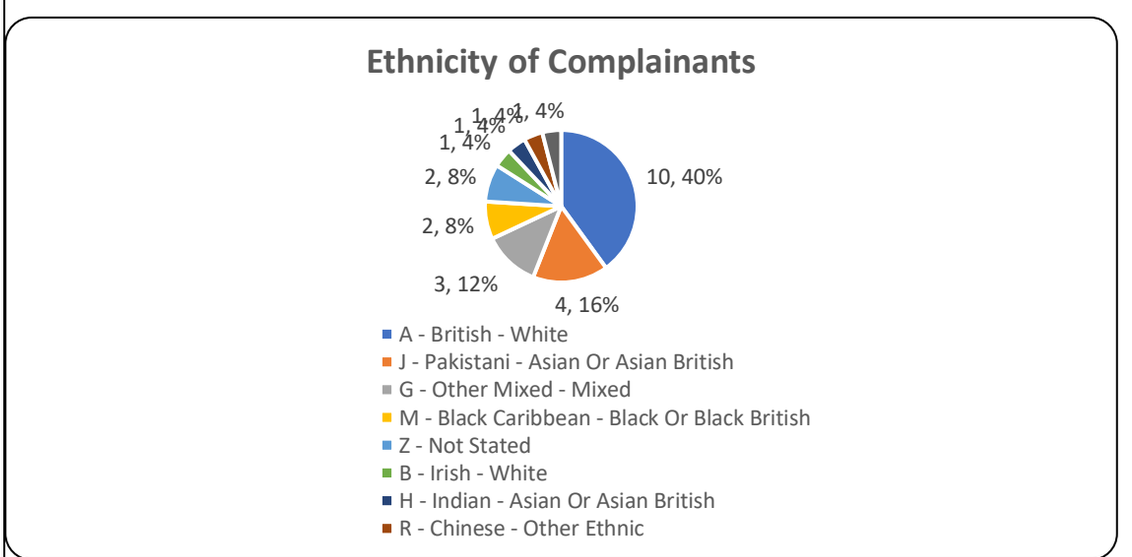
There were 3 complaints relating to concerns with clinical treatment for which concerns related to disputes over patient's diagnosis. This ranges from concerns with how ADHD assessments are completed to patients feeling their diagnosis was incorrect and requiring a second opinion.

3.34 Protected Characteristics

The following is a breakdown of Q1 complaints by protected characteristics;







Observations: Most of the complainants are under the age of 55. There are almost three times the number of male complainants to female. The main ethnic groups for complainants are White-British and Pakistani – Asian or Asian British. Comparing the data to Q4, there is an increase in the age of complainants from being under the age of 44 in Q4 to under 55 in this quarter. There has been a decrease in complaints from females and Black Caribbean – Black of Black British ethnicity with an increase from Pakistani – Asian or Asian British ethnicity. On-going monitoring of

this data, its meaning, and impact will be reviewed regularly through this committee. It is anticipated that further information including Religion, Marital Status, and Sexual Orientation will be part of this review process going forward.
Reason for consideration:
For the Board to be appraised of incidents being raised and actions being taken to reduce harm and improve patient and staff experience and safety. The 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:
The Board receives a bi-monthly report for Patient Safety and Complaints.
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)*
BAF/01 Potential failure to explore incident data, EBEs and patient safety partners in improving service user experience of care. BAF/02 Potential failure to focus on the reduction and prevention of patient harm. BAF/03 Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.
Equality impact assessments:
This quarterly report from September 2023 will include specific protected characteristics including age, ethnicity and gender and will work to develop in the coming months how 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.

Acute HTT: 27 Open Overdue Actions

Year	N° of Open SI Actions	N° Overdue	Ongoing
2021	3	3	0
2022	24	24	0
2023	0	0	0

Acute Inpatient: 4 overdue actions

Year	N° of Open SI Actions	N° Overdue	Ongoing
2022	4	4	0
2023	0	0	0

Recovery: 6 overdue actions and 0 ongoing

Year	N° of Open SI Actions	N° Overdue	Ongoing
2020	0	2	0
2021	0	4	2

Urgent Care: 17 overdue actions

Year	N° of Open SI Actions	N° Overdue	Ongoing
2018	2	2	0
2019	0	0	0
2020	3	3	0
2021	0	0	0
2022	12	12	0

ICCR: 2 overdue actions and 0 ongoing

Year	N° of Open SI Actions	N° Overdue	Ongoing
2023	3	2	0

Dementia and Frailty: 4 overdue actions and 1 ongoing

Year	N° of Open SI Actions	N° Overdue	Ongoing
2016	1	0	1
2021	2	2	0
2022	2	2	0

Specialties: 2 overdue actions

Year	N° of Open SI Actions	N° Overdue	N° of N/A
2021	1	1	0
2022	1	1	0

7. PEOPLE

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board**
Date of meeting	**2nd August 2023**
Date(s) of Committee Meeting(s) reported	**21 June 2023,**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Apologies for absence 2. Declaration of Interests 3. Staff Story – Madeeha Rahim-Rasool. 4. Minutes of the previous meeting & Action Log. 5. KPI report 6. Safer Staffing report. 7. Deep dive- inequalities. 8. Health and wellbeing Update. 9. Integrated Performance Report. 10. Board Assurance Framework. 11. Matters of Escalation to the Board of Directors. 12. Any Other Business 13. Feedback on Discussions.
Alert:	The Committee wishes to alert the Trust Board to the following issues: - • Some of the issues raised in the staff story i.e. the impact of the concerning language and portrayal of Islam as presented through the Prevent Agenda training. • Some of the issues around recruitment timelines – raised by colleagues at induction and through meetings and visits - and how these are impacting on delivery. • Alerting the Board of the financial pressures that are emerging, acknowledged to be from key workforce spend. These will require action to reduce spend over coming months which will impact on workforce and quality and may require some big decisions to be made especially around transformation. • Proposal to separate one of the BAF risks to reflect the different issues arising from inequality and diversity workstreams and culture/staff experience.
Assurance:	The Committee was advised of the following matters: • The safer staffing report provided a lot of assurance especially through the details of its content and elements of recruitment in some of these services.

	• The Inequality and Diversity deep dive gave the committee a lot of assurance around a number of the things that we are doing in relation to inequalities and feeding that to the BAF. We noted that we would be receiving a gap analysis to begin developing the Trust response to the recently published NHSE Equality and Diversity Work Plan and Improvement Plan. • We received a health and wellbeing update, although there are currently issues around uptake, there was a clear improvement plan in place to address the challenges, although some required additional funding both internally (dedicated management of the programme) and potentially externally (relaxation rooms).	
Advise	The Committee wishes to advise of the following matters: • The FPP and People Committee around will be working together in considering a recovery plan for finance will also ensure that QPES is part of that conversation so as to consider the implications of the finance recovery plan on quality and safety. • And as part of conversation earlier at the FPP, Board Committees will seek to work together in streamlining and making the Integrated Performance Report properly integrated.	
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:** 30 June 2023**.**

7.2. (b) People Committee Chair’s Assurance Report July

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board**
Date of meeting	**2nd August 2023**
Date(s) of Committee Meeting(s) reported	**19 July 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Network presentation 2. Integrated Performance Report 3. KPI report 4. Workforce Impact of Sustainability issues 5. Medical Directorate Quarterly Update 6. Psychological Professions 7. Shaping The Future Workforce Sub-committee Report 8. Transforming Our Culture And Staff Experience Sub-committee Report 9. Equality & Diversity: WRES and Equality & Disability – Bi-monthly Report 10. Pay Award 11. Recruitment and Retention – Audit Report 12. Data Quality – Staff Vacancies and Performance Measures – Audit Report
Alert:	The Committee wishes to alert the Trust Board to the following issues: - • Continued pressures from industrial action of consultants and junior doctors. Despite the work of colleagues there was concern that there would be a growing impact on services and therefore service users and colleagues. Committee urged those involved both nationally and locally to do what they could to resolve the issues quickly and minimise the impact. • The WRES/ WDES report highlighted that despite the significant work progressing across the Trust, further work that needs to continue to support change needed. The recommendations were approved as: ○ Implement new recruitment guidance ○ Equity Panel Members, Cultural Ambassador and Buddy Roles embedded within the Trust ○ Anti Racist Framework Rollout ○ Patient Carer Race Equity Framework Rollout ○ Refresh of EDI Fundamental Training Package ○ Mental Health and LD Recruitment Programme • Issues around recruitment numbers and timelines continue.

	•
Assurance:	The Committee was advised of the following matters: • The Medical Directorate Quarterly Update provided significant assurance that to date 225 out of 230 doctors (97.8%) with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust have completed their appraisal or have an appraisal which is not yet due. • The Psychological Professions update provided significant assurance and the Committee endorsed the Psychological Workforce Strategy and Planning, continues to be developed within the organisation alongside a commitment to work across relevant Provider Collaboratives to develop joint workforce approaches and solutions where possible with oversight at the People Committee. • The Committee recieved reported from both Sub Committees (Shaping our workforce and Transforming our culture). We took limited assurance from the Sub Committees as they had both recommended, given the level of outcome, impact and delivery achieved to date.
Advise	The Committee wishes to advise of the following matters: • The high cost of out of areas beds and continued use of temporary staffing, arising from staff vacancies, increasing workload in terms or numbers and acuity of care will result in a unplanned deficiet within the Trust. It is important that all the Committees are involved in any recovery plans developed to ensure that actions are planned in an integrate way, delivered as forecast and balanced against all areas of quality and safety, colleague health and well being and delivery of performance both operational and financial.
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

8. SUSTAINABILITY

8.1. (a) Finance, Performance & Productivity Committee Chair’s Assurance Report June

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: Finance, Performance & Productivity Committee**
Report presented at	**Board**
Date of meeting	**2nd August 2023**
Date(s) of Committee Meeting(s) reported	**21 June 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Apologies for absence 2. Declaration of Interests 3. Minutes of the previous meeting & Action Log 4. Integrated Performance Report 5. Finance Report 6. 6.1 OOA productivity plan 6.2 Key Milestones for the MHPC in Setting Out its Strategic Objectives 7. Income and Cost Trends 8. Information Governance Annual Report 9. Board Assurance Framework 10. Identifying risks for the Board Assurance Framework 11. Hot Topics 12. Any Other Business 13. Review of Meeting
Alert:	The Committee wishes to alert the Trust Board to the following: • Members reviewed the integrated performance reported and: - Noted that there were still performance issues with some metrics like the `IAPT seen within 6 and 18 weeks` as the Trust isn`t yet where it would like to be. - Discussed the Out of Area (OOA) metric to illustrate how two of its components i.e., Average length of stay and Delay Transfer of Care (DTOC) are picked up for example at the Emergency and Urgent Care meeting, however members agreed that they would like clarity on how these are escalated to them to facilitate their understanding. - Recommended that domain owners take greater ownership of their data in providing up-to-date narrative to underpin their metrics. - Members agreed that the key risks with regards to the OOA transformation programmes were around deliverability, cost and the potential for double counting and cautioned the team to watch out against the possibility of these and especially double counting.

	• The Committee recognised the difficult financial position of the Trust and noted that it could be in a deficit of £18 million if spending continues as witnessed in the first 2 months with £10 million pressure on OOA and annual expenditure of £44m on temporary staffing. • Members recommended that the Trust needs to start driving the conversation around spend and cost reduction with colleagues across the Trust so they could fully appreciate their actions, such as the implications of booking TSS or agency staff, on Trust long term finances. It was hoped that an early conversation would avoid more stringent measures being put in place in later months. • The Committee discussed the challenges around OOA and related financial implications and queried if saving of £5 million as planned could be achieved at the current pace of implementing the various transformation programmes.
Assurance:	The Committee was assured on the following: • The Committee was assured that some discussions around the metrics and trajectories are already taking place and that there are improvement and transformation programmes and plans to underpin some of the trajectories like OOA. • As regards IAPT, the Committee was informed that there is a workforce plan around trying to attract people to come and work in the organisation and to retain them. Some assurance was given around the deliverability of the workforce plan as the Trust and partners are working and sharing resources across BSOL as the Committee was further assured through verbal explanation that was provided. The Committee asked that in future these helpful explanations should be included in the report. • The Committee received the `Finance Report`, recognised the challenges around controlling spend and formulating a recovery plan and asserted that they were reassured by the awareness around our financial position and what is being done and noted that there are some tough decisions for us to make. In the light of being aware of what needs to be done, the Committee was informed that in order to get onto the right trajectory the Trust needs to start impacting on spend in the following big categories i.e. OOA, temporary staffing and delivery of savings plans. • The Committee received and endorsed the report on `Key Milestones for the MHPC` which outlined a `road map` for the development of a BSOL MHPC transformation strategy and encapsulating the potential strategic priorities, ambitions and transformation activities that could be realised across the collaborative and within BSMHFT over the next 4 years.

	• The Committee received and accepted the Information Governance Annual Report noting the good work that had been done by the team. • The Committee received the BAF and acknowledged the ongoing piece of work around updating the document. They endorsed it and were assured that it was progressing well in the right direct direction. Members however felt that the score of BAF04/FPP should be reconsidered and that the BAF be discussed at the start of the next meeting to enable the Committee to link it to the various reports that will be discussed.	
Advise	The Committee was advised of the following matters: • The current financial pressures on the Trust, including significant pressures on usage of Out of Area beds. A saving of £5m had been targeted, but at present it seems likely there will be a £5m overspend. • The Trust like other NHS organisations has received some additional funding against excess inflationary pressures. • Workforce challenges leading to increased spending arising from agency and temporal staffing. If the year to date expenditure was straight lined for the full year, this would equate to £44m. • The Committee received the report on `Income and Cost Trends` and commended the team for being open and transparent. Members agreed that it was helpful to see spending pre-Covid broken down by services and would welcome future information on areas such as Secure Services.	
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:** 30 June 2023**.**

8.1.1. (b) Finance, Performance & Productivity Committee Chair’s Assurance Report July

8.2. c) Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**8.2**		
Paper title	Month 3 2023/24 Finance Report		
Date	2 August 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 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).

Alert:

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

- 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.

Advise:

The Committee is asked to note the following:

The full year budget has been adjusted to reflect the 2023/24 pay award funding,

increasing both income and expenditure plan by £10m, resulting in no change to the bottom-line break-even plan for the year.

Capital position
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.

Cash position
The month 3 Group cash position is £78m.

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

Review month 3 financial position.

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

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

Previous consideration of report by: (If applicable)

Regular briefing on financial position with FPP chair.

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

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

Financial Implications *(detail any financial implications)*

Group financial position

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

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

Equality impact assessments:

N/A

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

Ongoing financial briefings via Operational Management Team and Sustainability Board.

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

Defining levels of assurance:

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

Finance Report

Financial Performance:

1st April 2023 to 30th June 2023

Month 3
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Original Budget	1.6% Pay Award Funding	Revised Plan	YTD Position		
				Revised Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	566,107	10,085	576,192	144,045	141,765	(2,280)
Other Income	18,832	-	18,832	4,708	5,612	904
Total Income	**584,940**	**10,085**	**595,025**	**148,753**	**147,377**	**(1,376)**
Expenditure						
Pay	(270,039)	(5,943)	(275,982)	(68,998)	(66,261)	2,737
Other Non Pay Expenditure	(277,459)	(4,142)	(281,601)	(70,395)	(72,330)	(1,936)
Drugs	(6,077)	-	(6,077)	(1,519)	(1,850)	(331)
Clinical Supplies	(795)	-	(795)	(199)	(195)	4
PFI	(12,611)	-	(12,611)	(3,153)	(3,102)	51
EBITDA	**17,959**	**-**	**17,959**	**4,490**	**3,638**	**(851)**
Capital Financing						
Depreciation	(9,906)	-	(9,906)	(2,476)	(2,433)	43
PDC Dividend	(1,717)	-	(1,717)	(429)	(429)	-
Finance Lease	(5,693)	-	(5,693)	(1,423)	(1,421)	3
Loan Interest Payable	(1,060)	-	(1,060)	(265)	(273)	(8)
Loan Interest Receivable	797	-	797	199	725	526
Surplus / (Deficit) before taxation	**380**	**-**	**380**	**95**	**(192)**	**(287)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	(380)	-	(380)	(95)	(96)	(1)
Surplus / (Deficit)	**0**	**-**	**0**	**(0)**	**(288)**	**(288)**

Month 3 2023/24 Group Financial Position

The month 3 consolidated Group position is a deficit of £288k year to date. This is £288k 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, significant out of area expenditure and staffing pressures including a significant level of temporary staffing. There has been slippage on new investment in month, with some income deferred in relation to this.

In month 3, the budget has been adjusted to reflect pay award funding for 2023/24. Total income has increased by £10m. This is offset by an increased expenditure plan of £10m (split £6m pay for Trust and £4m non pay for purchase of healthcare from NHS bodies by Reach Out and Mental Health provider collaboratives). There is no change to the bottom-line plan to break-even for the year.

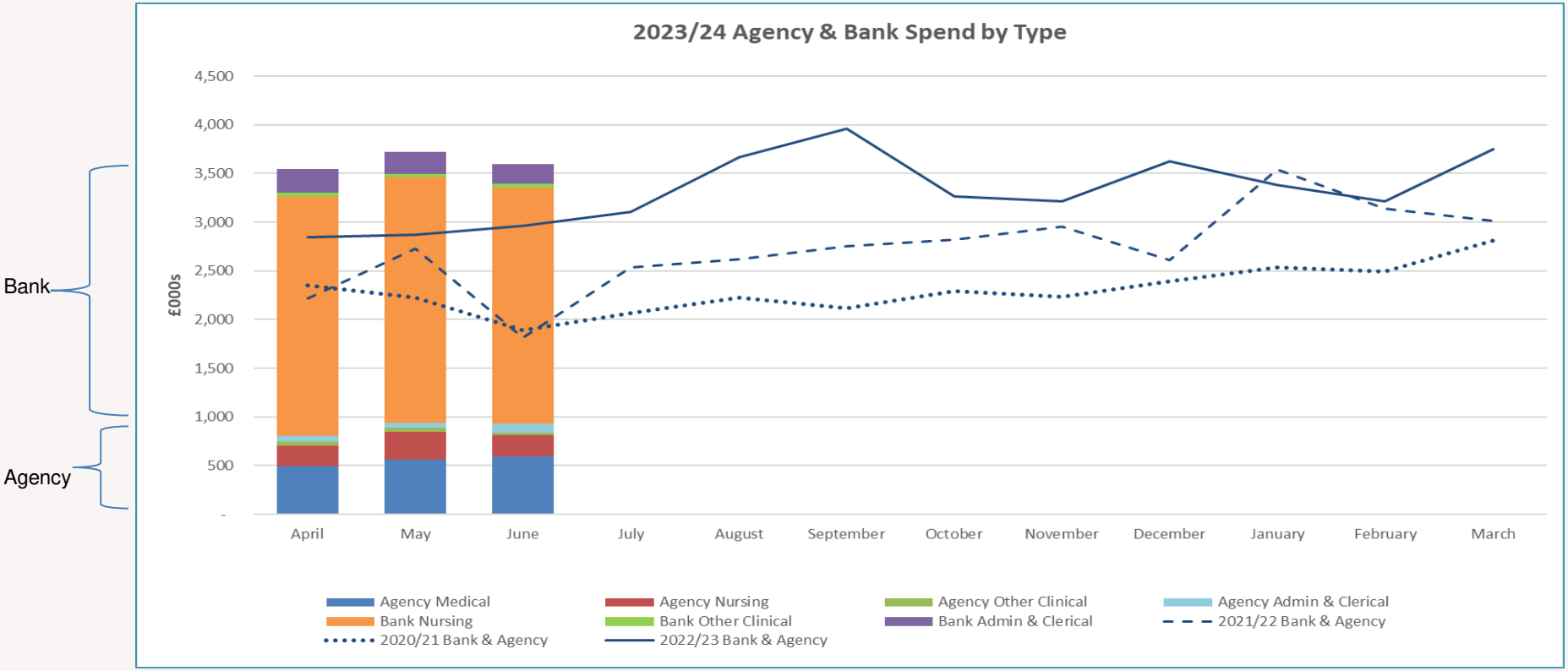
The Group position includes a £437k deficit for the Trust, £119k surplus for the wholly owned subsidiary, Summerhill Services Limited (SSL), a £62k surplus position for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads and a break-even position for the Mental Health Provider Collaborative (MHPC). For a segmental breakdown of the Group position, please see page 3.

Month 3 Group position
Segmental summary

Group Summary	Trust	SSL	Reach Out	MHPC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	84,556	-	36,944	91,287	(71,023)	141,765
Other Income	5,609	7,877	-	-	(7,875)	5,612
Total Income	**90,165**	**7,877**	**36,944**	**91,287**	**(78,897)**	**147,377**
Expenditure						
Pay	(62,123)	(3,467)	(404)	(334)	67	(66,261)
Other Non Pay Expenditure	(20,719)	(2,082)	(36,478)	(90,954)	77,903	(72,330)
Drugs	(1,935)	(742)	-	-	828	(1,850)
Clinical Supplies	(195)	-	-	-	-	(195)
PFI	(3,102)	-	-	-	-	(3,102)
EBITDA	**2,090**	**1,586**	**62**	**(0)**	**(100)**	**3,638**
Capital Financing						
Depreciation	(1,645)	(764)	-	-	(25)	(2,433)
PDC Dividend	(429)	-	-	-	-	(429)
Finance Lease	(1,417)	(96)	-	-	92	(1,421)
Loan Interest Payable	(273)	(512)	-	-	512	(273)
Loan Interest Receivable	1,237	0	-	-	(512)	725
Surplus / (Deficit) before Taxation	**(437)**	**215**	**62**	**(0)**	**(33)**	**(192)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(96)	-	-	-	(96)
Surplus / (Deficit)	**(437)**	**119**	**62**	**(0)**	**(33)**	**(288)**

Temporary staffing expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust



The month 3 year to date temporary staffing expenditure is £10.9m. The graph above shows a breakdown of the temporary staffing expenditure by type. If the year to date expenditure was straight lined for the full year, this would equate to £44m.

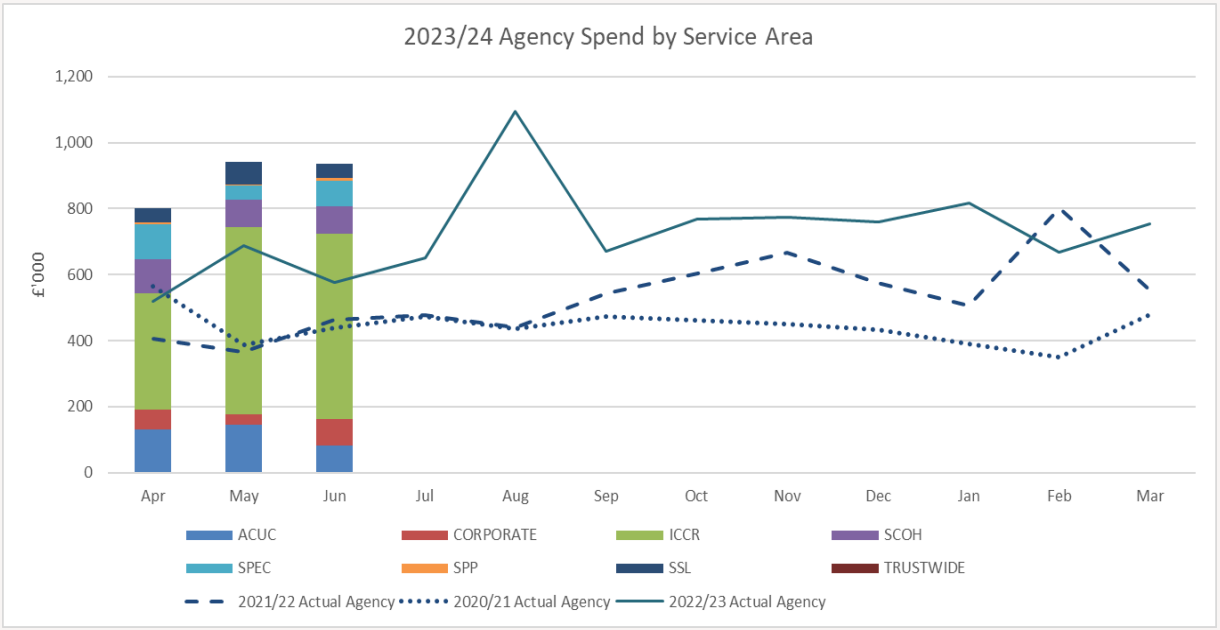
Bank expenditure £8.2m (75%) – the majority of bank expenditure relates to nursing bank shifts - £7.4m.

Agency expenditure £2.7m (25%) – the majority of agency expenditure relates to medical agency - £1.6m.

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

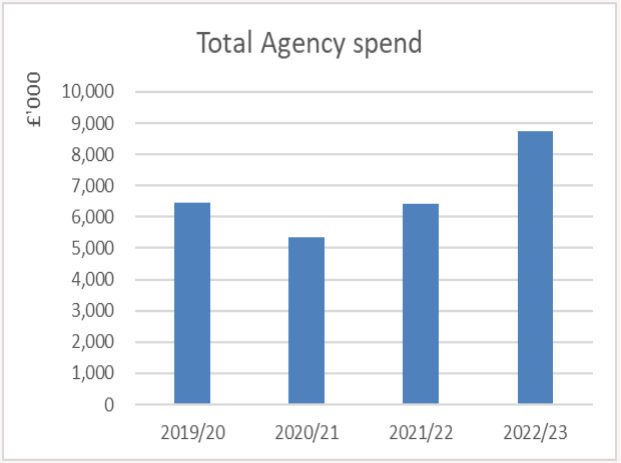
Agency expenditure analysis

Birmingham and Solihull Mental Health NHS Foundation Trust



KPIs	Target	Jun-23
Agency framework breaches	0	0
Above price cap agency bookings	0	40
Agency spend as % of pay bill (YTD)	3.7%	4.0%

Agency spend as % of pay bill YTD (by area)	Jun-23
ACUC	2.6%
CORPORATE	1.6%
ICCR	9.7%
SCOH	1.8%
SPEC	1.8%
SPP	0.8%
SSL	6.4%

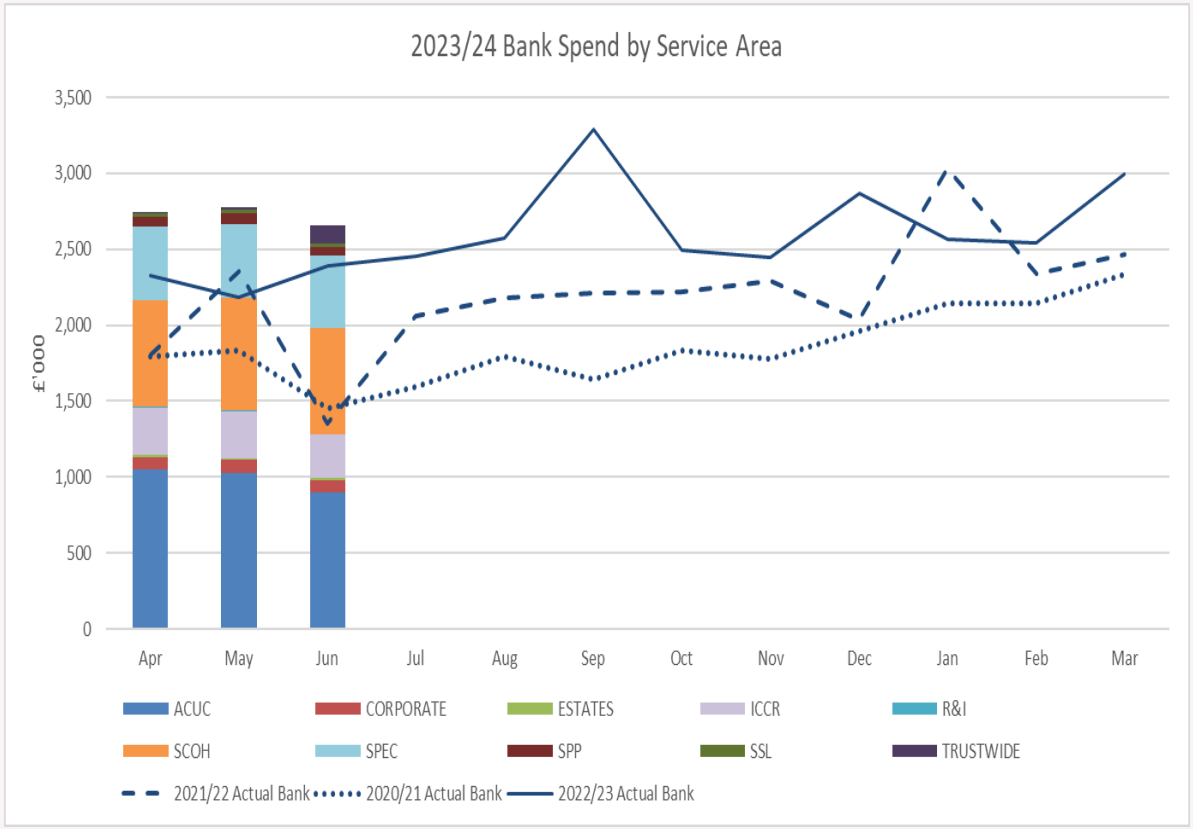


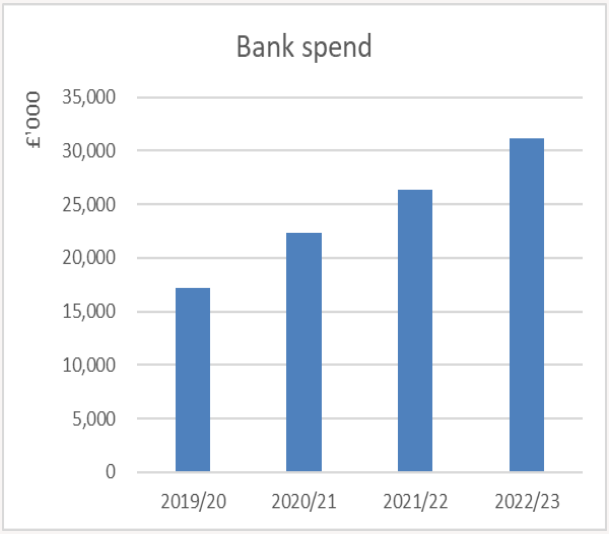
	2023/24 YTD
	£'000
Agency Expenditure	2,677
NHSE Ceiling (3.7% of pay bill)	2,452
Variance to NHSE ceiling	(225)
Agency Medical	1,648
Agency Nursing (Registered)	560
Agency Nursing HCA	156
Agency Other Clinical	109
Agency Admin & Clerical	203
Agency Expenditure	2,677

- Agency expenditure is £2.7m year to date. This is 4% of the year to date pay bill, compared to the NHSE ceiling of 3.7% - total breach of £225k.

- Total expenditure in June is in line with May. A reduction in Acute & Urgent Care and SSL agency spend has been offset by an increase in Specialties Medical agency and Corporate (due to catch up of year to date costs).
- 55% of the year to date expenditure was incurred by ICCR.
- 62% of total spend relates to medical agency.
- 27% of spend relates to nursing agency, with 6% relating to HCAs (mainly in Secure and Offender Health and Acute & Urgent Care).

Bank expenditure analysis



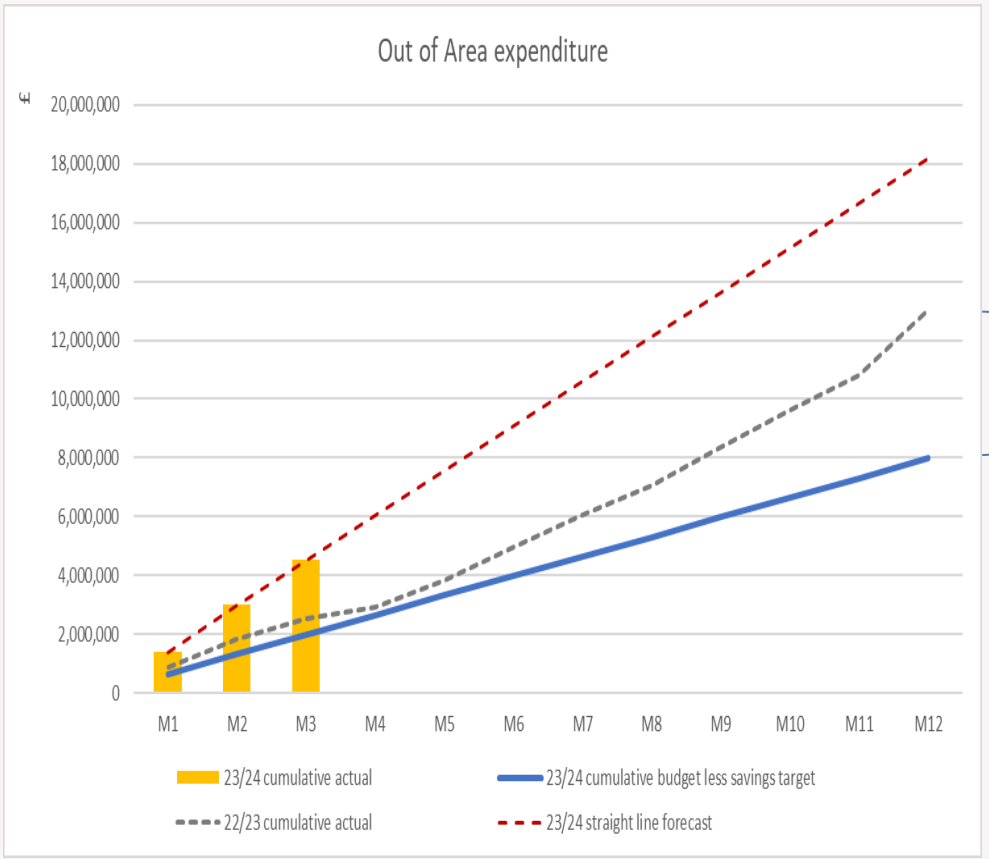


Type	YTD £'000
Bank Nursing	7,391
Bank Other Clinical	125
Bank Admin & Clerical	666
Grand Total	**8,181**

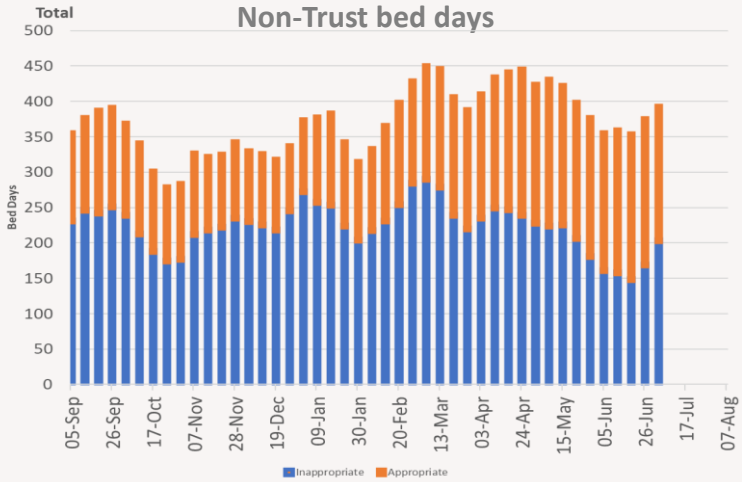
Bank expenditure

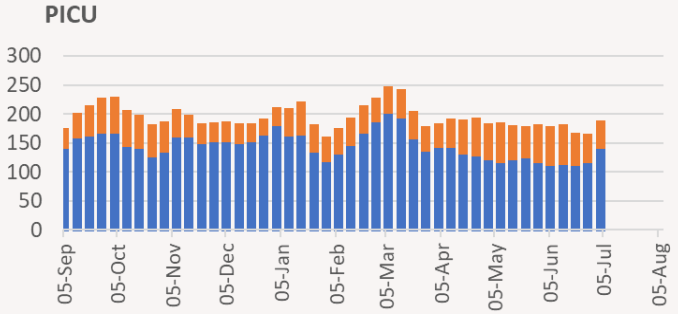
- Month 3 year to date bank expenditure is £8.2m.
- Bank expenditure in June has decreased by £115k compared to May, mainly driven by Acute & Urgent Care spend reduction of £129k.
- Year to date average expenditure is £134k higher than the 2022/23 monthly average and just under 50% higher than the 2020/21 average.
- 90% of year to date bank spend relates to nursing.
- Year to date bank expenditure has predominantly been incurred within the following service areas: Acute & Urgent Care £3m, Secure and Offender Health £2.1m and Specialities £1.4m.

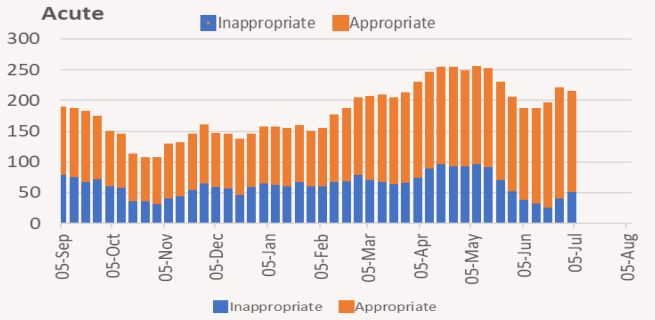
Out of Area overspend



Efficiency target £5m

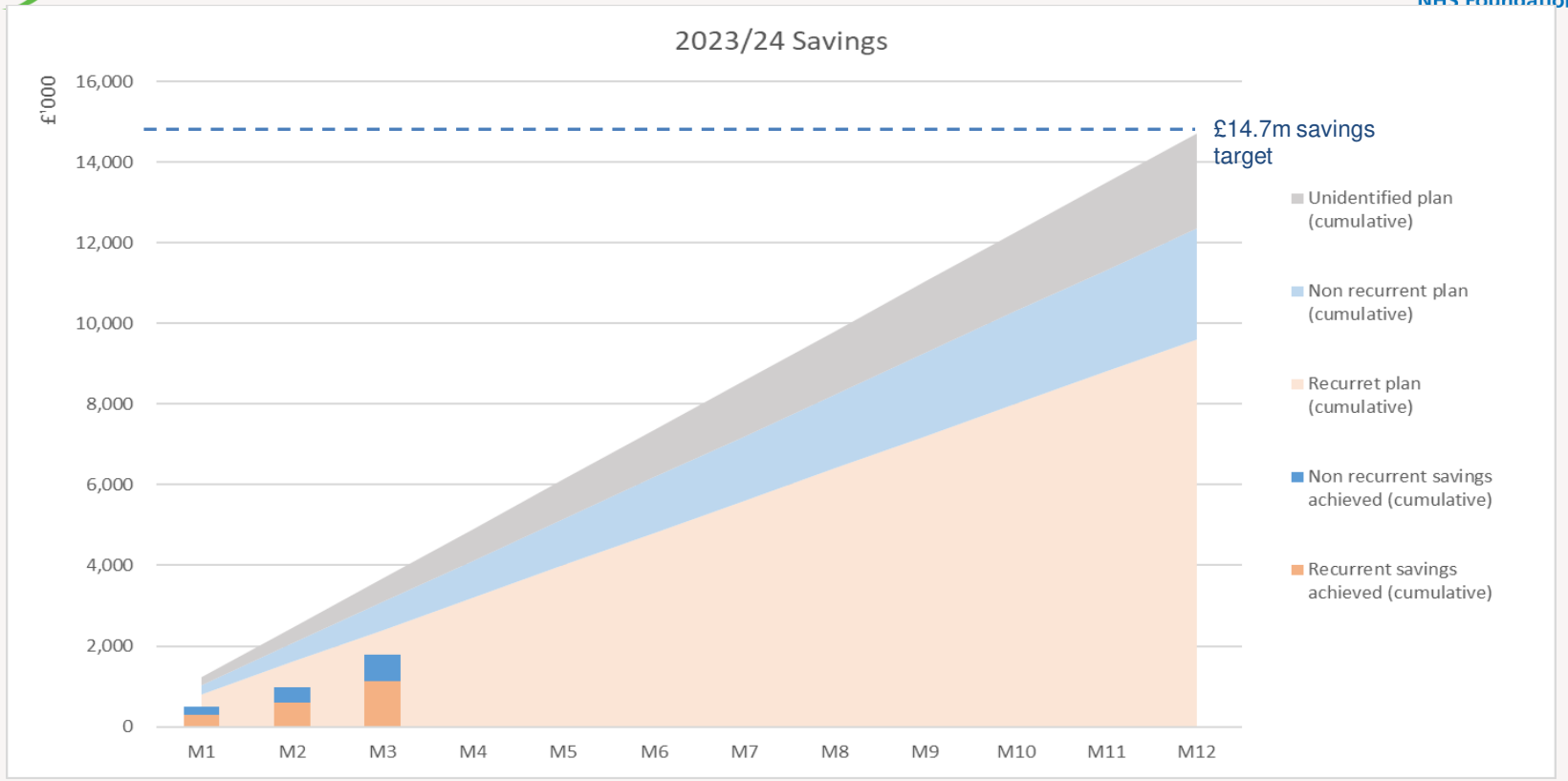






- Year to date out of area expenditure as at month 3 is £4.6m.
- If spend were to continue at the year to date rate for the full year, total expenditure would be £18m.
- Total 2023/24 plan for out of area, including a £5m savings target, is £8m.

Efficiencies



Recurrent/ Non-Recurrent	Sum of Annual Plan £'000	Sum of YTD Plan £'000	Sum of YTD Actual £'000	Sum of YTD Variance £'000
Non-recurrent	5,108	1,277	665	-612
Recurrent	9,609	2,402	1,127	-1,275
Grand Total	**14,717**	**3,679**	**1,792**	**-1,887**

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 3 totals £1.8m, which is a shortfall of £1.9m year to date (mainly due to slippage on out of area savings £1.3m and unidentified target £0.5m).

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Final'* 31-Mar-23 £m's	NHSI Plan YTD 31-May-23 £m's	Actual YTD 31-May-23 £m's	NHSI Plan Forecast 31-Mar-24 £m's
Non-Current Assets				
Property, plant and equipment	214.2	213.7	214.0	211.3
Prepayments PFI	1.3	1.3	1.6	1.3
Finance Lease Receivable	-	-	-	-
Finance Lease Assets	0.0	-	-	-
Deferred Tax Asset	(0.1)	-	-	-
Total Non-Current Assets	215.4	215.0	215.6	212.6
Current assets				
Inventories	0.6	0.6	0.6	0.6
Trade and Other Receivables	28.2	28.2	17.0	28.2
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	59.0	58.6	78.2	56.8
Total Curent Assets	87.9	87.4	95.8	85.7
Current liabilities				
Trade and other payables	(55.9)	(56.2)	(60.7)	(55.9)
Tax payable	(5.0)	(5.0)	(9.2)	(5.0)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.1)	(1.2)	(1.1)	(1.2)
Provisions	(1.5)	(1.5)	(1.4)	(1.5)
Deferred income	(40.4)	(40.4)	(42.0)	(40.4)
Total Current Liabilities	(106.5)	(106.8)	(116.9)	(106.6)
Non-current liabilities				
Deferred Tax Liability	-	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(25.1)	(24.4)	(24.1)	(23.0)
PFI lease	(45.7)	(45.4)	(45.2)	(43.8)
Finance Lease, non current	(7.9)	(7.7)	(7.5)	(6.8)
Provisions	(3.7)	(3.7)	(3.6)	(3.7)
Total non-current liabilities	(82.4)	(81.3)	(80.4)	(77.4)
Total assets employed	114.4	114.3	114.1	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)	(42.2)	(41.9)
Total taxpayers' equity	114.4	114.3	114.1	114.3

SOFP Highlights

The Group cash position at the end of June 2023 is £78.2m, this includes Reach Out and the Mental Health Provider Collaborative.

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

Current Assets & Current Liabilities

Ratios

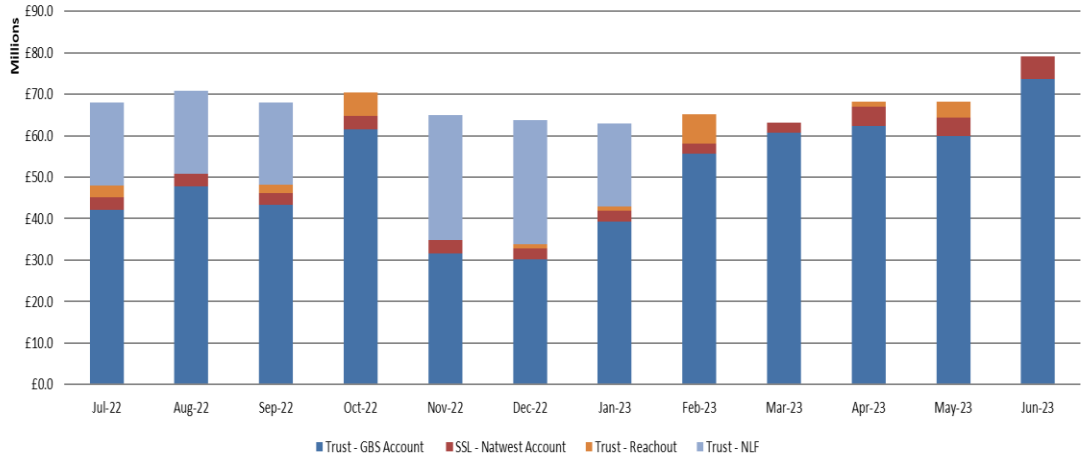
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

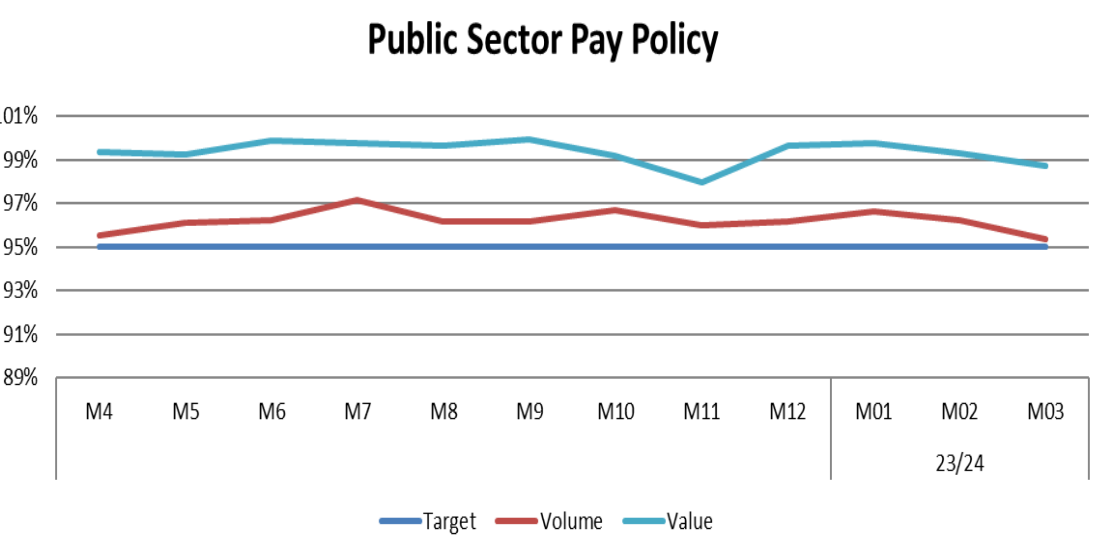
Current Ratio :	**£m's**
Current Assets	95.8
Current Liabilities	-116.9
Ratio	0.8

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of June 2023 is £78.2m.

In June 2023, a £30m deposit was placed with the National Loan Fund until the end of July 2023, at a rate of 4.6%.

Better Payments

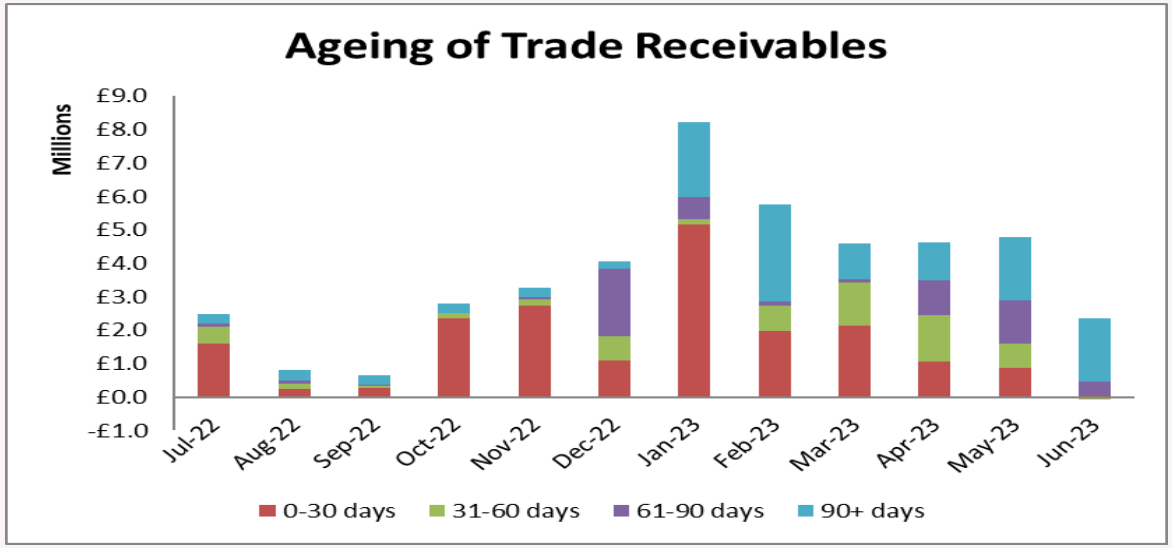
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

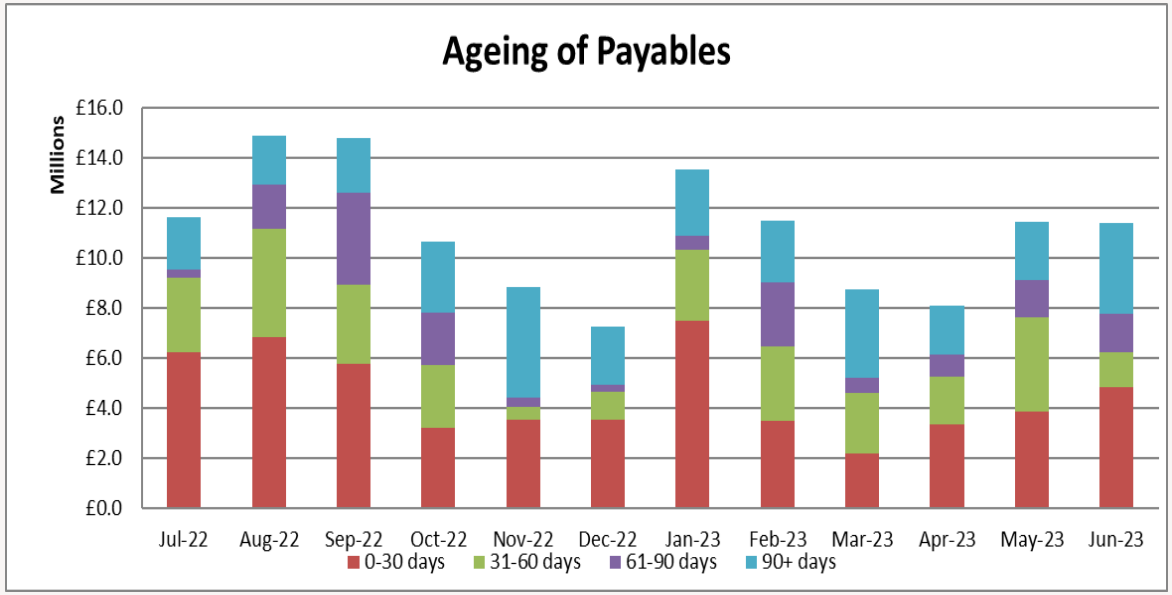
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	96%	✓	100%	✓
Non - NHS Creditors within 30 Days	95%	✓	99%	✓

Trust Receivables and Payables





Trade Receivables & Payables

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

Receivables :

- **0-30 days-** balance for scheduled monthly and ad hoc invoices with no known disputes at present
- **31-60 days-** significant decrease in balance overall various NHS bodies have made payments, the remainder of the balance relates to staff overpayments (on payment plans)
- **61-90 days-**significant decrease in month-main balance relates to UHB £638k under query due to services not fully provided moving to over 90 days (provision made for non-payment), balance mainly staff overpayments (on payment plans)
- **Over 90 days –**UHB £1.326m under query due to services not fully provided, credit note issued in July 23 (provision made for non-payment), South Warwickshire Partnership Trust £24k, DOH £57k still under review, staff overpayments (on payment plans).

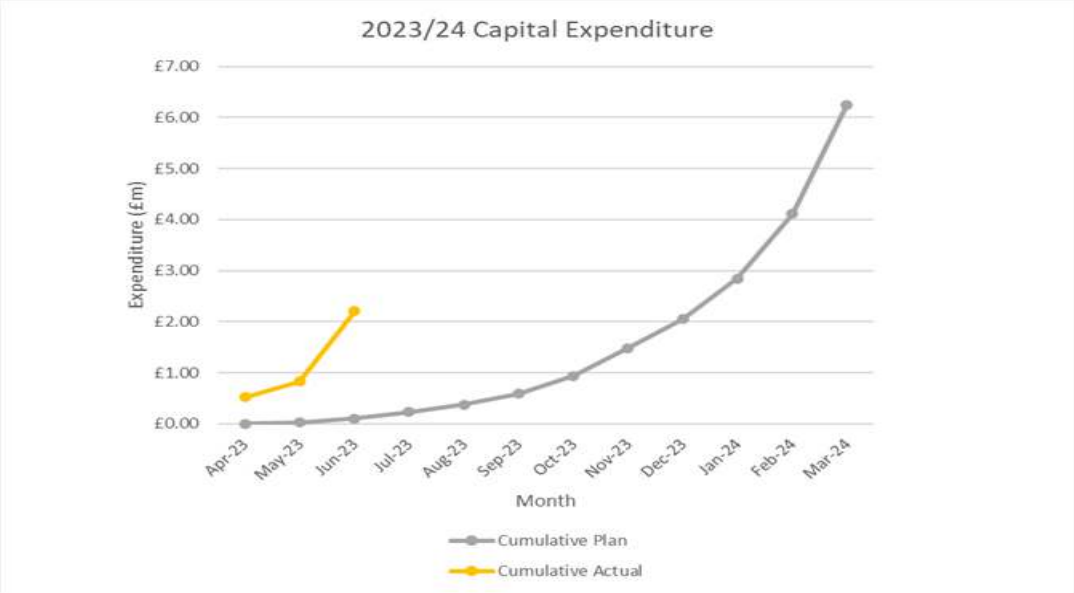
Trade Payables:
Over 90 days -

- Bham W&C £424k awaiting approval, Nottingham HC £416k RO in query, UHB £217k awaiting approval, NHS Property £212k-historic invoices
- Non-NHS Suppliers (67+) £2.1m – mainly bed fees invoices in query, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in July 2023.

Month 3 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	0.4		0.4
SSBM Works	2.0	0.1	0.1		0.0
ICT Projects	0.9	0.0	0.3		0.3
Risk Assessment Works	0.4	0.0	1.4		1.4
CAMHS Seclusion Suite (PDC Funded)	1.3		0.0		0.0
Total	6.3	0.1	2.2		2.1



Group Capital Expenditure

As at month 3, group capital expenditure is £2.2m. This is £2.1m 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 as in prior year, there will be a bidding process to be undertaken for any additional funding from the SCIF.

Trust Service Area analysis

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Budget	YTD Actual	YTD Variance
	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000
Acute and Urgent Care Services				
Other Income	(148)	(37)	(149)	112
Pay	42,346	10,546	13,922	(3,376)
Non Pay	17,077	4,269	5,807	(1,538)
Acute and Urgent Care Services Total	**59,276**	**14,778**	**19,580**	**(4,802)**
ICCR				
Other Income	(3,924)	(981)	(1,205)	224
Pay	56,730	14,151	15,248	(1,097)
Non Pay	10,336	2,556	2,714	(158)
ICCR Total	**63,141**	**15,726**	**16,757**	**(1,031)**
Specialties Services				
Other Income	(3,375)	(844)	(852)	8
Pay	42,839	10,710	12,882	(2,173)
Non Pay	3,243	811	1,050	(239)
Specialties Services Total	**42,707**	**10,677**	**13,081**	**(2,404)**
Secure Serv & Offender Health				
Other Income	(479)	(120)	(443)	323
Pay	53,731	13,433	15,171	(1,738)
Non Pay	8,712	2,178	2,317	(139)
Secure Serv & Offender Health Total	**61,964**	**15,491**	**17,045**	**(1,554)**
Corporate Services				
Other Income	(12,852)	(3,213)	(4,015)	802
Pay	42,568	10,642	12,582	(1,940)
Non Pay	37,860	9,465	10,963	(1,498)
PFI	12,611	3,153	3,102	51
Capital Financing	12,335	3,084	2,527	557
Corporate Services Total	**92,521**	**23,130**	**25,158**	**(2,028)**
HCI Total	**(331,164)**	**(82,791)**	**(83,501)**	**710**
Trustwide total	**11,999**	**3,100**	**(7,682)**	**10,782**
Surplus / Deficit - Trust	**444**	**111**	**437**	**(326)**

The month 3 Trust position is a £437k deficit, this is £326k adverse to plan. The breakdown of the Trust financial position is shown in the table opposite. Key variances are as follows (budget for in year pay award funding is held centrally):

Acute and Urgent Care Services (ACUC) £4.8m overspent

- Pay is £3.4m overspent (including £1.7m pay award). £3.2m temporary staffing spend (£2.8m bank) and £0.2m substantive overspend.
- Non pay is £1.5m overspent, predominantly due to out of area expenditure.

Integrated Community Care & Recovery (ICCR) £1m overspent

- Pay is £1m overspent (including £2m pay award). £1.3m substantive underspend, including Service Development Funding (SDF) is offset by £2.4m temporary staffing spend (£1.5m agency, £0.9m bank).

Specialties £2.4m overspent

- Pay is £2.2m overspent (£1.7m pay award). £0.6m substantive and £1.5m temporary staffing overspend (£1.3m bank).

Secure Care and Offender Health (SCOH) £1.6m overspent

- Other Income is £0.3m ahead of plan, mainly relating to specialling income.
- Pay is £1.7m overspent (including £2.2m pay award). £1.6m temporary staffing overspend (£1.4m bank).

Corporate £2m overspent

- Pay is £1.9m overspent (including £1.7m pay award). £1.3m substantive overspend and £0.6m temporary staffing overspend (£0.4m bank).
- Non pay is £1.5m overspent, this is offset by additional £0.8m income £0.8m and interest receivable £0.6m.

Month 3 DRAFT system position

At the time of writing, the month 3 BSOL system position is draft.

The draft revenue system position is a year to date deficit of £18m. This is a deterioration of £10m compared to month 2, mainly driven by the UHB position. The draft system capital position is showing expenditure at £6m ahead of plan, driven by BSMHFT £2m, UHB £2m and BWCH £2m.

Organisation	Surplus / (Deficit) - Adjusted Financial Position								Prior Month		Movement	
	Plan	Actual	Variance		Plan	Forecast	Variance		Actual	Variance	Actual	Variance
	YTD	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	Year Ending	YTD	YTD	YTD	YTD
	£000	£000	£000	%	£000	£000	£000	%	£000	£001	£000	£001
Birmingham And Solihull ICB	5,922	4,910	(1,012)	(0.1%)	-	(0)	(0)	(0.0%)	6,101	73	(1,191)	(1,085)
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(287)	(287)	(0.2%)	-	-	-	0.0%	(410)	(410)	123	123
Birmingham Community Healthcare NHS Foundation Trust	132	(837)	(969)	(1.1%)	-	-	-	0.0%	(663)	(751)	(173)	(217)
Birmingham Women'S And Children'S NHS Foundation Trust	-	(989)	(989)	(0.6%)	-	-	-	0.0%	(314)	(314)	(675)	(675)
The Royal Orthopaedic Hospital NHS Foundation Trust	164	(1,398)	(1,562)	(5.0%)	-	0	0	0.0%	(1,020)	(1,055)	(378)	(507)
University Hospitals Birmingham NHS Foundation Trust	(9,900)	(19,836)	(9,936)	(1.8%)	-	-	-	0.0%	(11,831)	(4,431)	(8,005)	(5,505)
ICS Total	(3,682)	(18,437)	(14,755)	(1.9%)	-	(0)	(0)	(0.0%)	(8,137)	(6,888)	(10,300)	(7,867)

Provider Capital BAU	Plan	Actual	Variance		Plan	Forecast	Variance		YTD as % of FOT
	YTD	YTD	YTD		Year Ending	Year Ending	Year Ending		
	£'000	£'000	£'000	%	£'000	£'000	£'000	%	
Birmingham And Solihull Mental Health NHS Foundation Trust	100	2,203	(2,103)	-2103.3%	6,977	6,977	-	0.0%	31.6%
Birmingham Community Healthcare NHS Foundation Trust	908	287	621	68.4%	6,372	6,372	-	0.0%	4.5%
Birmingham Women'S And Children'S NHS Foundation Trust	940	2,733	(1,793)	-190.7%	20,874	20,874	-	0.0%	13.1%
The Royal Orthopaedic Hospital NHS Foundation Trust	596	949	(353)	-59.2%	3,909	3,909	-	0.0%	24.3%
University Hospitals Birmingham NHS Foundation Trust	6,117	8,367	(2,250)	-36.8%	37,071	37,071	-	0.0%	22.6%
Total Provider charge against allocation	8,661	14,539	(5,878)	-67.9%	75,203	75,203	-	0.0%	19.3%

8.3. Audit Committee Chair`s Assurance Report July

Birmingham and Solihull Mental Health NHS Foundation Trust

Committee Chairs Escalation and Assurance Report

Name of Committee	**Report of: Audit Committee**
Report presented at	**Board**
Date of meeting	**2nd August 2023**
Date(s) of Committee Meeting(s) reported	**13 July 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: 1. Internal Audit Progress Report 2. LCFS Progress Report 3. Reactive Benchmarking Report 4. Fraud Risk Assessment – Audit Report 5. Gifts and Hospitality Audit Report 6. Single Tender Waivers/Losses and Special Payments 7. External Audit and Technical Update 8. Updated BAF 9. High-level operational risks from SSL 10. Risk Management Policy 11. Commissioning BAF 12. Clinical Audit Plan 13. Audit Committee Self-Assessment Survey Proposal
Alert:	The Committee wishes to alert the Trust Board to the following (for example): • Concerns in relation to Reaside were noted with the estimated costs being received at Capital Review Group. It was agreed the SSL update to the Board of Directors will cover this item in detail highlighting the risks and options available.
Assurance:	The Committee was assured on the following: • The Committee were assured by the progress with the Clinical Audit Plan and commended the team for the ongoing development. • The Committee noted the significant improvements in risk management and the BAF and were assured on the progress. • The Committee noted the substantial assurance in relation to the single tender waiver process. Waivers need to be completed with any request for purchase which is over the amount of £5k, this is now hosted by University Hospital Trust and this was noted as positive.

	• The Committee noted the Gifts and Hospitality Audit survey carried out in 2022 shows a good understanding from staff. The Committee were assured with ongoing support. • The Committee were assured by the Fraud Risk Assessment with no risks brought to LCFS's attention which would be of significant concern.	
Advise	The Committee was advised of the following matters: • The Committee were advised the Commissioning BAF is being drafted and will be received at the next meeting for review and assurance.	
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	Winston Weir	**Minutes available from:** Jackie Shakespeare

8.4. 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	**9.4**
Paper title	**Integrated Performance Report**
Date	08 August 2023
Author	Richard Sollars, Deputy Director of Finance Gill Mordain, Associate Director of Clinical Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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

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

There was discussion last month regarding whether the most appropriate metrics are included within the integrated report and how issues with other metrics are escalated. Discussion is in progress to address these matters.

Reason for consideration:

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

Previous consideration of report by:
Executive Team and Performance Delivery Group
Strategic priorities (which strategic priority is the report providing assurance on)
Clinical Services, Quality, People and Sustainability
Financial Implications *(detail any financial implications)*
None
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
N/A
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Ongoing performance monitoring via Performance Delivery Group

Integrated Performance Report

Context

All SPC-related charts and detailed commentaries can be accessed if you are on the Trust network via http://wh-info-live/PowerBI_report/IntegratedDashboard.html - please copy and paste this link into your browser.

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

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

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

The above areas have been considered by the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. Relevant Leads have provided an update on each area. Appendix 1 provides an update against improvement trajectories for these metrics.

There was discussion in previous months regarding whether the most appropriate metrics are included within the integrated report and how issues with other metrics are escalated. Discussion is in progress to address these matters. We will be providing a detailed update next month on the plan to address this as part of an overall review of the performance management framework.

Performance in June 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 impact of COVID-19 and the closure of beds has significantly impaired our ability to eliminate use of out of area beds. May's average figure is 32.5 patients
- **IAPT** – As discussed at FPP, there is a range of issues which require a system approach to resolve and additional investment
- **New referrals not seen** – As discussed at FPP, there are a range of issues here, including the level of Neuropsychiatry waits
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. This has deteriorated as a result of COVID, but the overall divergence between individual teams has long been a concern:
- **YTD financial position** is a deficit of £0.43 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

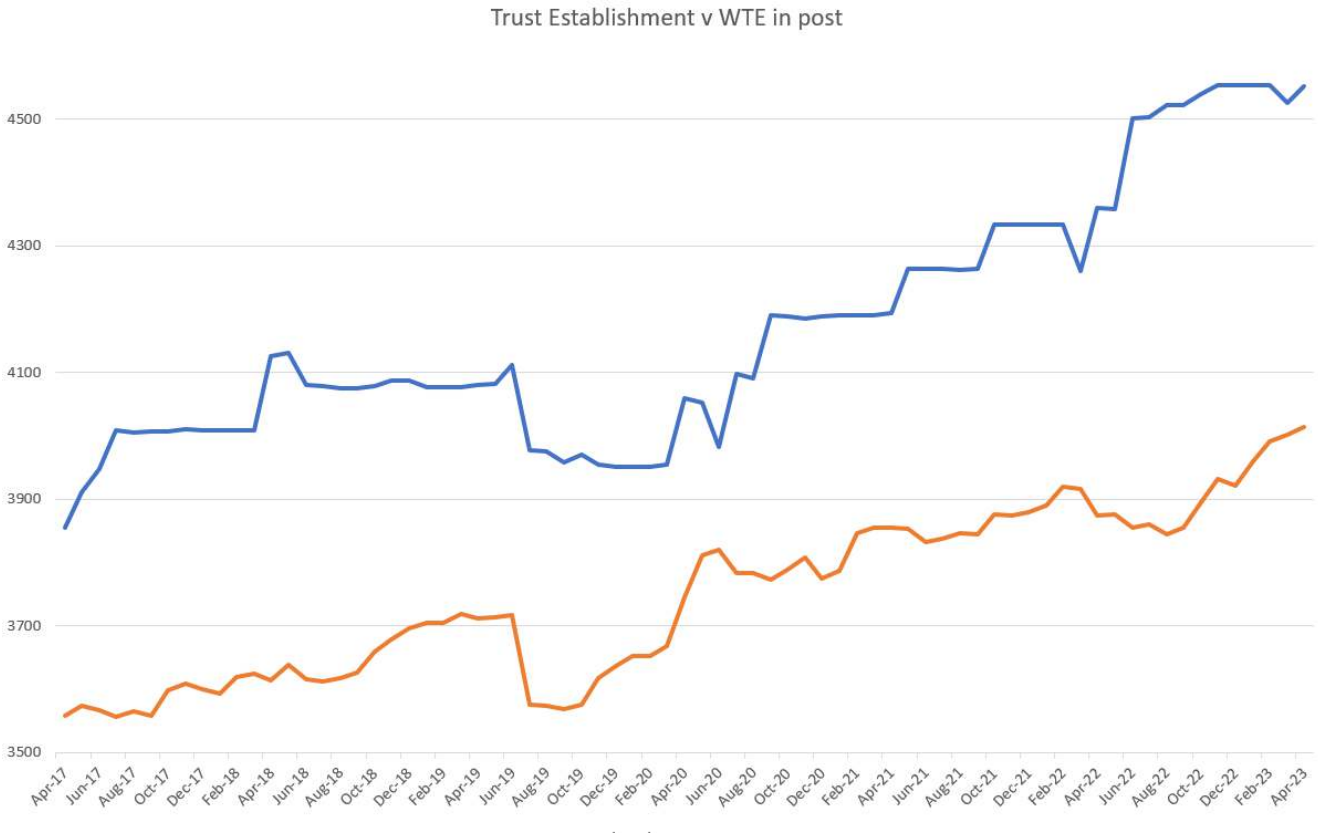
- Assaults on staff have risen from 95 in Feb-23 to 137 (the second highest figure in four years)
- **Key concerns: Staff assaults**

Performance

- The level of inappropriate Out of Area Patients remains a concern. The figure fell to 679 (22.6 patients per day), the lowest level since Jun-22 but this is significantly up from Apr-22 416 OBD (13.9) and represents a significant cost pressure
- CPA 7-day follow up is down to 84.5% and remains well below historic norms
- CPA with formal review in last 12 months up to 90.7% (highest figure since Feb-20)
- IAPT patients seen within 6 weeks of referral has improved to 42.5%. the best position since Mar-21. This is being discussed across BSol to identify how to address underperformance. Performance for within 18 weeks is stable at 79.6%, second best figure since Nov-21
- New referrals not seen within 3 months are down to 3,359. Of this, Neuropsychiatry represents the most significant issue
- **Key concerns: Out of Area, CPA 7-day follow up, IAPT waiting times, CPA 12-month review and new referrals not seen in 3 months**

People

- The People domain continues to show the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Scores are of concern across the board
- Vacancy levels are unchanged at 12.2% in June, significantly down on 14.9% in Aug-22. This is driven by changes to establishment and staff in post. ~~4,013.6 WTE in post is the highest number ever and is up by 118.2 since Oct-22~~. Vacancies total ~~539.3 WTE~~ and the vacancy rate varies by team. ICCR and Secure have the highest vacancy rate of the service directorates at 14.9% (~~153.1 WTE~~)



- Rolling 12-month sickness levels reduced to 4.3%, significantly down from Dec-22 (7.2%) and the lowest figure in five years. Highest service directorate in Jun-23 Secure (5.4%)
- Staff appraisals at 72.9%, highest figure since Jan-23 but well down on Sep-22 (84.0%) and target of 90%
- Bank and Agency fill rate fill down to 85.5%
- **Key concerns: Vacancies, appraisals, bank and agency fill rate**

Sustainability

- Financial position for the first 3 months is a deficit of £0.3m 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 3 months is £2.2m, which is £2.1m 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 is stable at £935k in June and remains higher than NHSE target, with key issues in medical staffing
- **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

June 2023

Performance

CPA 7 day FU	84.5%	↓
CPA with Formal Review last 12 mths	90.7%	↓
Data Quality Maturity Index (DQMI)	97.3%	↑
Delayed Transfer Bed Days	1237	↓
Delayed Transfer, percent of bed days	8.0%	↓
Eating disorders routine	100.0%	
First episode psychosis	100.0%	↑
IAPT into recovery	48.7%	
IAPT seen in 18 weeks	79.6%	↓
IAPT seen in 6 weeks	42.5%	↓
Out of Area Bed Days	679	↗
Referrals over 3 mths with no contact	3359	↓

People

Bank & Agency Fill Rate	85.5%	
Fundamental Training	91.1%	↓
Rolling 12m Turnover	9.6%	↑
Staff Appraisals	72.9%	↓
Staff Sickness	4.3%	
Staff Vacancies	12.2%	↓

Quality

Absconsions from inpatient units	7	
Commissioner reportable incidents	3	
Community confirmed suicides	0	
Community suspected suicides	1	↓
Failure to return	16	
Incidents of self harm	134	↑
Incidents resulting in harm (other)	14.8%	↑
Incidents resulting in harm (patients)	12.9%	↑
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	18	
Ligature with anchor point	4	
Patient assaults	66	↘
Patient assaults / 1000 OBD	3.6	↘

Sustainability

CAP Ex	£1,378k	
Cash	£78,199k	↑
CIP	£825k	
Info Governance	96.0%	
Monthly Agency	£935k	↓
Operating Surplus	-£122k	↓
SOF rating	3	↑

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

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Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: 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

June 2023

Performance

CPA 7 day FU	84.5%	↓
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IAPT into recovery	48.7%	
IAPT seen in 18 weeks	79.6%	↓
IAPT seen in 6 weeks	42.5%	↓
Out of Area Bed Days	679	↗
Referrals over 3 mths with no contact	3359	↓

People

Bank & Agency Fill Rate	85.5%	
Fundamental Training	91.1%	↓
Rolling 12m Turnover	9.6%	↑
Staff Appraisals	72.9%	↓
Staff Sickness	4.3%	
Staff Vacancies	12.2%	↓

Quality

Incidents resulting in harm (patients)	12.9%	↑
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	18	
Ligature with anchor point	4	
Patient assaults	66	↘
Patient ssaults / 1000 OBD	3.6	↘
Physical restraints	241	
Physical restraints/ 1000 OBD	13.1	↑
Prone restraints	68	
Prone restraints/ 1000 OBD	3.7	
Reported incidents	2327	↑
Staff assaults	137	↓
Staff assaults / 1000 OBD	7.5	↓

Sustainability

CAP Ex	£1,378k	
Cash	£78,199k	↑
CIP	£825k	
Info Governance	96.0%	
Monthly Agency	£935k	↓
Operating Surplus	-£122k	↓
SOF rating	3	↑

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

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Integrated Performance Dashboard

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
CPA 7 day FU	95.00	91.0%	91.2%	89.2%	87.9%	88.9%	84.5% ↓
CPA with Formal Review last 12 mths	95.00	86.8%	88.2%	88.8%	88.5%	88.7%	90.7% ↓
Data Quality Maturity Index (DQMI)	95.00	97.7%	96.6%	96.6%	97.5%	96.9%	97.3% ↑
Delayed Transfer Bed Days		838	896	937	991	1068	1237 ↓
Delayed Transfer, percent of bed days		5.4%	6.3%	6.0%	6.6%	6.8%	8.0% ↓
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	43.7%	49.9%	50.5%	51.8%	47.8%	48.7%
IAPT seen in 18 weeks	95.00	74.9%	73.7%	74.2%	71.2%	79.9%	79.6% ↓
IAPT seen in 6 weeks	75.00	35.8%	40.2%	40.8%	33.0%	41.1%	42.5% ↓
Out of Area Bed Days	893.00	1153	991	1302	1202	1006	679 ↗

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
CPA with Formal Review last 12 mths	95.00	86.8%	88.2%	88.8%	88.5%	88.7%	90.7% ↓
Data Quality Maturity Index (DQMI)	95.00	97.7%	96.6%	96.6%	97.5%	96.9%	97.3% ↑
Delayed Transfer Bed Days		838	896	937	991	1068	1237 ↓
Delayed Transfer, percent of bed days		5.4%	6.3%	6.0%	6.6%	6.8%	8.0% ↓
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	43.7%	49.9%	50.5%	51.8%	47.8%	48.7%
IAPT seen in 18 weeks	95.00	74.9%	73.7%	74.2%	71.2%	79.9%	79.6% ↓
IAPT seen in 6 weeks	75.00	35.8%	40.2%	40.8%	33.0%	41.1%	42.5% ↓
Out of Area Bed Days	893.00	1153	991	1302	1202	1006	679 ↗
Referrals over 3 mths with no contact		3273	3277	3201	3409	3414	3359 ↓

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Staff Vacancies		13.0%	12.3%	11.5%	11.8%	12.2%	12.2% ↓
Staff Sickness	4.28	6.3%	5.4%	5.2%	4.8%	5.0%	4.3%
Staff Appraisals	90.00	73.4%	71.3%	69.0%	68.8%	70.7%	72.9% ↓
Rolling 12m Turnover		10.7%	10.7%	9.9%	9.7%	9.7%	9.6% ↑
Fundamental Training	95.00	92.7%	90.3%	90.2%	91.4%	91.5%	91.1% ↓
Bank & Agency Fill Rate		84.5%	81.3%	84.6%	84.1%	89.0%	85.5%

Top Line Commentary (Trust level)

KEY CONCERNS

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

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

Integrated Performance Dashboard

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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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
Absconsions from inpatient units		11	2	4	6	2	7	
Commissioner reportable incidents		5	6	12	3	5	3	
Community confirmed suicides		0	0	0	0	0	0	
Community suspected suicides		1	1	4	1	3	1	↓
Failure to return		11	12	18	10	16	16	
Incidents of self harm		158	150	165	169	173	134	↑
Incidents resulting in harm (other)		14.5%	13.7%	13.9%	13.0%	13.6%	14.8%	↑
Incidents resulting in harm (patients)		19.2%	16.1%	14.2%	16.2%	13.3%	12.9%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	0	
Ligature no anchor point		36	19	14	29	18	18	
Ligature with anchor point		0	0	1	1	0	4	
Patient assaults		42	46	42	45	59	66	↘
Patient ssaults / 1000 OBD		2.3	2.7	2.2	2.5	3.1	3.6	↘
Physical restraints		316	277	297	285	294	241	
Physical restraints / 1000 OBD		17.1	16.5	15.0	15.8	15.7	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

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Incidents of self harm		158	156	165	169	175	154
Incidents resulting in harm (other)		14.5%	13.7%	13.9%	13.0%	13.6%	14.8%
Incidents resulting in harm (patients)		19.2%	16.1%	14.2%	16.2%	13.3%	12.9%
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		36	19	14	29	18	18
Ligature with anchor point		0	0	1	1	0	4
Patient assaults		42	46	42	45	59	66
Patient ssaults / 1000 OBD		2.3	2.7	2.2	2.5	3.1	3.6
Physical restraints		316	277	297	285	294	241
Physical restraints/ 1000 OBD		17.1	16.5	15.9	15.8	15.7	13.1
Prone restraints		62	36	69	84	86	68
Prone restraints/ 1000 OBD		3.4	2.1	3.7	4.7	4.6	3.7
Reported incidents		2415	2287	2467	2192	2431	2327
Staff assaults		121	95	121	100	140	137
Staff assaults / 1000 OBD		6.6	5.7	6.5	5.5	7.5	7.5

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
CAP Ex		£487k	£3,830k	£1,748k	£517k	£308k	£1,378k	
Cash		£62,889k	£65,242k	£59,020k	£68,159k	£68,246k	£78,199k	↑
CIP		£656k	£656k	£3,662k	£483k	£483k	£825k	
Info Governance		96.7%	94.5%	94.9%	83.9%	94.6%	96.0%	
Monthly Agency		£817k	£668k	£755k	£801k	£941k	£935k	↓
Operating Surplus		-£16k	-£7k	-£2,873k	£59k	£352k	-£122k	↓
SOF rating		3	3	3	3	3	3	↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

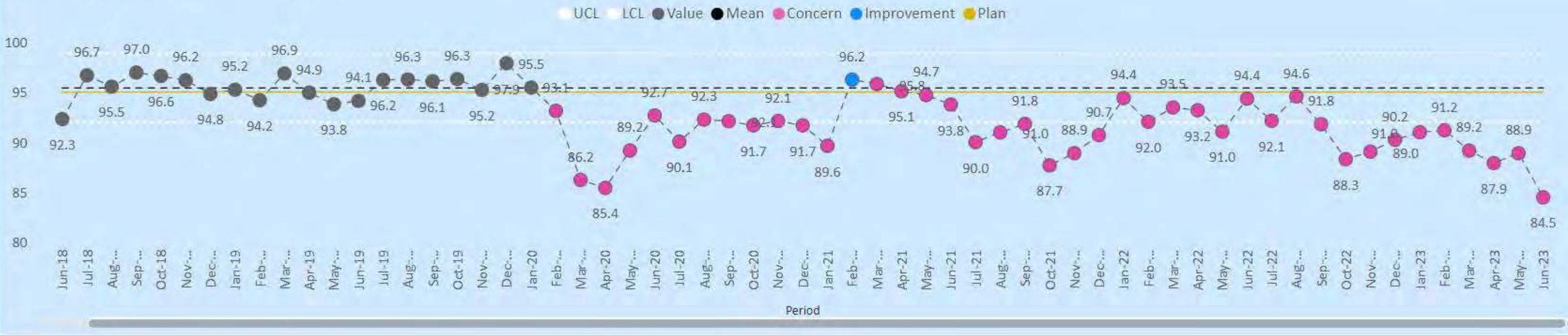
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	91.0%	91.2%	89.2%	87.9%	88.9%	84.5%
B: Acute and Urgent Care	85.0%	90.6%	89.6%	90.7%	90.8%	87.3%
C: ICCR	66.7%	66.7%	62.5%	60.0%	81.3%	76.5%
D: Secure Serv & Offender Health	100.0%	100.0%	100.0%	50.0%	75.0%	83.3%
E: Specialties	0.0%	100.0%	95.2%	95.0%	90.9%	76.9%

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 88.9% for May 2023.
May 2023 performance is below the target of 95%. This relates to 18 outstanding follow ups from 162 discharges in May of which, 2 patients were discharged to the care of FTB, 4 patients were discharged to another mental health trust, 1 patient was discharged to a care home and contact was with staff only, attempts were made to see 1 patient but were unsuccessful, 2 patients were seen outside 7 days, 2 patients did not return from leave and have been reported as missing to the police, 1 patient wet to Romania on discharge, 1 patient was taken into custody on discharge, Attempts have been made to see 2 patients, 1 patient was recalled to hospital for a few hours and then discharged and 2 cases will be a pass when data entry has been completed. Of the 18 exceptions 11 were adult acute and 4 in ICCR and 1 in older adults, 1 in Specialties and 1 in secure services. When Rio data entry has been completed this will increase compliance to 90.1%.

Detailed Commentary

CPA 7 day FU

June 2023

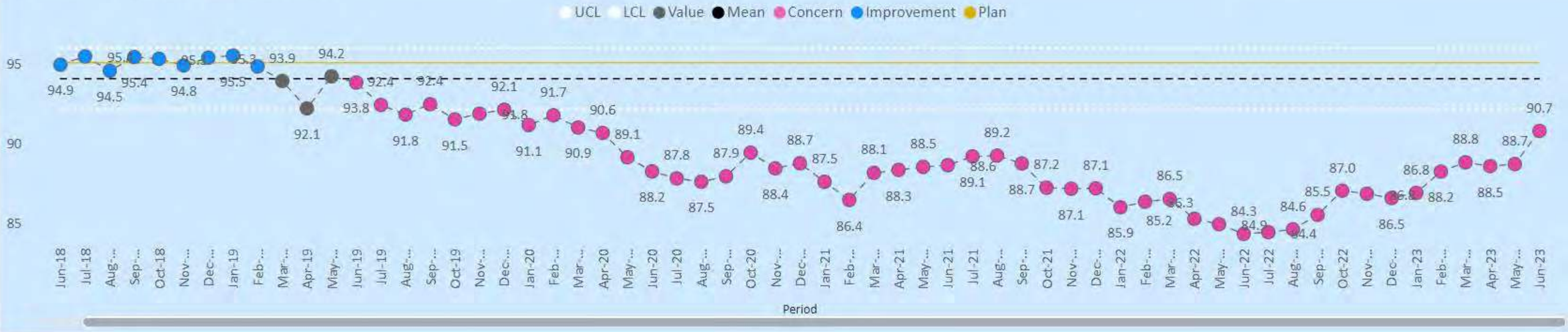
Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 84.8% for June 2023. June 2023 performance is below the target of 95%. This relates to 18 outstanding follow ups from 116 discharges in June of which, 2 patients were discharged to the care of FTB, 2 patients were discharged to another mental health trust, attempts were made to see 2 patients but were unsuccessful, 1 patient did not return from leave and has been subsequently taken into custody, 1 patient was discharged to prison, 1 patient was seen outside 7 days, 1 patient was not referred to HTT for follow up, and 8 cases will be a pass when data entry has been completed. Of the 18 exceptions 10 were adult acute and 4 in ICCR, 3 in Specialties and 1 in secure services. When Rio data entry has been completed this will increase compliance to 91.3%.
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 4/18 patients were discharged to FTB or another trust. Recording has been challenging for a number of months as a number of staff have undertaken bank shifts with teams they do not normally work in and therefore were not set up to record contacts. Teams have had additional support to rectify where this has occurred. Late data entry within services is also a factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD. There were 8 follow ups which are awaiting data entry in June.
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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	86.8%	88.2%	88.8%	88.5%	88.7%	90.7%
B: Acute and Urgent Care	14.3%	50.0%	100.0%	66.7%		100.0%
C: ICCR	85.1%	87.7%	88.5%	87.8%	88.5%	90.7%
D: Secure Serv & Offender Health	97.7%	98.4%	97.8%	97.8%	98.0%	97.8%
E: Specialties	82.5%	84.3%	82.6%	85.7%	76.6%	77.8%

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 May 2023 being sustained at 88.6%. Within divisions and teams there is variation in performance with between 1-34 reviews outstanding. 2 adult CMHTs have more than 30 reviews outstanding. ICCR and Specialties have a plan in place to increase performance back to 95% by October 2023. Older Adult CMHTs have a total of 32 outstanding and Adult CMHTs have 198 outstanding. Adult CMHT account for 49%, older adult CMHT for 4%, Secure for 16% and AOT for 25% of the total outstanding.

CPA with Formal Review last 12 mths

June 2023

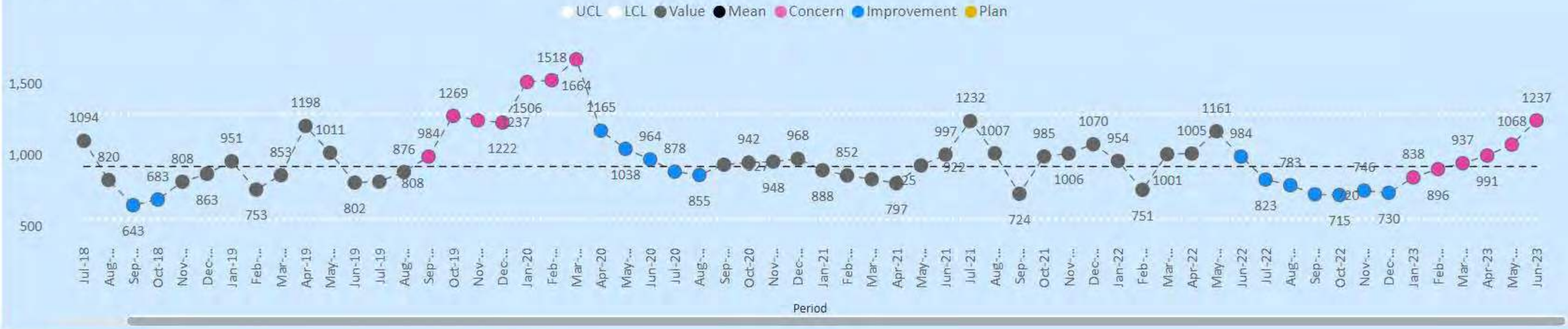
Question	Answers
A: What has happened?	The number of reviews taking place has consistently declined over the last year and has been outside control limits since July 2019. The rate was maintained at an average of 89% from April 2021 until October and then declined to 87%. November 2021 onwards showed an overall decline until July 2022, where the trend was reversed, and performance has started to increase with June 2023 increasing to 90.7%. Within divisions and teams there is variation in performance with between 1-30 reviews outstanding. Adult CMHTs now have only 1 team with 30 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 31 outstanding and Adult CMHTs have 157 outstanding which has reduced by 44 since last month. 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. 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.
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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	838	896	937	991	1068	1237
B: Acute and Urgent Care	106	399	532	557	485	562
D: Secure Serv & Offender Health	80	252	279	232	248	229
E: Specialties	72	245	126	202	335	446

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 has started to increase with May at 1068 days. This is due to an increase in older adults. Adults are waiting for further non acute NHS Care and older adults are waiting for nursing home placement.

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	5.4%	6.3%	6.0%	6.6%	6.8%	8.0%
B: Acute and Urgent Care	4.8%	6.6%	7.8%	8.5%	7.3%	8.6%
D: Secure Serv & Offender Health	3.9%	4.5%	4.5%	3.9%	3.9%	3.7%
E: Specialties	8.9%	9.9%	4.7%	8.1%	12.3%	16.3%

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 started to increase with May 2023 at 6.78%. Adults moved from 8.5% in April to 7.3% in May which related to 27 patients with a main DTOC attribution of NHS. Older adults moved from 8.6% in April to 14.6% in May which related to 16 patients and a main DTOC attribution of both health and social care. Secure care remained at 3.9% in May which related to 8 patients and specialties moved from 6.06% in April to 4.8% in May 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer Bed Days

June 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 has started to increase with June at 1237 days. This is due to an increase in both adults and older adults. Adults are waiting for further non acute NHS Care and older adults are waiting for nursing home placement.
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. These included the possibility of employing 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

June 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 started to increase with June 2023 at 8%. Adults moved from 7.3% in May to 8.6% in June which related to 31 patients with a main DTOC attribution of NHS. Older adults moved from 14.6% in May to 19.8% in June which related to 17 patients and a main DTOC attribution of both health and social care. Secure care moved from 3.9% in May to 3.7% in June which related to 8 patients and specialties moved from 4.8% in May to 4.7% in June 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. These included the possibility of employing 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 seen in 6 weeks

Divisions

Statistical Process Control (SPC)

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

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	35.8%	40.2%	40.8%	33.0%	41.1%	42.5%
E: Specialties	35.8%	40.2%	40.8%	33.0%	41.1%	42.5%

Commentary

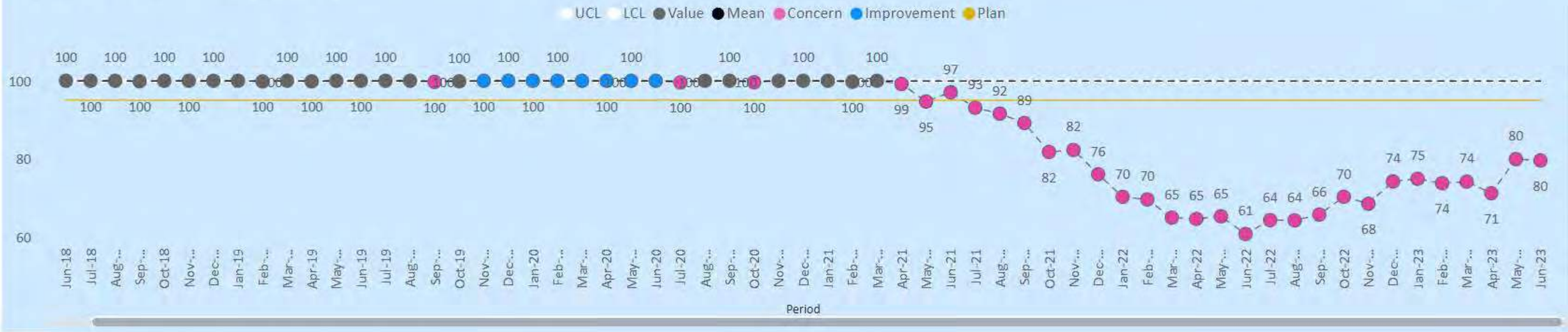
Performance has been on a reducing trend since March 2020 below the 75% target. July 2022 onwards has shown a steady increase until April 2023 which saw a decrease to 33%. May has increased to 41.1%.

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	74.9%	73.7%	74.2%	71.2%	79.9%	79.6%
E: Specialties	74.9%	73.7%	74.2%	71.2%	79.9%	79.6%

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 May showing a significant improvement at 79.9%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

June 2023

Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 below the 75% target. July 2022 onwards has shown a steady increase until April 2023 which saw a decrease to 33%. June has increased to 42.5%.
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.
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	The waiting times will be equal to or be above the 75% target.

Detailed Commentary

IAPT seen in 18 weeks

June 2023

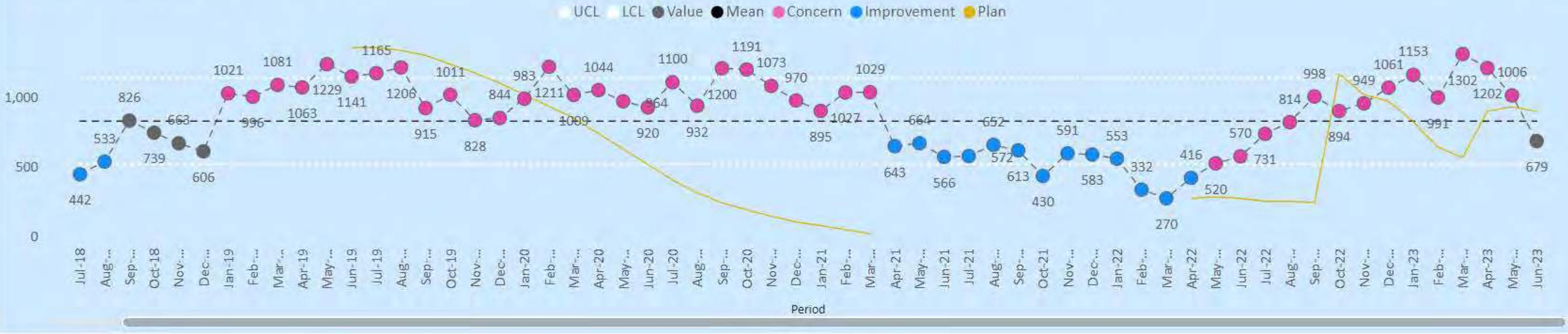
Question	Answers
A: What has happened?	Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 12 months. Levels have been increasing from July 2022 with Junes figures remaining at 79.58%.
B: Why has it happened?	The ability to see patients face 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 service also has a large number of vacancies following staff retirements. Significant challenges have been faced around retention with staff leaving to take further training, work outside of the NHS or moving to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. High intensity Therapist training is now only available in canterbury and requires staff to travel to Canterbury and London on regular basis and may not be attractive to staff
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. 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.
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 95% 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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	1153	991	1302	1202	1006	679
B: Acute and Urgent Care	1153	991	1302	1202	1006	679

Commentary

Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January 2022 at 575 bed days. Numbers started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease continued in March 2022 to 270 OOA bed days. April 2022 onwards saw a significant increase until March 2023 which has started to fall with May at 1006 days. This is due to the beds at Kings Norton being counted as appropriate as well as a larger number of discharges this month which has enabled a larger number of admissions to BSMHFT beds. There were 10 admissions to PICU beds and 5 to an acute bed.

There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 51 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

June 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. This is due to the increased bed capacity at Kings Norton being counted as appropriate. There were 6 admissions to PICU beds and 5 to an acute bed. The number of appropriate placements has remained at 37 for June 2023. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 36 OOA placements a reduction of 15 since May. 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 June 2023 is 893 OOA bed days and is under the target this month. From the 1st October 2021 NHSE have agreed a Standard Operating Protocol (SOP) with the Trust to enable 10 Priory acute beds based in Willenhall to be classified as 'appropriate placements', in addition to the same classification for the MERIT beds. It has also been agreed by NHSE that any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements' from the 1st January 2022. Internal reporting and commissioner reporting from 1st October 2021 has been amended to reflect these changes. NHSE have also agreed that up to 10 patients admitted to an acute bed at the Active Care Group in Kings Norton from February 2023 will also be classed as 'appropriate placements' and internal reporting reflects this change (backdated to February 2023). However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHS Digital currently does not recognise the bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The increases over the last 10 months are a combination of a number of issues and risks. Taking into account the procurement of 22 additional beds with the Priory (12 PICU and 10 acute beds)and the 10 acute beds at Kings Norton, 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, however there were a higher number of discharges in the month which has enabled a higher level of admissions. 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 reduced in June but still accounted for 562 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

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

June 2023

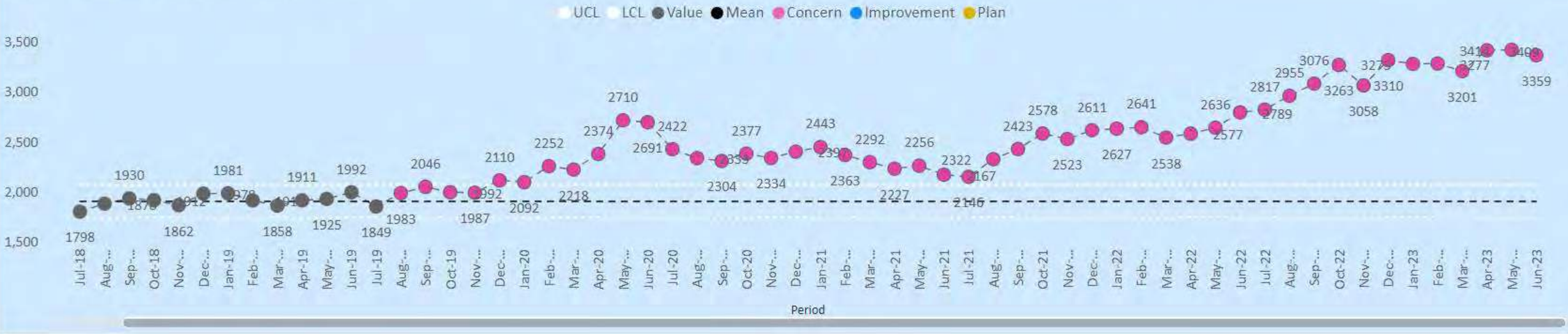
Question	Answers
	acute beds)and the 10 acute beds at Kings Norton, demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. It has been highlighted that those placed outside the locally agreed additional beds experience a longer length of stay. Length of stay within BSMHFT beds has continued with high acuity and high levels of observations required, however there were a higher number of discharges in the month which has enabled a higher level of admissions. 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 reduced in June but still accounted for 562 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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	3273	3277	3201	3409	3414	3359
C: ICCR	1630	1527	1419	1312	1303	1207
D: Secure Serv & Offender Health	130	126	120	119	127	140
E: Specialties	1585	1585	1618	1679	1731	1802

Commentary

The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular.
The number of patients who have not been seen after 3 months of referral has shown an increase from August 2021 reaching a peak in in May 2023 of 3414. This measure has been above the upper control limit since December 2019.
The number of referrals not seen within 3 months of referral has decreased in SOLAR but has increased in Memory Assessment, older adult CMHTs, CAMHS primary mental health and Oaks group therapy programmes.
Neuropsychiatry service accounts for 23% and Adult CMHTs 23% of referrals open for over 3 months without a contact.

Detailed Commentary

Referrals over 3 mths with no contact

June 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 June 2023 at 3369. This measure has been above the upper control limit since December 2019. The number of referrals not seen within 3 months of referral has decreased in SOLAR,CAMHS Primary Mental health and OAKS group therapy programmes, but has increased in Memory Assessment and Forensic CAMHS Community. Adult CMHTs have remained at 792 referrals. Neuropsychiatry service accounts for 23% and Adult CMHTs 24% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts have reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. Based on available research, it is expected that the backlog of service users not seen or choosing not to access services during the Covid period together with new demand arising as a result of the impact from Covid -19 will result in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. This indicator also relies on teams outcoming appointments on Rio and work is being undertaken with services on an ongoing basis to reduce the number outstanding. ICCR: have undertaken a deep dive of those with longer waits and have identified that there are a number with future appointments in place. Where there were no appointments a number themes were highlighted which has shown that a number are transfers from another BSMHFT/FTB team so are still actively under these teams, a number are recurrent DNAs and that actions from MDT are not followed through e.g. discharging patients. Regular caseload reviews not taking place as frequently as needed due to staff capacity issues. Specialties: We currently have an aging population and better awareness of mental health concerns within the population and at primary care level. This has led to a consistent increase in number of referrals to our Older Adult CMHT, particularly for patient with dementia, but has not been accompanied with any increase in the Older Adult CMHT workforce. Caseloads of care coordinators are currently high (some CPNs have 50+ against an ideal maximum of 35) reducing CPN capacity to see new assessments and take new patients on. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There are discrepancies in medical workforce numbers between the teams causing higher waits for medical outpatient clinics in some teams. There is also a significant number of patients in care homes where, due to pandemic restrictions, our service was unable to see or communicate with directly however, through carers were able to provide consultation and commence treatment, however these have remained on the waiting list. For all service it is important to note that where patients DNA, they are likely to have been provided with an appointment within 3 months - this is a particular issue for perinatal patients where due to having an infant patients frequently cancel or DNA appointments prior to eventually being seen. In bi-polar service, patients will already be under a CMHT in order to access their service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred.
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service

Referrals over 3 mths with no contact

June 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: 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 BSOl Primary care Networks. The aim is to work towards reducing the wait for first appointment, with a 20% reduction in those not seen within 18 weeks by October 2023. Within older adult CMHTs we expect there to be some improvement in waiting lists, however staffing in Solihull is challenging and will affect their ability to improve. The service however expects any improvement to be limited across the service due to the small number of patients suitable for community transformation development and the rising demand for dementia care in secondary services, with no additional funding in this area. January and March 2023 have seen the highest levels of referrals to older adult CMHTS in the last 3 years. It is unlikely that Neuropsychiatry waiting times will be improved.
F: How will we know when we have addressed issues?	Where national access standards are in place e.g. Eating Disorders, First episode psychosis, these are consistently met by services. For adult and older adult community services success will be meeting the national 4 week target which has yet to be formally introduced. The delivery of this standard is part of the community services transformation work plan and planned revised pathways to support service users.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Vacancies

Divisions

Statistical Process Control (SPC)

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

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	13.0%	12.3%	11.5%	11.8%	12.2%	12.2%
B: Acute and Urgent Care	10.5%	10.9%	12.1%	13.3%	13.4%	14.3%
C: ICCR	18.5%	16.8%	16.1%	15.3%	14.6%	12.2%
D: Secure Serv & Offender Health	10.7%	10.2%	14.1%	14.7%	14.7%	14.8%
E: Specialties	11.1%	10.6%	11.1%	12.3%	13.3%	14.9%
F: Corporate	10.9%	10.1%	0.5%	-0.4%	1.4%	1.1%

Commentary

The vacancy rate in May has increased to 12.2% by 0.4% and is above the KPI target of 6.0%. In April, new budgets were set and additional budget provided to the Trust allowing growth in our establishment. This large increase reflects the new allocation of additional budget.

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

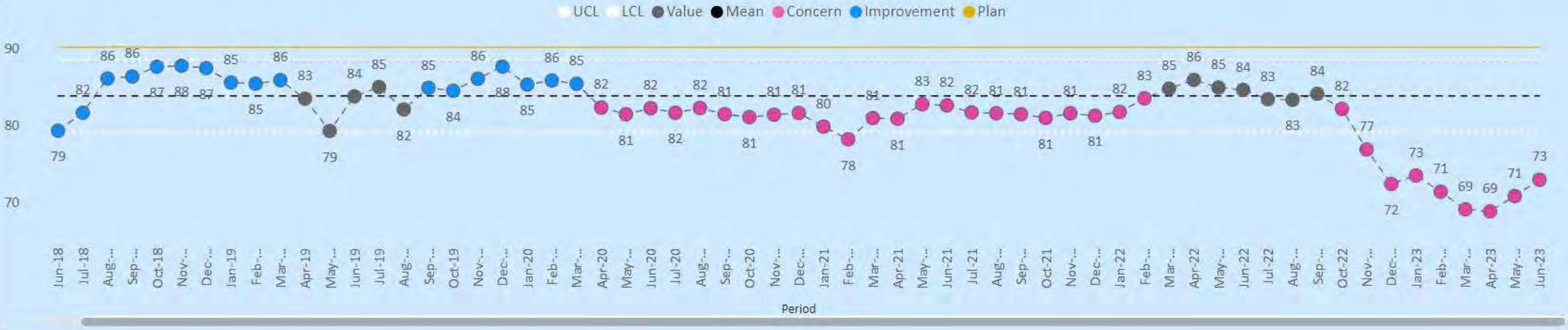
Acute and Urgent Care – 13.9%,
Chief Executive Locality – 15%,
Exec Director - Medical Locality – 5.3%,
Exec Director - Nursing Locality – -1.4%,
Exec Director - Resources Locality – -4%,
Exec Director - Strategy People and Partnerships Locality – -5.2%,
ICCR – 14.9%,

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	73.4%	71.3%	69.0%	68.8%	70.7%	72.9%
B: Acute and Urgent Care	64.6%	55.2%	54.8%	53.9%	55.6%	56.8%
C: ICCR	77.0%	75.8%	74.6%	73.8%	74.8%	80.3%
D: Secure Serv & Offender Health	76.4%	77.5%	75.3%	75.1%	79.0%	80.5%
E: Specialties	77.2%	75.7%	72.6%	75.4%	77.9%	78.1%
F: Corporate	70.6%	69.7%	64.5%	61.6%	61.1%	63.4%

Commentary

Appraisal rates have increased from 66.9% to 70.9% at the end of May. The appraisal rate had been maintained consistently above the 85% CCG target from November 2019 to March 2020, however fell below this in April 2020 due to the impact of Covid-19. The appraisal rate breakdown by division for May is as follows:

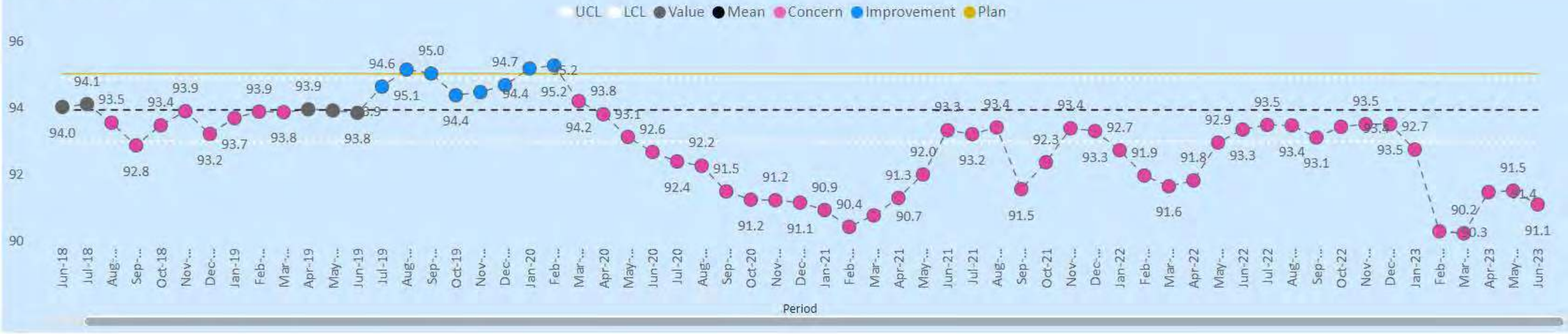
Acute and Urgent Care – 54.4%,
Chief Executive Locality – 60.0% ,
Exec Director - Medical Locality – 75.3%,
Exec Director - Nursing Locality – 57.8%,
Exec Director - Resources Locality – 61.5%,
Exec Director - Strategy People and Partnerships Locality – 49.4%,
ICCR – 76.2%,
Specialties – 78.0%
Secure Services and Offender Health – 78.7%

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	92.7%	90.3%	90.2%	91.4%	91.5%	91.1%
B: Acute and Urgent Care	90.6%	89.2%	89.4%	89.4%	89.9%	89.3%
C: ICCR	93.9%	91.6%	91.4%	91.9%	91.2%	90.9%
D: Secure Serv & Offender Health	93.2%	91.9%	91.8%	92.0%	92.9%	92.2%
E: Specialties	93.7%	91.9%	91.5%	92.7%	92.4%	91.2%
F: Corporate	93.8%	92.5%	93.8%	91.1%	90.5%	91.7%

Commentary

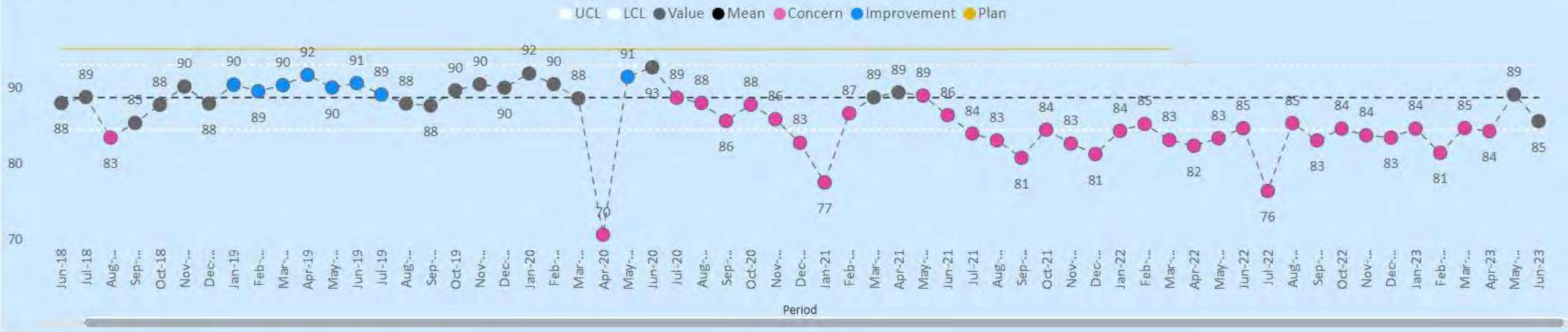
Substantive staff (Trust Target 95%, Commissioners Target 90%))
Overall, Trust's Fundamental Training compliance figure slightly increased from 91.4% in April 2023 to 91.5% in May 2023.
FT breakdown by division:
- Chief Executive Locality – 76.8%,
- Exec Director - Medical Locality – 94.2%,
- Exec Director - Nursing Locality – 91.4%,
- Exec Director – Operations
  - Acute and Urgent Care – 90.1%,
  - ICCR – 91.1%,
  - Secure Services and Offender Health – 92.9%

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	84.5%	81.3%	84.6%	84.1%	89.0%	85.5%
B: Acute and Urgent Care	85.3%	81.8%	81.3%	81.0%	87.7%	84.0%
C: ICCR	96.7%	91.4%	93.1%	90.6%	94.9%	91.1%
D: Secure Serv & Offender Health	72.0%	69.5%	78.5%	76.3%	81.7%	76.5%
E: Specialties	89.1%	85.7%	85.8%	90.0%	92.4%	90.7%
F: Corporate	98.2%	97.8%	99.5%	98.7%	98.9%	98.0%

Commentary

The bank and agency fill rate increased to 89% in May from 84.2% in April. 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 – 88.1%,

ICCR – 95.1%,

Specialties – 92.4%,

Secure Services and Offender Health – 81.7%

The number of shifts requested in May decreased by 282 compared to April.

Bank filled 540 more shifts in May than April, and agency filled 108 more shifts. The breakdown of shifts requested by division is as follows:

Acute and Urgent Care – 5,971

ICCR – 2,602

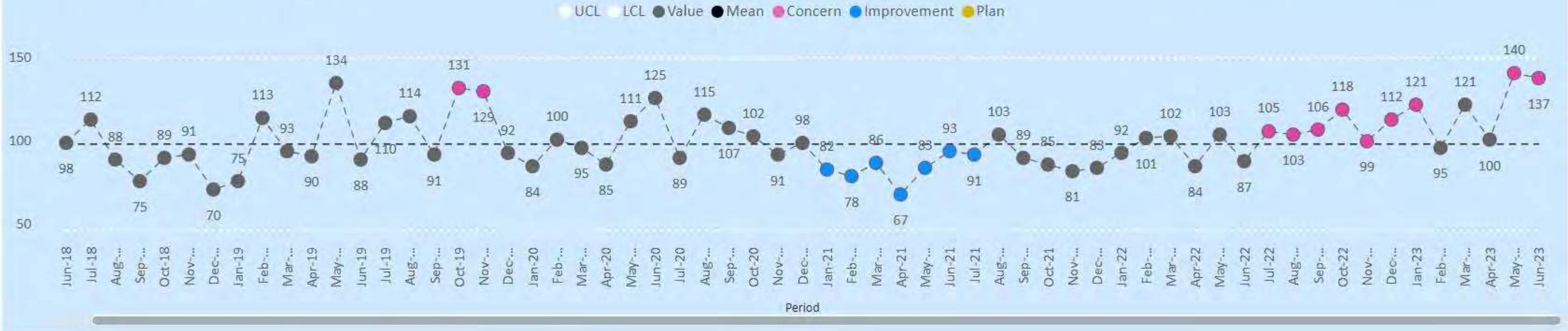
Specialties – 3,059

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	121	95	121	100	140	137
B: Acute and Urgent Care	63	57	85	68	88	84
C: ICCR	5	2	5	7	3	2
D: Secure Serv & Offender Health	12	12	19	12	26	13
E: Specialties	41	24	12	13	23	37

Commentary

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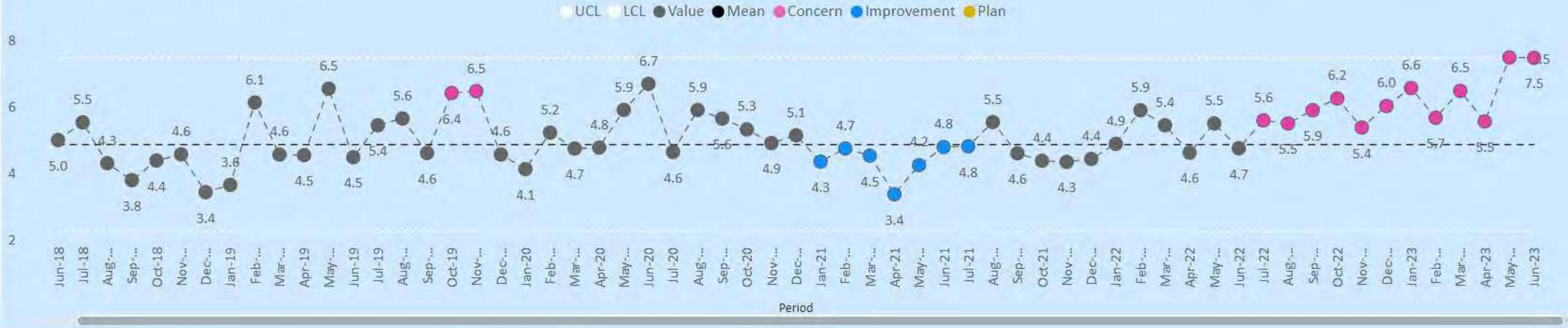
Birmingham and Solihull Mental Health NHS Foundation Trust

Staff assaults / 1000 OBD

Divisions

Statistical Process Control (SPC)



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

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	6.6	5.7	6.5	5.5	7.5	7.5
B: Acute and Urgent Care	9.2	9.4	12.4	10.3	13.2	12.9
C: ICCR	1.9	0.8	1.8	2.6	1.1	0.8
D: Secure Serv & Offender Health	1.9	2.1	3.0	1.9	3.9	2.0
E: Specialties	15.8	9.6	4.5	5.2	8.4	13.4

Commentary

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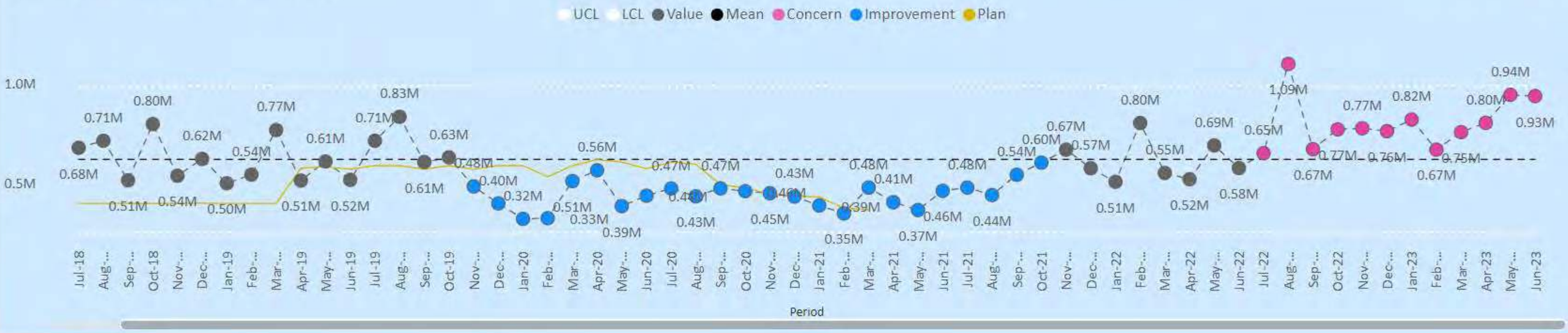
Birmingham and Solihull Mental Health NHS Foundation Trust

Monthly Agency

Divisions

Statistical Process Control (SPC)



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

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	£817k	£668k	£755k	£801k	£941k	£935k

Commentary

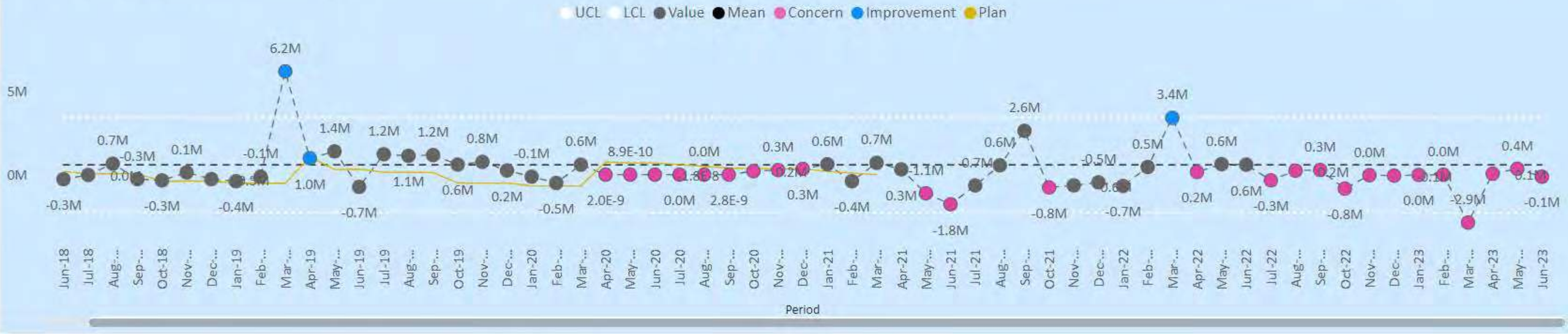
There has been a increase in agency spend from c. £801K in April to c. £941K in May.

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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	-£16k	-£7k	-£2,873k	£59k	£352k	-£122k

Commentary

YTD deficit of £411k against plan of breakeven

Operating Surplus

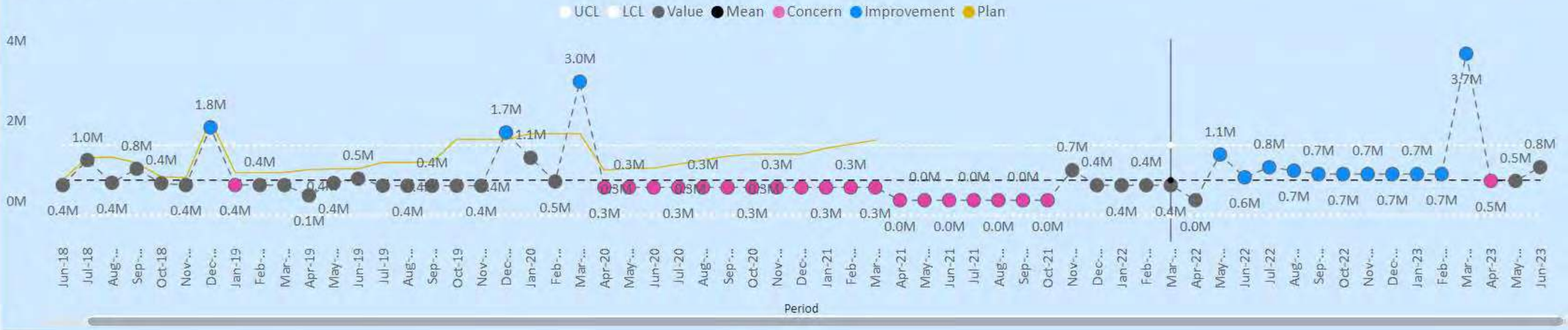
June 2023

Question	Answers
A: What has happened?	YTD deficit of £287k against plan of breakeven, but significantly improved 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

CIP

Divisions

Statistical Process Control (SPC)



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

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
A: All	£656k	£656k	£3,662k	£483k	£483k	£825k

Commentary

YTD efficiencies are £1.8m against £3.7m plan.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

CIP

June 2023

Question	Answers
A: What has happened?	YTD efficiencies are £1.8m against £3.7m plan.
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

Birmingham and Solihull Mental Health NHS Foundation Trust

Trust Board August 2023

Performance metric trajectory updates

Trust Performance Metrics

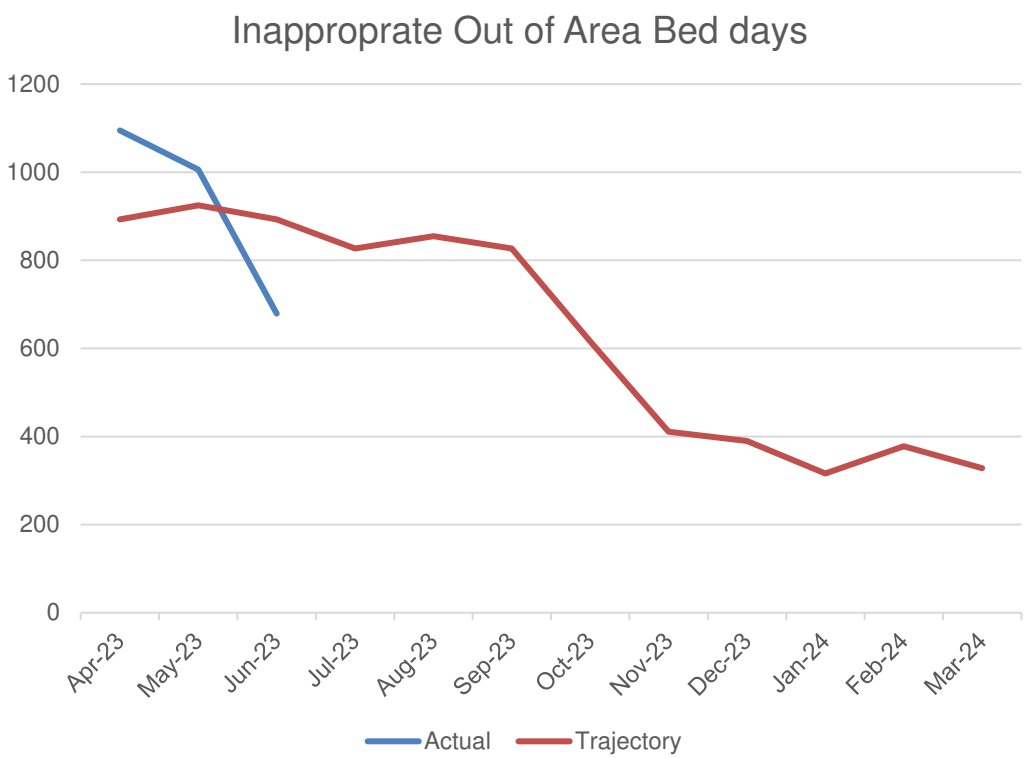
At the February 2023 FPPC meeting, members requested an update on the performance for the following metrics in line with the plans and trajectories already provided:

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



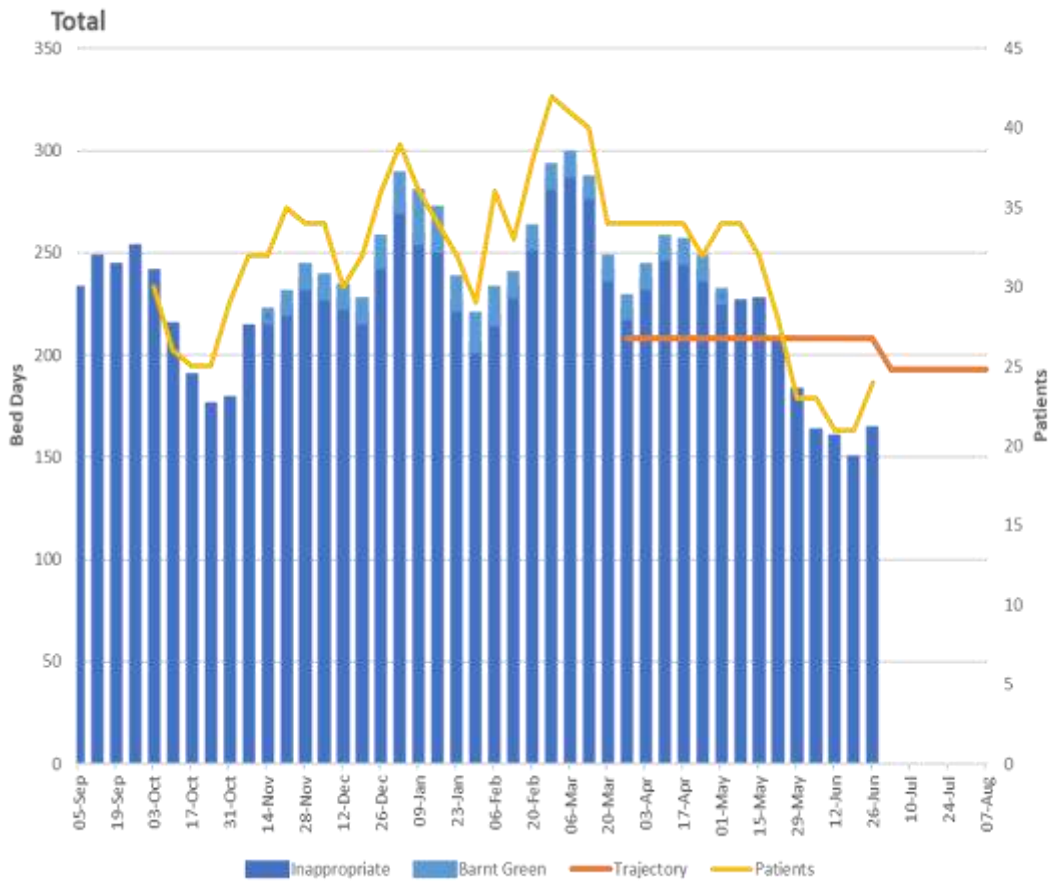
Inappropriate Out of Area trajectories have been agreed as part of the national planning round for 2023/24. The aim is to reach 328 bed days in March 2024.

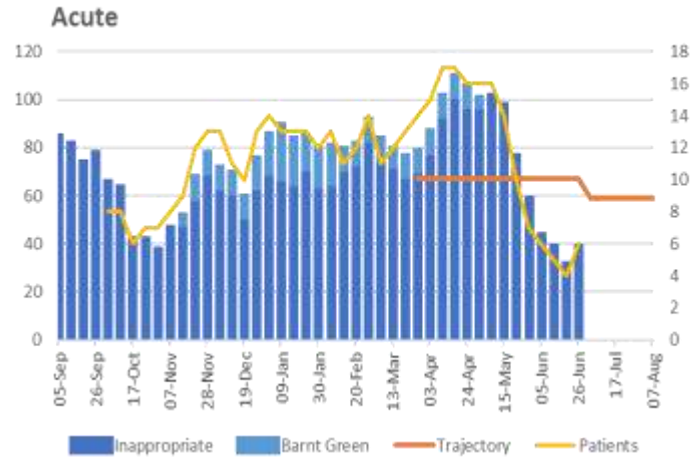
The action plan to transform the acute & urgent care pathway will focus on 4 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 4 workstreams are :

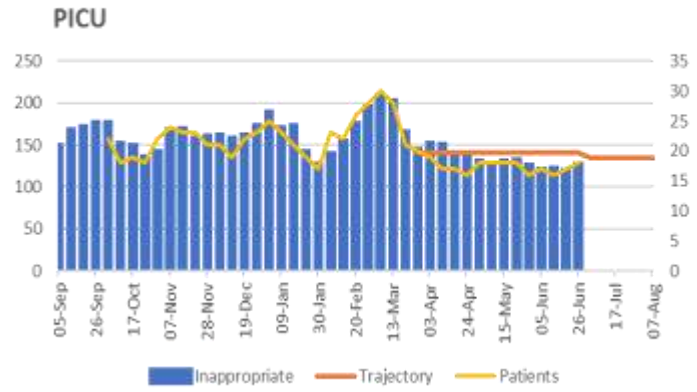
1. Demand Management
2. Reducing Length of Stay/DTOCs
3. Optimise capacity
4. Locality model development

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 currently below trajectory. See slide below for detail on acute and PICU position.

2. Inappropriate Out of Area Bed Usage - BSMHFT



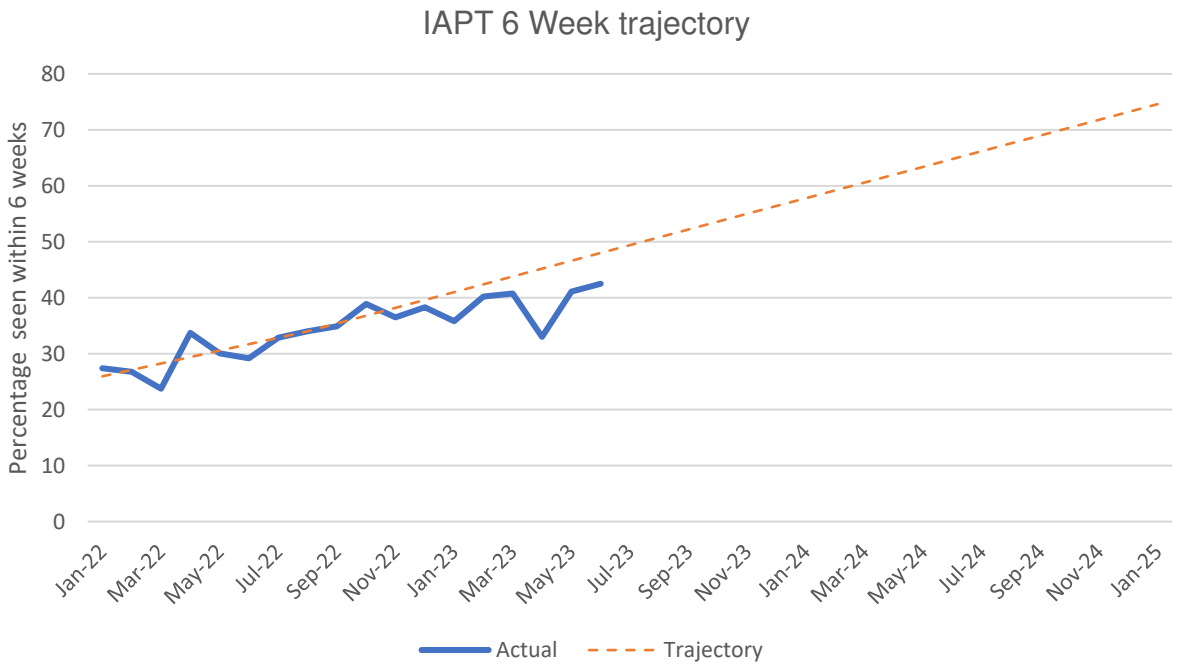


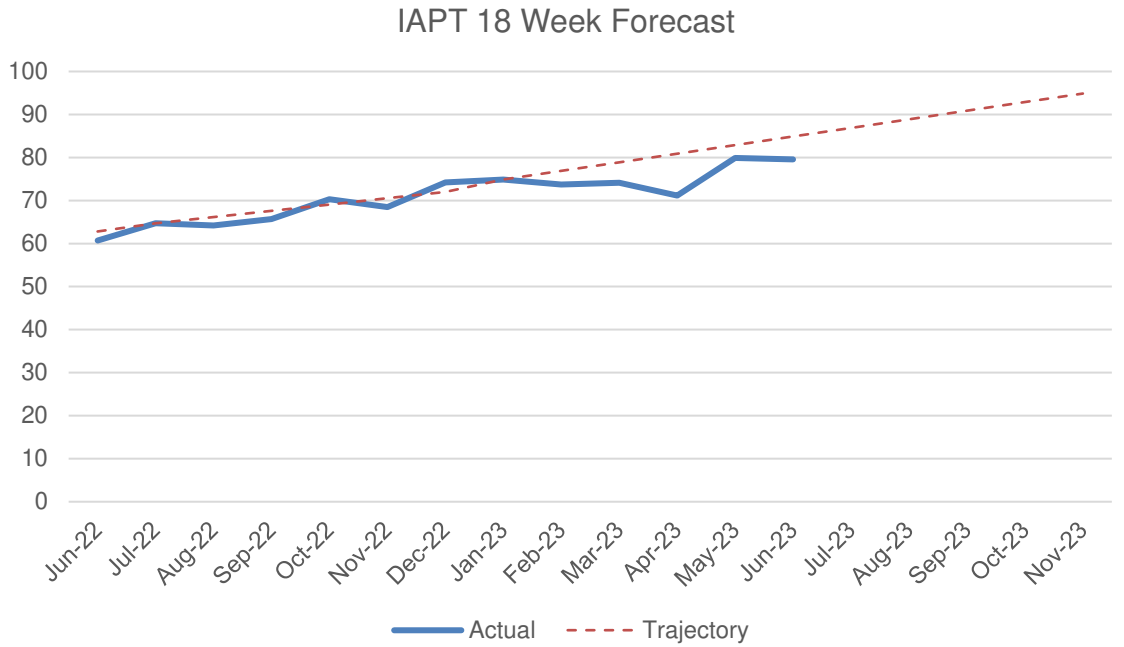


- Despite an increase in acute bed usage this week, there is continuing positive performance in both acute and PICU inappropriate out of area bed usage, both running ahead of the trajectories
- Barnt Green bed usage (most recently in early May) is still classified as inappropriate pending clarification and shown in light blue on the charts

Talking Therapies waiting times 6 &18 weeks

Birmingham and Solihull Mental Health NHS Foundation Trust





The aim is to reach the 75% target by January 2025.
June 2023 performance at 42.5% which has shown a slight improvement but remains below trajectory.

Trajectory provided by Associate Director for Specialties

The aim is to reach the 95% target by November 2023.
June 2023 Performance at 79.6% below trajectory.

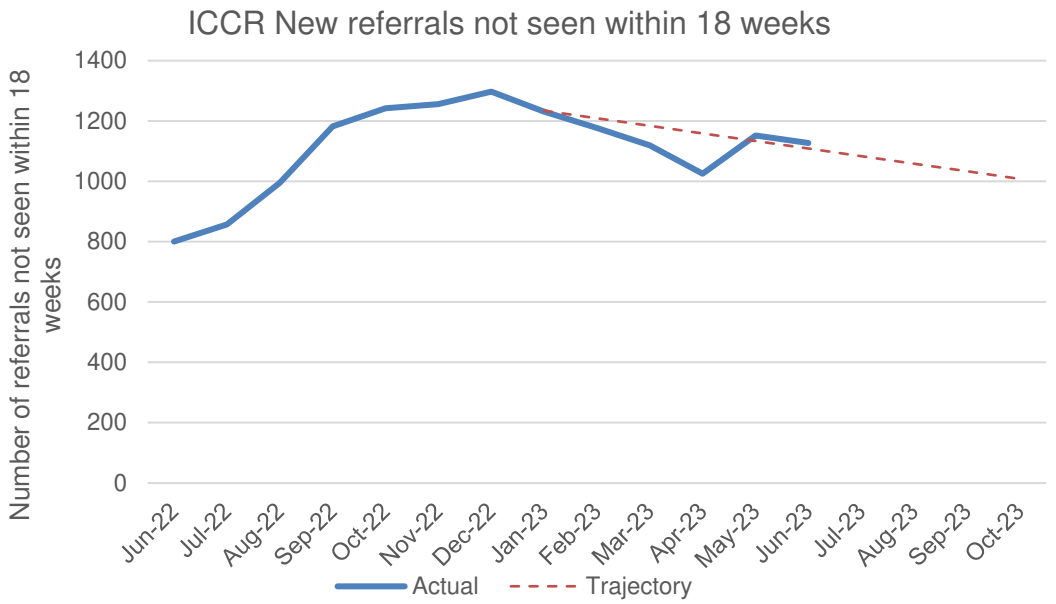
compassionate inclusive committed

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 has progressed with 5 new staff having commenced with a further 13 planned to commence 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.
- Recruiting timeframes 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.
- Additional capacity (150) for assessment and treatment has been sourced through Xyla (a 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 due to commence 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.
- 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. June 2023 at 1127 above the trajectory of 1108.



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

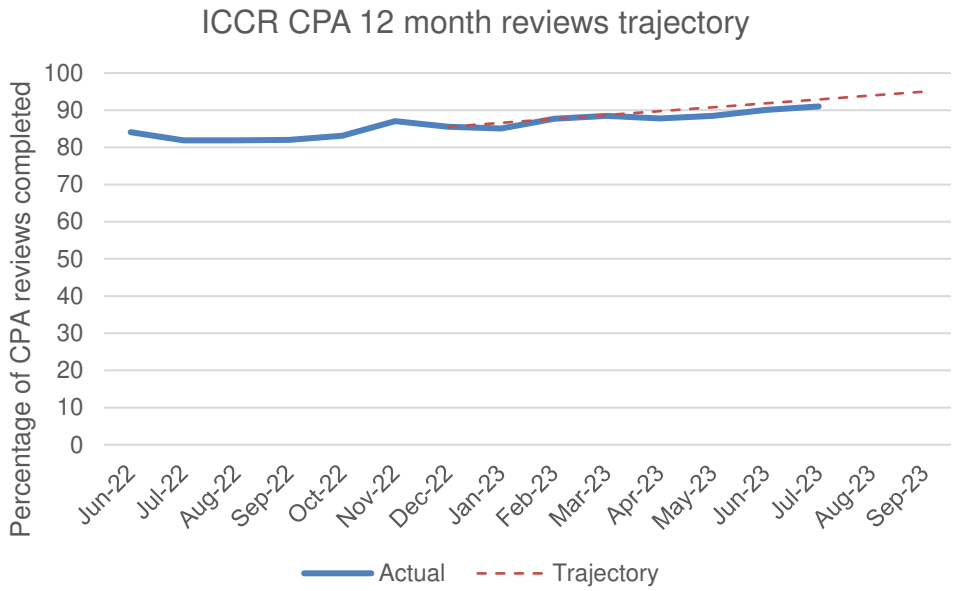
Older adults CMHTs – In line with the report submitted to February FPPC and discussed in detail at the Specialties Deep Dive meeting on 4th May, the service is facing significant challenges including high caseload management and long-term consultant and qualified nurse vacancies impacting on the ability 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.

The service continues to face significant challenges with the increase in the number of referrals, high caseloads and vacancies within the directorate. 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 with 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

Birmingham and Solihull Mental Health NHS Foundation Trust



ICCR performance for June at 91%

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.

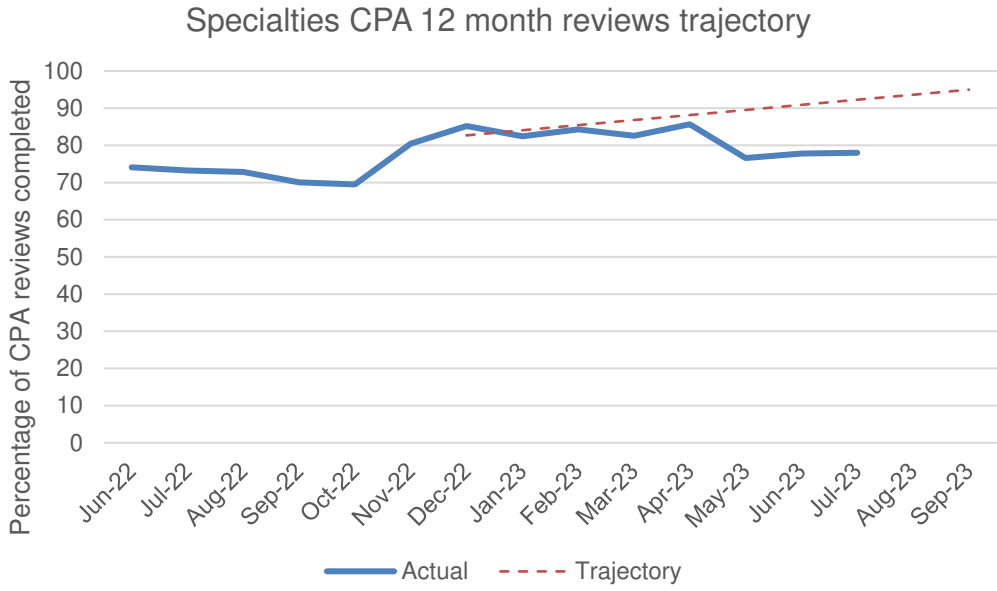
The CMHT in Solihull is experiencing significant staffing challenges and currently has only 1 CPN and staffing will not improve until September so outstanding reviews will be a challenge in the medium term.

Note - Trajectory position provided by Associate Directors for Specialties and ICCR

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 12 month reviews

Specialties performance for June at 78% O**lder adults** CMHTs – Improvement trajectory to achieve 95% by the end of September 2023. However, it should be noted that the significant staffing challenges especially within Solihull CMHT which has four band 6 vacancies. Agency staff have commenced and in the process of managing caseloads. Team managers have been asked to review outstanding CPA reviews in caseload supervision to ensure that the service user is on the correct level of care. Demand and capacity issues remain challenging.



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 June 2023 at 84.48% - 4/18 service users were discharged to other trusts (including FTB) and 8 follow ups have been completed but awaiting data entry, once confirmed this will take the compliance level up to 91.38%

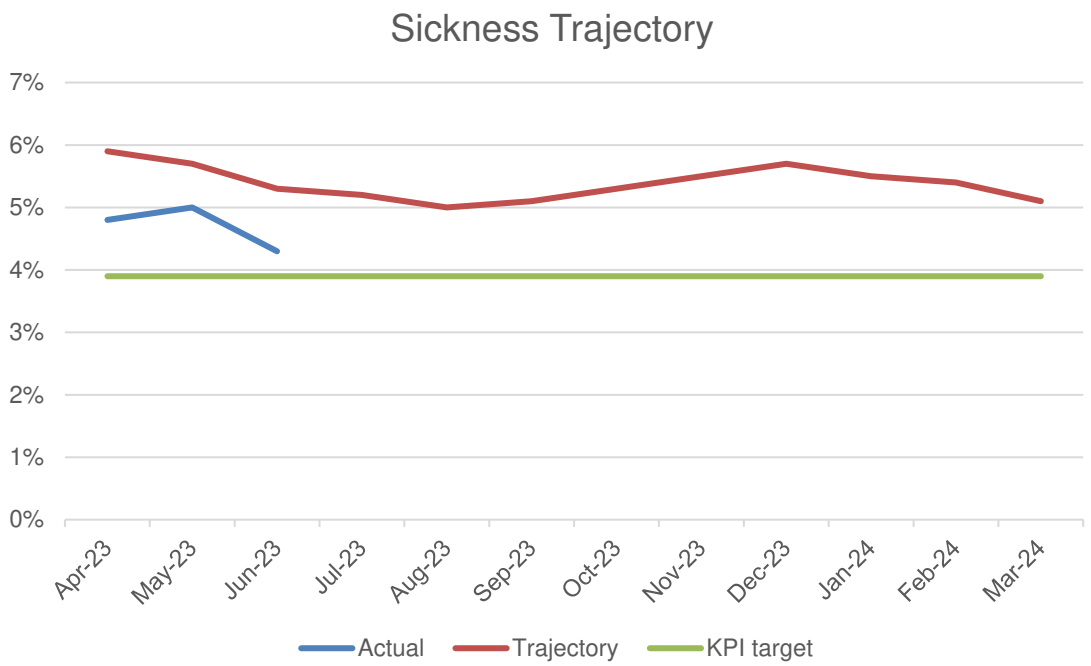
Note – Commentary above provided by the AD for Performance & Information

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories

The workforce trajectories commenced in April 2023

Sickness Absence



Note - Trajectory provided by People team

Sickness for June decreased to 4.3% below the trajectory of 5.7%. There has been a decrease in short-term sickness to 1.54% with long term sickness showing a small reduction to 2.77%.

- The new Health, Wellbeing and Attendance Policy has now been ratified through Transforming our Culture and Staff Experience Committee. An associated toolkit and training package are being finalised. The policy and toolkit will be made widely accessible for managers to download from Connect.
- The training element will form part of the overall First Line Management training package with dates to be published in August.
- 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.

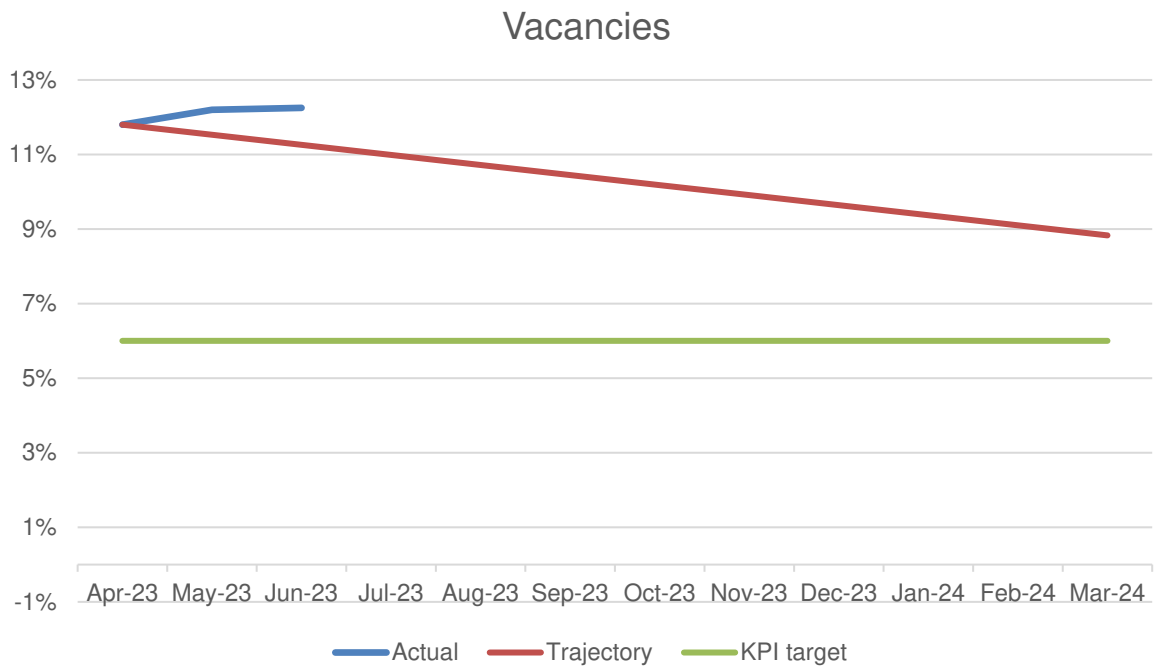
Sickness absence

- 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.
- 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

Vacancies



Note - Trajectory provided by People team

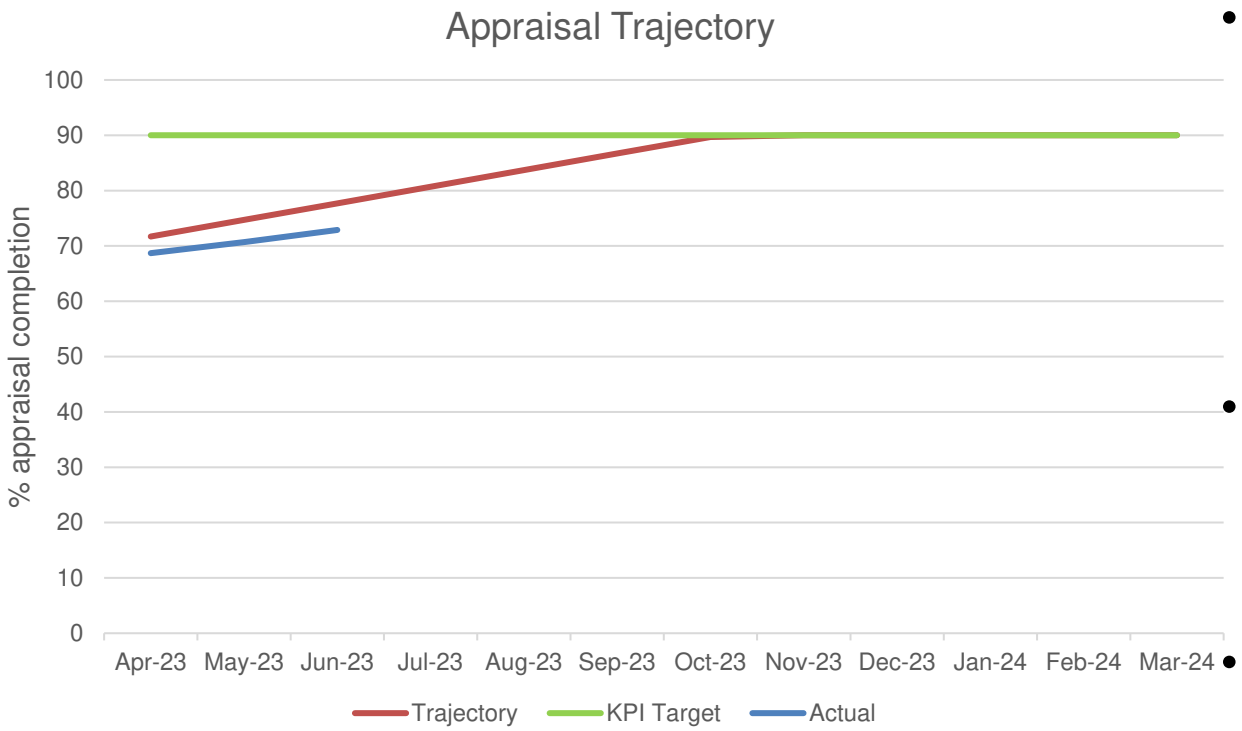
The HR lead has confirmed that the target for 2023/24 has been agreed for a 3% reduction in vacancies over the year. With a trajectory starting at 11.8% and moving to 8.8% by March 2024. The KPI target is 6%. June at 12.25%

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 September. 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.

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 is being held during week commencing 17th July 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.

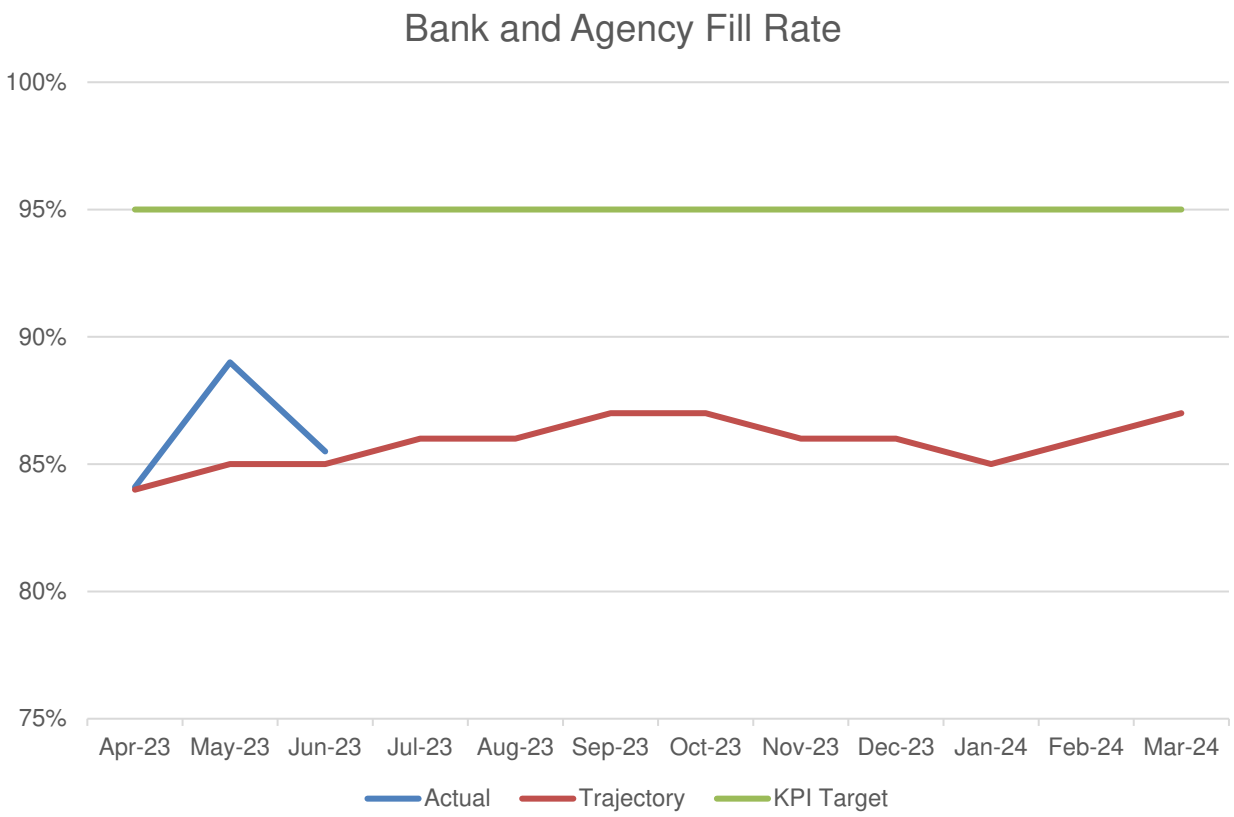
Appraisals



Note - Trajectory provided by People team

- Appraisals at 72.9% below the trajectory of 70.7% for June 2023.
- A new appraisal system has been recently introduced which has had an impact on performance. This also means that appraisals during this year will be recorded in 2 different systems which makes monitoring challenging.
- 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.
- In terms of next steps L&D will maintain targeted and supportive interventions to areas that have below 75% compliance.
- L&D and the ESR are in the process of producing a plan in support of increasing the efficiency of smart card access.

Bank and Agency fill rate

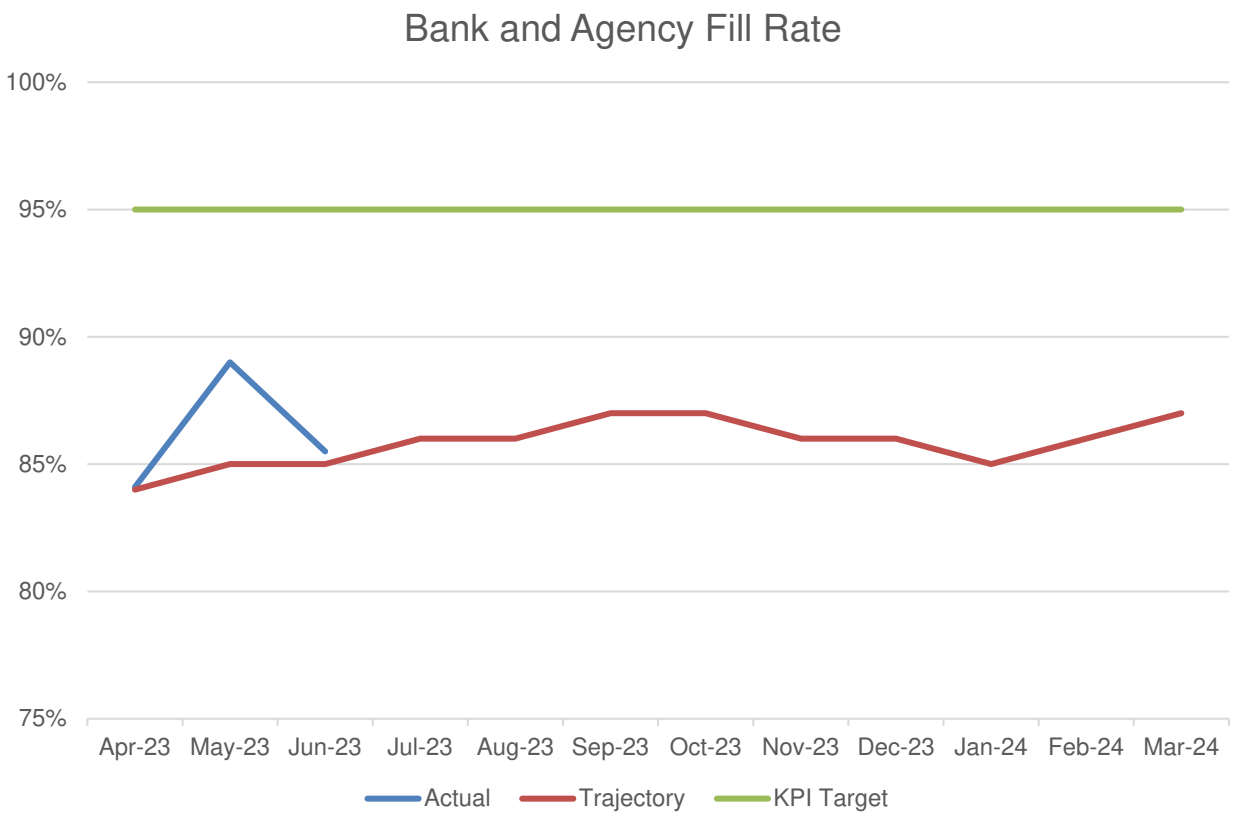


Note - Trajectory provided by People team

Bank and agency fill rate has decreased to 85.5% above the trajectory of 85% for June 2023.
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 plan 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



Note - Trajectory provided by People team

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.

In June 48 bank workers started with the trust.

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- There has been a decrease in agency spend from c. £941K in May to c. £935K in June. In June 48 bank workers started with the trust, alleviating the need for agency.
- A detailed agency reduction plan 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 plan) are the expediating and streamlining of the TSS bank worker to substantive process and the reduced reliance on block bookings. Other proposals include Executive sign-off being required for all future block bookings (currently 80% of all expenditure via TSS is block bookings) and potentially giving areas 6 months' notice that HCA's via agency will no longer be permitted - only 2.29% of all TSS shifts are for agency HCA's, which equates to 3.83 WTE's. BSMHFT spent over £250k last financial year on this however so it would provide a "quick win".
- 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.
- In June 48 bank workers started with the trust, alleviating the need for agency.

8.5. Summerhill Services Limited Business Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**8.5**		
Paper title	Summerhill Services Limited (SSL) Business Report		
Date	2 August 2023		
Author (s)	Shane Bray		
Executive sponsor	Dave Tomlinson		
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:

The report highlights the financial and operational performance of SSL. The key areas to note are:

- Developments across all SSL FM services provided to the Trust
- Development and progress of Summerhill Pharmacy
- Development of our external services – ICS and Primary Care
- New commercial opportunities

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

For information and 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)

At which other meetings has this report been previously discussed or presented?

Strategic priorities (which strategic priority is the report providing assurance on)
PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users
Financial Implications *(detail any financial implications)*
Group financial position

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
None
Equality impact assessments:
None
Engagement *(detail any engagement with staff/service users)*
None
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).	

Summerhill Services Limited (SSL) Business Report

April 2023– June 2023

This report summarises the performance and activities of SSL from April 2023 to June 2023.

The first quarter of the year has been very busy, maintaining services across the Trust, implementing numerous capital and back log maintenance projects. SSL continues to develop new services for the trust, including the management and distribution of all Trust staff uniform.

SSL external revenue and opportunities continue to develop, as we support the BSOL ICS, Birmingham Primary Care with over 270 GP's and the development of our patented PFI Healthcheck with initially 4 NHS organisations in Staffordshire, London, Gloucestershire, and West Midlands.

SSL can't overstate the importance of our hard working and dedicated staff. We recognise how important it is to retain, develop and recruit our staff. As result, SSL has continue to implement new initiatives to recruit and engaged with our staff. SSL has successfully implemented a " Refer a Friend" program and supported a number of external recruitment day events. This has resulted in an increase in substantive posts and reduction in agency/ temporary staff. Staff engagement continues to improve with the introduction of a Weekly and Bi Monthly news letters and we are starting our next rounds of business briefing sessions for all staff. Development is also key and SSL will be introducing a SSL Futures program, which combines an apprenticeship and graduate program.

Our Pharmacy Services continues to perform well, providing compliance aids and prescriptions to all Trust community teams. With our compliance aid robot getting a bit older, we are looking to invest in a new upgraded robot, which may include automatic checking feature. The automatic checking feature, should ensure even greater accuracy and enable more trust pharmacy staff to focus on other tasks.

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Review April 23 to June 23

Facilities Management

Domestic and Housekeeping Services

The successful implementation of the New National Cleaning Standards has been completed, but recruitment is still underway.
Cleaning Quality Operational Group developed members comprising Infection Prevention and Control Team, Matrons and Service Partners, SSL and Amey Community Ltd, This group reports into the Infection Prevention Partnership Committee (IPPC).
Cleanliness is continually quality monitored through our FM (Facilities Management) systems and audit processes

Catering Services

Master Catering Programme 23/24 project group has commenced, the programme of works includes:

- New 4 weekly menu and recipe book – recipe book has been compiled; menu is being worked on by the team with the support of the temporary dietician.
- Implementation of new food management and tablet-based ward ordering software. – Implementation plan formulated.
- Re branding of all SSL managed cafeterias.
- Review of internal retail pricing underway across all sites
- Revised and enhanced loyalty card scheme.
- Production of Master Catering Folder is underway.

The EHO inspected The Barberry and Reaside with both achieving a 5 star rating.

SSL have been working collaboratively with NHS Supply Chain; Food (Tower 10) integrating the Multi-Temperature Distribution model to achieve value for money.

SSL is continuing to provide compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS “Plastic Pledge”.

Laundry and Linen Management

We continue to work with, audit and manage the Trust wide supplier for laundry and linen Elis.
Regular contract, service quality and performance meetings are conducted by SSL, the Trust and PFI Partners with the supplier.

- On January 2023 Trust received notice from Elis that the contract ended March 31st 2023.
- Multiple meetings have been held with SSL / Trust procurement teams to review position but the only viable option was to extend the contract with Elis.

- Elis responded with a request to alter the KPI's of the contract and also proposed an uplift in costs of 39.1%.
- Discussions and negotiations are ongoing between all parties With Elis unwilling to accept current contract KPI's.
- Initial discussions held with a new supplier Oxwash and procurement who are on a national NHS framework agreement, initial costing appear favourable, further meetings ref contractual terms and KPI's progressing.

Grounds and Gardens

- Ground Control have now replaced Goulds Landscapes across North PFI and Retained estate.
- Tree surgery works have been scheduled and underway across multiple sites.
- Trust Strategic Property Group planned; SSL will play key roles.
- SSL developed and issued Sustainable Development Strategy and Action Plan (Green Plan) on behalf of BSMHFT.
- SSL have developed B1 Options proposals and have appointed Management Surveyors to carry out multi-million vacation negotiations, looking for Trust early exit from their lease obligations.

Transport & Logistics

- Non Urgent Patient Transport (NEPT) – expansion of NEPT core hours from 06:00 am to 22:00 is still in process, Business case is submitted. Trust advise to run it for 12 month trial, business case will be presented to the board.
- 3 new electric General Routes vehicles were delivered in June, and 1 electric classroom vehicle for the BSMHFT, making a total of the 70 vehicles in the fleet with 11 of them being electric and 1 hybrid.
- Tissue Viability Products, Contract for 6-month Trial is agreed and signed. With start date 31 July 2023. Trial will determine resource need to run the service.
- SSL Warehouse – Warehouse is operating from SSL HUB. AS well as SSL staff being based at the HUB, we will also have Birmingham Community Hospital with their PPE operation and medical equipment plus the Trust ICT team, who will operate from a purpose built offices providing new device and support to all trust staff.
- Current Warehouse Provision:
    - PPE, Trust Uniforms,
    - SSL Uniforms,
    - Covid tests,
    - Other Stock: Blood pressure monitors, Recycling Bins, Ecig Bins, Food Bins and sharps bins, Physical health equipment
- Potential future Warehouse provision: Dressing, Nutrition's/ Supplements, SSL Dry Goods, Cleaning Products
- SSL still able to provide effective GT service – pharmaceutical, specimen, samples, post – additional activity undertaken during COVID with delivery of samples for testing to acute hospitals.

Water Management

Water management is a well-documented and structured process for all members of the Trust and SSL staff. SSL and Trust operate and manage over 50 sites across BSOL, however, over the past year one building has been more challenging more than others – Forward House.

Forward House provides the Trust and SSL with challenges in water management. These challenges are managed via the Water Safety Group (WSG) examining the options available and agreeing the appropriate actions and recording the decisions.

The Water Safety Group comprises; Trust Nurse Management, Trust Clinical Management, SSL Estates Teams, Trust appointed Microbiologist, Trust Infection Prevention Team, and Authorising Engineer.

In addition, due to the challenges, SSL appointed a Water Safety Specialist (the appointed specialist is also a qualified Authorising Engineer) to add further experience and knowledge to options and decision making, in addition to give an informed but unbiased independent opinion.

Since the initial outbreak, we have followed the industry guidance, Water Safety Group and leading independent water specialist advice and testing process to manage this situation. Unfortunately, even after the many actions and the extensive physical works, we still have a small number of legionella counts in some outlets in some rooms; these have all been isolated.

The Water Safety Group is now considering more mechanical options by changing and replacing pipework, by changing from tank fed water to mains fed supply to outlets this will significantly improve the water flow in the building. However, regular staff and service user usage and flushing will still be an important part of the ongoing water management.

SSL as part of the Water Safety Group and independent experts have learnt quite a lot over the past year and the key aspects to date are:

- Water Safety Group working needs to manage the governance around all water management decisions.
- Water flow is always needed to prevent stagnation, greater coms between Trust and SSL where it is found that outlets aren't being used.
- Fitting Water Filters (As per guidance) to manage Legionella creates additional operational and IPC requirements and should be used as part of the measures when appropriate.
- Fitting Water Flushing Valves (As per guidance) to manage Legionella creates additional operational and IPC requirements and should be used as part of the measures when appropriate.

Capital Projects

- Capital Programme 22/23 completed successfully.
- Capital Programme 23/24 progressing
- Project work associated with Nightingale for 16 bed female HDU ward – feasibility completed with sketch plan, high level costs and programmes sent to Trust for review. ·
- SSL supporting Black Country Healthcare FT on their Capital programme, on 6 schemes ·
- Highcroft progressing via Modular development of 30 beds- considerable resource support and commitment to develop the Business Case.

- Discussions begun with partners re-funding opportunities following Department of Health announcement of capital funding doesn't include BSMHFT projects.
- Reaside project discussions begun with partner opportunities following Department of Health announcement of the next phase of major funded schemes, which doesn't include BSMHFT sites. Concern regarding age, functional suitability, lifecycle and High/ Significant Backlog Maintenance requirement of the current facility.

SSL PFI/Contract Management

- ERIC has been challenging in gaining required data for submission, but this is now progressing.
- SSL contract manages two significant and complex PFI contracts
- SSL is finalising negotiated Settlement Agreements across both PFI's following performance management challenges of services. These agreements will deliver a high six figure settlement values. Plus an Energy Management settlement of six figure sum.
- The SSL PFI Team have been invited by PFU to act as an exemplar Trust to support and share good practice with other Mental Health NHS Trusts with PFI Projects. SSL will continue to develop of relationships with other trusts to assist them with their PFI needs and requirements.
- PFI Health Check Paper is progressing well, where we are seeking Intellectual Rights governance to protect the document for SSL.
- SSL are starting our 9th Market Test, this being the BNHP Joint Security Market Test. Challenging, with significant cost avoidance, whilst retaining positive relations with all stakeholders.
- PFI Expiry Presentation being held October to Trust Finance and PFI Team.

ICS Primary Care

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

- Significant progress has been made in the reporting period with the completion of six Clinical Strategies in conjunction with Attain.
- The target date for completion of the six Estate Locality Strategies is the end of August, the West Locality Strategy first draft is now complete, once the format for this particular strategy is agreed this will form the template for the remaining five strategies.
- With focus on delivering the objectives detailed in the Fuller Report, SSL have been providing Estate support and advice to set up and support several Primary Care Hubs. These provide significant reduction to secondary care pressure by providing a clinical pathway for same-day urgent GP appointments. An assessment of the Hubs is currently being completed and outcome is due to report to the August Primary Care Board. Void and Underused Bookable Space
- SSL is also leading a project to assess the accuracy of the information held for system wide void and bookable space commenced in July. The anticipated output with defines recommendations for potential changes to the management and allocation of this space.

- Capital Programme, Working in conjunction with NHSPS, SSL are overseeing the refurbishment of Saltley Healthcare Centre, to be prepared supporting the development of the Estates Locality Strategies.

In addition to the Primary Care Estates business as usual work plan SSL have continued to provide support for.

- 2 Mobile clinics
- Community Red sites
- Vaccination Centres across Birmingham and Solihull
- Primary Care Capital Works
- Net zero Carbon projects
- GP lease renewal negotiations etc

Outpatient Dispensing Services

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 2 externally reportable incidents from approximately 45,000 dispensed items. No service users were harmed as a result of these externally reportable incidents and all of them have been dealt with promptly.
- SSL implemented a Prescription Tracker which tracks our pharmacy performance (Please see Appendix D, E & F).
- SSL Pharmacy is planning to upgrade both its Prescription tracker and compliance aid machine in 2023
- SSL robot continues to deliver an accuracy of 99% on compliance aids,(see appendices)

Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	June-23
99%	99%	99%	99%	99%	99%	99%

Financial Performance

SSL over £1m ahead of budgeted revenue after the first 3 month of this financial year. This is mainly due to the National NHS Unconsolidated pay award which was paid out during this period and the continuing cost pressures from energy and general inflation. Revenue from External work is steady and we have 3 main revenue streams , Primary Care, ICS and PFI Consultancy.

- Primary Care – We continue support over 270 GPs across BSOL, as well as maintaining a number COVID vaccine sites in preparation for the next vaccination campaign planned for September 2023
- ICS – We are supporting the ICB with their sustainability and Green plan. In addition, SSL is providing project management support for two key ICS developments
- PFI Consultancy – We have been commissioned by 4 organisations to complete our patented "PFI HEALTHCHECK". We have an additional pipeline of projects for the 2nd half of the financial year. The FM support team is working on a pipeline but there is nothing firm yet.

In relation to our Trust contracts expenditure in all areas is stable with small variances and we expect this profile to continue to the end of the year, with a potential reduction next year when the rates in Utility will materially drop.

HR Strategy/People Plan Staff

- Health Surveillance requirements have been reviewed for all SSL employees and data prepared for Occupational Health. A considerable number of SSL employees have not been called for vaccination by Occupational Health as per the contract and therefore SSL are now arranging for them to be processed by occupational health. SSL have also reviewed health surveillance requirements for all estates personnel and again this is also being arranged by Occupational Health.

Resourcing and Reward

- SSL since December 2022 has considerably increased its permanent establishment and maintained its FTE from 340 to 370 therefore reducing an increase in spend on agency employees. This has been achieved by undertaking the following actions:
    1. Attendance at Job and Markets and positively promoting via "Love Brum".
    2. Working with the "I Can" NHS programme "Swap Scheme" Birmingham Council Scheme and local charities to encourage un-employed people to enter work schemes.
    3. "Recruit a Friend Scheme" (15 referrals in 6 months and 7 employees taken on)
    4. New Recruitment Microsite.
    5. Advertising on Total Jobs and CV library

- SSL has also been working with its existing workforce to introduce a range of development opportunities through apprentice schemes and offer external apprentice programmes this has resulted in:

Apprentice Programme	**Number**
Level in Management	1 (Internal employee)
Level 4 in Facilities Management	2 (Internal employees)
Level 3 Hospitality Supervisor	3(Internal employees)
Level 2 Facilities Team Member	6 (Internal employees)
Level 3 Chef	5 (External candidates Appointed)
Level 3 HR Apprentice and Level 5 HR Business Partner	2 (One external candidate one employee)
Level 2 Facilities Soft Monitoring	1 (External employee)

- SSL is currently liaising with its Senior Management Team and looking to launch its SSL Futures Programme which will be aimed at those studying a degree or having completed a degree to commence in Summer of 2024 to either undertake an internship or commence a graduate scheme with SSL. The programme is to support succession planning due to 55% of SSL's employees are above 50 years of age. Initially it will look to commence with 2 interns and 2 -4 graduates.

- SSL is currently reviewing its benefit and recognition scheme and is currently undertaking a pulse survey to seek its employees views following which recommendations will be made to the Remuneration Committee.
- The SSL Board agreed to implement the national NHS pay award and bonus to all SSL staff on agenda for change terms and conditions and all SSL staff on SSL terms and conditions.

Employee Engagement (Communications)

- SSL has invested heavily in engaging with its employees and has launched a range of communication and engagement initiatives to make us an employee of choice. The initiatives are identified underneath:
  - SSL Weekly News – This is a weekly bullet-in which is sent to all employees to keep them informed on Estates and Facilities New
  - SSL held in April its first SSL People and Value Awards which was attended by over 100 SSL employees to celebrate their achievements.
  - SSL has launched in June its Mood and Pulse Surveys. In June the pulse survey was in relation to Leadership and Management. SSL is looking to invest in tablets which can be utilised by employees purely as communication devices to encourage participation.
  - In June SSL celebrated it second Estates and Facilities Day and rewarded staff with the idea of the "SSL Big Night In" whereby staff received a £15 just eat voucher, popcorn and quiz to enjoy a night in with their family.
  - In June SSL has also launched "A Day in the their Shoes". All SSL Senior Managers are going back to the shop floor and supporting our front line employees undertake their role to encourage communication and openness.

Equality, Diversity & Inclusion

- SSL's EDI forum, continues to go from strength to strength. EDI statistics have been shared with the forum and the meeting have commented on the statistics and the need for then to be shared across SSL which is being arranged.
- SSL's EDI forum are actively raising issues which impact on the organisation and are with management support themes being raised are being addressed.
- SSL's EDI forum presented a presentation on management and leadership which resulted in the leadership and management pulse survey. Results will be shared with the next forum.
- SSL have arranged Equality and Diversity Training for all Supervisors and Managers.

Corporate, Property and Sustainability

- SSL will be developing further the 'Green Plan' for the Trust to include Scope 1,2 and 3 baseline data and targets
- SSL will be introducing both food waste recycling (sites with preparation kitchens) and a 'OPT in' waste recycling option for the Trust

- SSL have been working with National Express regarding the issue of free bus passes for all new SSL and BSMHFT starters – encouraging sustainable travel whilst at the same time giving the new starters the option of free travel
- SSL will be developing an EV charging point option for BSMHFT to consider during 2022/23. This will provide BSMHFT with all the information it should need to consider whether or not it intends to implement such charging points for staff / visitors / patients
- SSL are developing its 'fleet' to support BSMHFT Services by adopting Plug in Hybrid / All electric vehicles where it can and where costs and range permit
- SSL has managed energy procurement on behalf of BSMHFT and will be procuring all of its directly procured electricity from Zero Carbon sources for 2022/2023

Business Development, Opportunities and Plans

PFI Consultancy

- SSL continues to develop our PFI consultancy services which includes PFI Healthcheck (Trademarked), PFI Handback and Liftco Consultancy.
- We have a number of commissions including
    - Newham
    - Gloucester
    - North Staffordshire
    - West Birmingham
- All are progressing well and will be concluded in the next 4weeks, with additional commissions starting late summer.
- We have also been approached by leading PFI finance providers to deliver healthchecks on their portfolios – we are evaluating the resources required and the potential contract value.

Training

- We have one of the first accredited training hubs to delivery the new National Cleaning Standards. This has given us an opportunity to develop further new business opportunities with external partners:
    - External Training courses underway with Amey for NHS Cleaning Standards & Level 2 Food Safety
    - Costs being reviewed for provision of food safety training @ East Cheshire NHS Trust, Macclesfield General Hospital & BCH.

Facilities Management

- We have quoted and been successful for a number of facility contracts within BSOL primary care.
- We are also exploring opportunities with one of the largest PCN's in the UK
- In addition, we are supporting another local trust with their Capital programme, details to be confirmed.

ICS/ICO BSol Strategic Delivery

- SSL is currently reviewing our business structure to enable SSL to be a successful ICS partner in the future ICS structure.
- Expansion of our facilities managements and estates services and support to Primary Care.
- In addition, SSL have been requested to support the ICS Green Strategy agenda, and have submitted proposals to deliver this service until the end of the financial year.
- We have also had initial meetings with two other ICS's, who are interested in commissioning similar services we currently deliver to BSOL.

Governance and Assurance

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

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

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

SSL

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Appendix A – Financial Statement April 23 – June 23

SSL Financial Position	Annual budget	M3		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	14,682	3,671	4,171	500
Lease & Long License	3,023	756	840	84
Contract Management	1,992	498	728	230
Facilities Services	3,237	809	1,058	248
Grounds and Garden	399	100	77	(23)
PPE & Warehouse	149	37	47	10
Pharmacy	3,235	809	828	19
External Services - Head of Assets	0	0	7	7
External Services - STP	97	24	22	(2)
External Services - CCG Vaccine Pro	435	109	82	(27)
External Services - PFI	80	20	17	(3)
External Services - FM	37	9	1	(9)
Total income	27,368	6,842	7,878	1,036
Pay costs	(10,419)	(2,605)	(3,467)	(863)
Drug costs	(2,854)	(713)	(742)	(29)
Non pay costs	(7,935)	(1,984)	(2,077)	(93)
Clinical supplies costs	57	14	(5)	(19)
Total Expenditure	(21,151)	(5,288)	(6,292)	(1,004)
EBITDA	**6,217**	**1,554**	**1,586**	**32**
Depreciation	(3,105)	(776)	(764)	13
Interest Payable	(2,010)	(502)	(512)	(9)
Interest Receivable	0	0	0	0
Finance Lease	(382)	(96)	(96)	0
Profit / (Loss) before tax	**720**	**180**	**215**	**35**
Taxation	(380)	(95)	(96)	(1)
Profit / (Loss) after tax	**340**	**85**	**119**	**34**

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix C/D: Dispensing Performance Community Teams

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

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

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

Outpatient prescriptions (Non-urgent) – KPI = 48 hours

Team	Achieved to date/time June-23	Not Achieved to date/time June-23	Percentage Achieved to date/time June-23	Percentage Achieved to date/time May-23	Percentage Achieved to date/time Apr-23
Aston and Nechells Community Team	82	4	95%	96%	95%
Central Assertive Outreach	41		100%	98%	98%
East hub Older Adults	2		100%	100%	100%
East Assertive Outreach	21		100%	94%	100%
Handsworth AOT	33		100%	100%	100%
Kingstanding & Erdington CMHT	130	7	95%	96%	95%
Ladywood & Handsworth CMHT	70	4	95%	96%	100%
Longbridge CMHT	136	3	98%	100%	100%
Lyndon CMHT	37	2	95%	93%	97%
Newbridge Clinic	67	2	97%	98%	99%
Newington CMHT	64	1	98%	100%	98%
North Assertive Outreach	52	2	96%	94%	91%
North Hub Older Adults	10		100%	100%	100%
Reaside Community	93	5	95%	99%	90%
Riverside CMHT	23		100%	100%	100%
Small Heath CMHT	27	1	96%	100%	91%
Solihull Assertive Outreach Team	38	2	95%	100%	98%
Solihull Early Intervention Service	97	5	95%	93%	95%
South Assertive Outreach Team	24	1	96%	92%	97%
Sutton Coldfield Community Team	64	3	96%	99%	95%
The Homeless Team	11		100%	100%	100%
Warstock Lane CMHT	129	7	95%	100%	98%
West Hub Older Adults	7		100%	100%	100%
Yewcroft CMHT's	44	2	96%	94%	96%
Zinnia CMHT'S	165	9	95%	97%	96%
South Hub Older adults	2		100%	100%	100%
Wilson Lodge	5		100%	100%	100%
Intensive Community Rehab Team	5		100%	100%	100%
Grand Total	**1479**	**60**	**96%**	**97%**	**96%**

Compliance Aids – KPI – 72 hours

Compliance Aids	Achieved to date/time June-23	Not Achieved to date/time June-23	Percentage Achieved to date/time June-23	Percentage Achieved to date/time May-23	Percentage Achieved to date/time Apr-23
Aston and Nechells Community Team	10		100%	100%	93%
Central Assertive Outreach @Small Heath	16		100%	94%	93%
East Assertive Outreach	12		100%	100%	100%
Handsworth AOT	21	1	95%	93%	92%
Kingstanding & Erdington CMHT @Northcroft	16	1	94%	100%	100%
Ladywood & Handsworth CMHT @Osborne House	21	1	95%	92%	94%
Longbridge CMHT	34	1	97%	96%	94%
Lyndon CMHT (Solihull South)	10		100%	100%	90%
Newbridge Clinic @ Small Heath Centre	11		100%	100%	95%
Newington CMHT	32	1	97%	93%	100%
North Assertive Outreach	20		100%	92%	90%
North Hub Older Adults					
Reaside Community	27	1	96%	100%	91%
Riverside CMHT	2		100%	100%	
Small Heath CMHT	6		100%	100%	
Solihull Assertive Outreach Team	16		100%	100%	90%
Solihull Early Intervention Service	7		100%	100%	100%
South Assertive Outreach Team	23	1	96%	93%	100%
Sutton Coldfield Community Team @Northcroft	4		100%	100%	100%
Warstock Lane	33	2	94%	93%	93%
Yewcroft CMHT's	9		100%	100%	100%
Zinnia CMHT'S	36	2	95%	97%	100%
MHSOP				100%	
Grand Total	366	11	**97%**	**96%**	**95%**

9. GOVERNANCE & RISK

9.1. Annual Medical Appraisal and Job Planning

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**	
Agenda item	**9.1**	
Paper title	**Medical Directorate Annual Update**	
Date	**2 August 2023**	
Author (s)	**Kerry Rowley**	
Executive sponsor	**Dr Fabida Aria**	
Executive sign-off	☒ Yes	☐ No

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

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

Executive summary & Recommendations:

This report is presented to Trust Board to update and provide assurance on Medical Directorate work in relation to medical appraisal, revalidation, and job planning. Recommendations are to continue with the development of our established appraisal, revalidation, and job planning processes, to continue to engage with our internal auditors where required and to continue to develop via the PDSA process.

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

Trust Board are requested to note the content of this report, receive assurance, and approve the signing of the Annual Board Report and Statement of Compliance (Annex D) provided as appendix 1.

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.
- Quality.
- Clinical Services.
- People

Financial Implications *(detail any financial implications)*

The contract for medical appraisal and job planning was renewed in December 2021 for a 3-year period. The total contract price is £96,391, however additional licenses have needed to be purchased due to a significant increase in the number of locum doctors recently appointed to the Trust - cost in the region of an additional £8500 per annum.

Going forwards there will be a requirement to review the current staffing model in terms of administrative staff, medical appraisers and auditors so as to be able to effectively support this increase in workload beyond the current financial year.

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

No new risks identified.

Equality impact assessments:

Not applicable for this report

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

- Revised job planning policy - formal consultation process.
- Revised medical appraisal policy – formal consultation process.
- Regular Medical Directorate communications.
- Dedicated administrative support.
- Direct engagement sessions.
- Discussions with Trust Expert by Experience to support medical appraisal.

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

AOA – Annual Organisation Audit.

ARC – Appraisal and Revalidation Committee.

BSMHFT – Birmingham and Solihull Mental Health Foundation Trust.

DCC – Direct Clinical Care.

ELA – Employment Liaison Officer.

GMC – General Medical Council.

MHPS – Managing Health Professional Standards.

MPIT – Medical Practice Information Transfer.

NHSE – NHS England.

PDSA – Plan, Do, Study, Act.

PA's – Programmed Activities.

SAS Doctor – Specialty and Specialist Grade Doctors.

SI's – Serious Incidents.

SPA – Supporting Professional Activities.

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. Situation

The Medical Directorate are required to report into Trust Board annually.

2. Background

The report is presented to Board members to update on key events and achievements of the Medical Directorate in relation to the medical workforce, in particular medical appraisal, revalidation and job planning.

3. Assessment

Medical Appraisal:

The Appraisal and Revalidation Oversight Committees (ARC) remit is to provide assurance to the Board that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is undertaking its statutory responsibilities to ensure that all doctors with a designated body connection to the organisation can be successfully revalidated, as well as supporting the decision making process for revalidation recommendations in complex cases.

The Committee provides support and advice to the Medical Director in the exercising of their duties as the Responsible Officer in relation to the process of medical appraisal and revalidation.

The members of the Committee are:

- Executive Medical Director (Chair).
- Deputy Medical Director (Professional Practice, Legal and Transformation).
- Associate Medical Director (Medical Education).
- Medical Directorate Manager.
- Medical Appraisal Auditor(s)
- Appraisal and Revalidation Administrator.

Dr Hilary Grant retired from the organisation at the end of June 2022. Dr Fabida Aria joined BSMHFT as Executive Medical Director on 1st August 2022. In the interim, Dr Giles Berrisford, Deputy Medical Director (Professional Practice, Legal and Transformation) undertook Responsible Officer duties in line with the Responsible Officer Regulations.

For the period of 1st April 2022 and 31st March 2023, 221 out of 224 doctors (98.7%) with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust completed their annual appraisal or had an appraisal which was not due, due to the doctor being very newly employed within the organisation.

Three doctors were identified as having an approved incomplete or missed appraisal during this time for the following reasons:

- Long term sickness x 2 doctors
- Maternity leave (12 months) x 1 doctor

Out of the 221 doctors who completed their 2022/23 appraisal, 178 doctors (80.5%) completed their appraisal on time with 36 out of 43 doctors submitting deferral requests to formally request approval by the Responsible Officer for them to complete their appraisals outside of the agreed timeframe. Reasons given are as follows:

- Sickness x 4 doctors
- Retire and return x 3 doctors
- Incomplete documentation x 6 doctors
- Annual leave x 1 doctor
- Personal circumstances x 5 doctors
- Clinical commitments x 1 doctor.
- Appraiser/appraisee availability x 16 doctors.

The 7 doctors who were highlighted as not having submitted a formal deferral request, did however complete their appraisal during the 2022/2023 appraisal year.

The Trust retains 27 appraisers to conduct medical appraisals as part of their job plans, which is 6 appraisers fewer than last year. The number of which is sufficient and meets the NHSE (NHS England) Framework of Quality Assurance for Responsible Officers and Revalidation– Core Standards, providing the remaining appraisers can commit to complete the maximum number of appraisals per annum. However, 3 further appraisers are due to retire in the coming months.

In addition, we have had 1 of our 3 appraisal auditors retire from the organisation. We have also been advised that 1 of the 2 remaining appraisal auditors is very likely to retire at the end of 2023.

To date we have been unsuccessful in recruiting replacement medical appraisers and auditors, and we are currently in the process of exploring alternative options.

Furthermore, there was no administrative support available for the vast majority of 2022, due to long term sickness absence, with the postholder subsequently retiring. During this time, and due to the specialist nature of support required, the Medical Directorate Manager very successfully managed and stepped in to administer the Trusts process for 10 months. Interim administrative support is now in place by way of a fixed-term contract, which has given us the opportunity to complete a review of the staffing structure and requirements. Following review, we have gone out to advert for substantive administrative cover and will be interviewing on 1st August 2023.

Going forwards and due to a significant increase in the number of locum doctors recently appointed to the Trust, there will be a requirement to further review the current staffing model in terms of additional administrative support, medical appraisers and auditors so as to be able to effectively support this increase in workload beyond this current financial year.

During the 2022/2023 appraisal year, 36 doctors were reviewed for revalidation. All have had their revalidation documents reviewed. Five doctors required additional information before a positive recommendation for revalidation could be made. These doctors were appropriately supported through this process.

As part of the revalidation review process, the panel also review GMC Clinical and Educational Supervisor accreditations. All doctors who supervise a Core Trainee are required to be a Clinical Supervisor, whilst all doctors with a senior role in medical education, or those who supervise a Senior Trainee are required to be Educational Supervisors. To support successful accreditation, supporting documentation and evidence is required to be included and discussed as part of a doctors annual appraisal.

From 12th April 2022, GMC extended the routine revalidation notice period from 4 to 12 months. Feedback was sought about the benefits of this change after having to extend the notice periods for doctors whose submission dates had moved in 2020 in response to the Covid pandemic.

This new arrangement will offer the flexibility for Responsible Officers to submit recommendations to revalidate doctors when they are ready, and help organisations better manage any peaks or troughs in workload.

Additionally, it will also give organisations the opportunity to communicate with and support doctors that have missing supporting information, allowing them to resolve this before their submission date.

Organisations will now be able to submit a recommendation that a doctor is revalidated up to twelve months before their submission date. Upon GMC approving submitted recommendations, doctors will be given a new revalidation date five years from the date of their previous revalidation date. This will have the effect of extending the next revalidation cycle for these doctors if a recommendation is made earlier in the window.

Deferral recommendations - If an organisation needs to make a deferral recommendation, organisations will only be able to do this via GMC Connect when a doctor is within 4 months of their submission date.

Non-engagement recommendations – Non engagement recommendations will not be able to be submitted until a doctor is within 4 months of their revalidation date and the matter has been discussed with our GMC Employer Liaison Adviser (ELA).

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on appraisal rates.

Our organisation continues to demonstrate improvement in the management and quality of medical appraisals, having achieved the following this past year:

- Further scoped and devised a mechanism for appraiser 1-1 feedback sessions.
- Further scoping and attempt to implement reciprocal organisational peer review.
- Review of our process for inclusion of Trust Expert by Experience
- Completed triangulation of SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

Future Plans:

- Further review of the current staffing model in terms of additional administrative support, medical appraisers and auditors.
- Implement appraiser 1-1 feedback sessions.
- Further review our process for inclusion the inclusion of Trust Expert by Experience or Lay Member as an alternative.
- Finalise a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

Medical Job Planning:

E-Job Plan, part of Allocate Software's HealthMedics Optima, is designed to help facilitate the process of job planning as set out by the national consultant contract, allowing users to populate, review and sign off job plans all in one place. The system provides organisations with the facility to manage and report on current and historic information at an individual, departmental, or organisational level, presenting a valuable opportunity to maximise efficiency through increased transparency.

Medical job plans are measured in Programmed Activities (PA's). PAs are blocks of time, usually equivalent to four hours, in which contractual duties are performed. There are four basic categories of contractual work:

- Direct clinical care (DCC).
- Supporting professional activities (SPAs).
- Additional responsibilities.
- External duties.

A job plan will set out how many PAs a doctor is working and how many will be used undertaking these different types of work.

A significant proportion of a job plan may be spent on DCC. Direct clinical care work is any work that involves the delivery of clinical services and administration directly related to them.

However, a job plan will cover other activities that are essential to a doctor's professional development and to the wider NHS.

E-JobPlan provides consistency in the format of job plans, accurate calculations for PAs and on call work including prospective cover, and the ability to reflect the most complex work patterns through the combination of annualised and timetabled activities.

Electronic medical job planning has been in situ within the Trust since February 2015 and is now a mandatory annual process in which the doctor whose job plan is being reviewed has a formal planned structured meeting to agree individual programmes of work that contribute to the overall delivery of services. This meeting requires a partnership approach and should take place with all relevant clinical manager(s). It is an iterative process with incremental improvements and refinement on an annual basis (or sooner if a doctor changes their role).

Declining to participate reasonably in the process may affect:

- Pay progression.
- Application for new and/or renewal of Clinical Excellence Awards (Consultants) and
- May be subject to investigation and disciplinary action.
- Appraisal – a current job plan must be in place prior to an appraisal taking place,unless this is beyond the doctor's control.

The review of PA allocations above 10 per week is a key part of the job planning process and in all cases to support individuals own wellbeing, medical staff should not be working, and therefore being paid more than 13.5 PAs as agreed by the Trust Remuneration Committee. In exceptional circumstances where there is a requirement to undertake more than 13.5 Programmed Activities, this is considered and approved by the Chief Operating Officer and the Executive Medical Director in line with the Trusts Pay Policy and comply with the requirements of the European Working Time Directive.

The 2023/2024 round commenced in January 2023 and requires medical staff to complete their job plans to cover the period of 1st April 2023 to 31st March 2024.

Medical job planning remains very important and needs to accurately reflect the amount of work that our medical colleagues are undertaking for the Trust, both direct clinical care and supporting professional activities. We recognise that it has been an extremely busy period, and this may feel like an additional task at a time of pressure, but it is only with this information that we can start to make progress towards job plans becoming a truly prospective annual event, capturing work which is needed and very much valued.

Consistency Panel Review meetings to undertake third and final sign off have been arranged with each directorate/area. Panels have been put in place to ensure job planning is consistent between

specialties, management groups and to provide assurance that job planning is in line with Trust guidance.

The 2023/2024 round identifies 223 doctors who are required to complete a job plan. This consists of 123 Consultants, 100 SAS doctors, other non-training grade and Trust locum doctors. The position at the point of writing this report is as follows:

Service Area	Total Number of Job Plans for Completion	Total Number of Job Plans remaining in Discussion	Total Number of Job Plans Awaiting Doctor Agreement or Clinical Lead Sign Off (1st)	Total Number of Job Plans Awaiting Clinical Director Sign Off (2nd)	Total Number of Job Plans Awaiting Consistency Review Panel Sign Off (3rd)	Total Number of Job Plans Entered into Mediation	Total Number of Job Plans Fully Completed and Signed Off	Total Number of Job Plans Incomplete and Locked Down.
Under Graduate Medical Education	**3**	0	0	0	0	0	3	0
Acute Care	**38**	7	7	3	9	0	11	1
Urgent Care	**15**	2	0	0	5	0	8	0
Primary Care and Dementia Services	**57**	0	0	0	0	1	40	16
Integrated Community Care and Recovery	**69**	33	19	2	15	0	0	0
Secure Care and Offender Health	**41**	0	0	0	0	0	19	22

Learning continues to be taken from the current round to determine a prospective timetable for the next round. We have adopted a Quality Improvement approach with Clinical Leads and Clinical Directors completing their own job plans in the first instance, so that they can gain a better understanding of the process and system in order for them to be able to better support members of their team with the process. This will help to ensure that job plans are not only completed, but are truly meaningful, reflecting the work being done by our doctors.

Job plans should now be fully completed and be signed off by Clinical Leads and Clinical Directors. This is an annual event, and we are hoping that we are starting to get into the routine of doing them. To try to improve things further, all Clinical Directors, Clinical Leads, and Deputy Medical Directors have been meeting regularly to improve the process. As a result, we have simplified the options for Direct Clinical Care and Supporting Professional Activities to make it as easy as possible to complete, with this forming the basis of conversation between a doctor and their line manager.

In terms of timeline – job plans are prospective for the financial year ahead, and so should have been completed and signed off by the end of March 2023 in readiness to commence 1st April 2023. It is noted that this current round of job planning has presented some challenges. However, it must

be recognised that as an organisation not all directorates have Clinical Leads in situ to support the job planning workstream, but that we remain focused and are making continuous incremental progress.

Additionally, plans are to be implemented for the review of data captured within job plans, which will be utilised to evaluate how posts can be made more interesting and attractive for medical staff.

Undergraduate Medical Education, Primary Care and Dementia Services and Secure Care and Offender Health have undertaken their final Consistency Panel Review meetings. No further meetings are to be held and any incomplete job plans have been locked down. Final meetings with Acute and Urgent Care and Integrated Community Care and Recovery are imminent.

It is anticipated that the 2024/2025 job planning round will commence in October 2023 following an annual review and data cleanse of the electronic system.

4. Recommendation.

The Board is requested to note the content of this report, receive assurance, and **approve** the signing of the Annual Board report and Statement of Compliance (Annex D) provided as appendix 1.

NAME: Kerry Rowley
TITLE: Medical Directorate Manager
DATE: July 2023

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Hilary Grant retired from the organisation at the end of June 2022. Dr Fabida Aria joined BSMHFT as Executive Medical Director on 1st August 2022. In the interim, Dr Giles Berrisford, Deputy Medical Director (Professional Practice, Legal and Transformation) undertook Responsible Officer duties in line with the Responsible Officer Regulations.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Going forwards and due to a significant increase in the number of locum doctors recently appointed to the Trust, there will be a requirement to further review the current staffing model in terms of additional administrative support, medical appraisers and auditors so as to be able to effectively support this increase in workload beyond this current financial year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

There is robust monthly monitoring of all licensed practioners with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust which is further enhanced by the triangulation of information at the pre-employment check stage.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Following the Covid pandemic The Medical Appraisal policy has been updated to incorporate the revised approach for Medical Appraisal. The policy is due for full review in 2024 or earlier should any element of practice change.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

It was anticipated that a reciprocal organisational peer review would be arranged however, we have been unsuccessful in agreeing this with our MERIT partners. We had also identified an alternative organisation that were willing to participate in a reciprocal arrangement, but we have not yet been successful in arranging reviews.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Robust processes are currently in place to identify locum and short term workers within the organisation. Annual appraisal is provided to those doctors with a designated body connection to BSMHFT, in addition to regular 1-1 meetings, supervision meetings, provision of fundamental and other relevant training and access to governance activities and meetings.

Section 2a – Effective Appraisal

A mechanism for the transfer of information relating to complaints, SI's and learning from deaths has been established which ensures that all doctors have access to this information for the purpose of medical appraisal. Refresher training for existing appraisers and new appraiser training for new appraisers is provided and updates on the revised approach for appraisal. We are planning to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SI's (serious incidents), complaints, mortality case note reviews and disciplinary.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The Medical Appraisal policy has been reviewed and ratified by our Trusts Transforming our Culture and Staff Experience Sub Committee. The policy has been updated to incorporate the revised approach for Medical Appraisal. The policy is due for full review in 2024 or earlier should any element of practice change.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust retains 27 appraisers to conduct medical appraisals as part of their job plans, which is 6 appraisers fewer than last year. The number of which is sufficient and meets the NHSE (NHS England) Framework of Quality Assurance for Responsible Officers and Revalidation– Core Standards, providing the remaining appraisers can commit to complete the maximum number of appraisals per annum. However, 3 further appraisers are due to retire in the coming months.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Appraiser Peer Support Sessions are held twice per anum and are attended by our appraisers.

Appraiser Refresher training was undertaken by all appraisers in March 2023

There are plans in place to implement appraiser 1-1 feedback sessions.

The Trusts Medical Appraisal policy has been reviewed and updated to incorporate the revised approach for Medical Appraisal.

We plan to continue our process for the inclusion of Trust Expert by Experience or Lay Member as an alternative.

Further scoping and attempt to implement reciprocal organisational peer review.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> We have an established Appraisal and Revalidation Committee. Their remit is to provide assurance to the Board that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is undertaking its statutory responsibilities to ensure that all doctors with a designated body connection to the organisation can be successfully revalidated, as well as supporting the decision making process for revalidation recommendations in complex cases.
>
> In addition we are attempting to implement a reciprocal organisational peer review arrangement and plan to undertake further review of the involvement by Trust Expert by Experience (lay persons) in the medical appraisal process

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	224
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	221
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	3
Total number of agreed exceptions	3

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Medical Appraisal was fully reinstated within the Trust in April 2021, recognising the exceptional stresses that the COVID-19 pandemic has placed on healthcare workers and the need for the provision of a flexible opportunity for a confidential professional discussion as part of supporting professional development and well-being, with preparation being straightforward and proportionate.

From 12th April 2022, GMC have extended the routine revalidation notice period from four to twelve months. Feedback was sought about the benefits of this change after having to extend the notice periods for doctors whose submission dates had moved in 2020 in response to the Covid pandemic.

This new arrangement will offer the flexibility for Responsible Officers to submit recommendations to revalidate doctors when they are ready, and help organisations better manage any peaks or troughs in workload.

Additionally, it will also give organisations the opportunity to communicate with and support doctors that have missing supporting information, allowing them to resolve this before their submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All positive revalidation submissions are made immediately following the Trusts Revalidation Committee meeting, with doctors being notified in writing the same day. Conversations relating to deferrals or non-engagement are held with the doctor prior to any submission being made.

Additionally, there is a process in place to notify the GMC Liaison Officer prior to revalidation for any doctors where non engagement is a concern.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Trust currently have an Appraisal and Revalidation Committee in situ which links into clinical governance via the Executive Medical Director/Responsible Officer.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust has established links for the sharing of information between the Investigation, Complaints, Learning from Deaths and HR teams. The Trust also has in situ a Decision Making Group and follows the MHPS process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The organisation follows the MHPS which is underpinned by policy.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

The Human Resources Department report into People Committee and Board. The Medical Director, Deputy Medical Director and Human Resources representative have regular meetings with the GMC Liaison Officer to discuss current and potential concerns. We use the MHPS Framework to identify and the Decision Making Group to address required actions.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[3]

A robust method for the use of Medical Practice Information Transfer Forms (MPIT) is in use within the Trust, We are also in the process of scoping a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

We have benchmarked our governance and performance against 'The Effective Clinical Governance for the Medical Profession document'.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The use of robust documentation to enhance the sharing of information between teams continues to work successfully.

Section 6 – Summary of comments, and overall conclusion

Dr Hilary Grant retired from the organisation at the end of June 2022. Dr Fabida Aria joined BSMHFT as Executive Medical Director on 1st August 2022. In the interim, Dr Giles Berrisford, Deputy Medical Director (Professional Practice, Legal and Transformation) undertook Responsible Officer duties in line with the Responsible Officer Regulations. For the period of 1st April 2022 and 31st March 2023, 221 out of 224 doctors (98.7%) with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

completed their annual appraisal or had an appraisal which was not due, due to the doctor being very newly employed within the organisation.

Three doctors were identified as having an approved incomplete or missed appraisal during this time for the following reasons:

- Long term sickness x 2 doctors
- Maternity leave (12 months) x 1 doctor

Out of the 221 doctors who completed their 2022/23 appraisal, 178 doctors (80.5%) completed their appraisal on time with 36 out of 43 doctors submitting deferral requests to formally request approval by the Responsible Officer for them to complete their appraisals outside of the agreed timeframe. Reasons given are as follows:

- Sickness x 4 doctors
- Retire and return x 3 doctors
- Incomplete documentation x 6 doctors
- Annual leave x 1 doctor
- Personal circumstances x 5 doctors
- Clinical commitments x 1 doctor.
- Appraiser/appraisee availability x 16 doctors.

The 7 doctors who were highlighted as not having submitted a formal deferral request, did however complete their appraisal during the 2022/2023 appraisal year.

The Trust retains 27 appraisers to conduct medical appraisals as part of their job plans, which is 6 appraisers fewer than last year. The number of which is sufficient and meets the NHSE (NHS England) Framework of Quality Assurance for Responsible Officers and Revalidation– Core Standards, providing the remaining appraisers can commit to complete the maximum number of appraisals per annum. However, 3 further appraisers are due to retire in the coming months.

In addition, we have had 1 of our 3 appraisal auditors retire from the organisation. We have also been advised that 1 of the 2 remaining appraisal auditors is very likely to retire at the end of 2023.

To date we have been unsuccessful in recruiting replacement medical appraisers and auditors, and we are currently in the process of exploring alternative options.

Going forwards and due to a significant increase in the number of locum doctors recently appointed to the Trust, there will be a requirement to further review the current staffing model in terms of additional administrative support, medical appraisers, and auditors so as to be able to effectively support this increase in workload beyond this current financial year.

During the 2022/2023 appraisal year, 36 doctors were reviewed for revalidation. All have had their revalidation documents reviewed. Five doctors required additional information before a positive recommendation for revalidation could be made. These doctors were appropriately supported through this process.

Our organisation continues to demonstrate improvement in the management and quality of medical appraisals, having achieved the following this past year:

- Further scoped and devised a mechanism for appraiser 1-1 feedback sessions.
- Further scoping and attempt to implement reciprocal organisational peer review.
- Review of our process for inclusion of Trust Expert by Experience
- Completed triangulation of SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

Future Plans:

- Further review of the current staffing model in terms of additional administrative support, medical appraisers and auditors.
- Implement appraiser 1-1 feedback sessions.
- Further review our process for inclusion the inclusion of Trust Expert by Experience or Lay Member as an alternative.
- Finalise a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

Section 7 – Statement of Compliance:

The Board of Birmingham and Solihull Mental Health NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body.

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Birmingham and Solihull Mental Health NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

Publication reference: PR1844

9.2. Council of Governor Minutes

9.3. Review and update of the BAF – Cover sheet

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	9.3.1		
Paper title	Review and update of the Board Assurance Framework		
Date	2 August 2023		
Author (s)	David Tita (Associate Director of Corporate Governance / Interim Company Secretary)		
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:

The Board Assurance Framework (BAF) is one of the most important tools in the Board of Director`s toolkit that can enable it to gain assurance, evidence and confidence that principal risks to the delivery of the Trust`s strategic goals are effectively mitigated, managed and monitored in line with the organisation`s risk management arrangements and best practice. The BAF brings together in one place all the relevant information on the principal risks to the board`s strategic objectives.

The review and update of the Trust`s BAF is a logical extension of its risk management arrangements and builds on the work that had previously been undertaken by ANHH a few years ago to develop a BAF for the Trust. Significant inclusions in this updated version of the BAF are; greater ownership, involvement and leadership from Executive Directors, additional columns for gaps in controls, assurance, gaps in assurance, actions and better engagement with related high level operational risks on the corporate risk register.

Each Board Committee i.e. People Committee, QPES and FPP reviewed their BAF risks 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 have been incorporated in this final version of the BAF being presented to the Board for approval and assurance.

By receiving, 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 and scrutiny. This report then concludes that the key determinants of an effective and

sustainable BAF include, a dynamic, agile, integrated, proactive and enterprise-wide process which relies on engagement, a good risk-aware culture, leadership, continuous horizon scanning and a robust risk management landscape.

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
FRC – Financial Reporting Council
ANHH – ANHH Consultancy

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:

The HM Treasury Guidance on Assurance Frameworks (2012) on the other hand, defines an assurance framework as "…a structured means of identifying and mapping the main sources of assurance in an organisation, and coordinating them to best effect". The GGI argues that "a good board assurance framework (BAF) is a live tool that helps boards to undertake [its] duty by providing a simple yet comprehensive means by which to effectively manage the principal risks to meeting the strategic [goals]".

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".

The FRC Risk Guide states that:

> The board has ultimate responsibility for risk management and internal control, including for the determination of the nature and extent of the principal risks it is willing to take to achieve its strategic objectives and for ensuring that an appropriate culture has been embedded throughout the organisation.

In practice the Board may delegate the above responsibility to the Audit Committee, however, it will be helpful for the Board to review, scrutinise and provide `check and challenge` on the updated BAF so the Trust could maintain and sustain its continuous improvement while optimising its use.

1.1 A good and effective BAF should: -

- Provide a structure and process for the Board to focus on those principal risks that could undermine the achievement of its strategic goals.
- Enable the Board to appropriately prioritise investment and enhance decision-making.
- Enable the Board and its Committees to remain strategic and design agendas which focus on strategic and reputational risks rather than operational issues.
- Enable the Board and its Committees to gain a clear and comprehensive understanding of the principal risks to the delivery of the Trust`s strategic goals, the type and quality of assurance currently obtained, consider their effectiveness and identify any gaps for strengthening.

For the BAF to effectively add value, the Board and its Committees must create the space and time to review and provide some `constructive challenge` to its content while ensuring that the controls in place, assurance and actions being implemented to attain the target risk scores are all fit-for-purpose.

1.2 Pillars and enablers of a flourishing BAF culture include: -

- Capacity and capability building and development in risk management for the Board and staff across the Trust including in areas such as risk appetite, risk tolerance, risk assessment and scoring as well as risk governance, scrutiny and oversight.
- A good risk management strategy or policy is important in providing a framework and structure in underpinning the Trust`s BAF and risk management arrangements.
- Regular review, constructive challenge and effective oversight of the BAF.
- Effective leadership from the Board, its Committees and senior management is also a key driver for embedding a robust BAF culture across the Trust

2. Conclusion:

A good BAF thus demonstrates 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 have a clear plan in place for mitigating, managing and monitoring such risks. Hence, the Board needs to gain assurance that the controls in place and risk treatment plans for mitigating and managing such risks are robust, effective, efficient and fit-for-purpose. An effective BAF should leverage added value and tangible gains through enhanced decision-making, a better safety culture, better investments and prioritisations, greater scrutiny and accountability and above all, improvements in patient care, quality and enhanced experience.

9.3.1. 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 June 2023

Table 1a: Combined 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.	12	⟷
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 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 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	Executive Director of Operations	QPES	Head of Strategy, Planning and Business Development/ ADs of Operations	16	⟷

	mental health services across our systems					
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-	Executive Director of Strategy, People &	People Committee	AD of EDI	16	⟷

	discriminatory organisation	Partnerships				

1b. Combined BAF Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic				BAF04/FPP	
4 Major			BAF01/FPP	BAF03/QPES BAF05/QPES BAF06/QPES BAF07/QPES BAF03/FPP BAF05/FPP BAF01/PC BAF02/PC BAF03/PC BAF04/PC	
3 Moderate		BAF02/FPP	BAF02/QPES	BAF01/QPES BAF04/QPES	
2 Minor					
1 Insignificant					

Appendix 1: Details of Combined 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**	**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.				

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. • A overwhelmed workforce unable to embrace new and innovative ways of working.	• 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.	• Changes in the Policy landscape and the creation of ICBs and system working. • Challenges around workforce as	• 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 a cultural shift required to capture the needs of families and carers. • 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.	• The developing Participation and experience team is 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.	genuine engagement requires sufficient and consistent staff.		
	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	

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.

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**	3	3	9		
		Target Risk Score	3	2	6	**Date**	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.				

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*	Internal: • Mortality Reviews • Rapid Improvement Week. • Mortality Case Note Reviews. • Structured Judgement Reviews. • Physical Health Strategy and Policy. • Learning from Deaths Group. • Clinical Effectiveness Advisory Group. • SI oversight Group • Patient Safety Advisory Group (PSAG). • patient satisfaction	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Learning from Deaths Reports. • Community Deaths Reports.	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board. • Learning from Deaths Reports. • Community Deaths Reports. • Medical Examiner Reports. • NHS Digital Quarterly Data. Learning for improvement: • Learning from Peer Review/National	Learning From Improvement 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	• Medical Examiner Reports. • NHS Digital Quarterly Data. <u>Learning for improvement</u>: • Serious Incident Reports. • Executive Chief Nurse's Assurance Reports to QPES Committee and Board. • Legal Quarterly Report. • Never Events Reports • Commissioner and NED quality visits. <u>Third level assurance</u>: • CQC planned and unannounced inspection reports.	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 • 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.

			• Internal and External Audit reports.		
	• *lack of self-awareness of services that are not delivering.*	Clinical Governance meetings Directorate/Specialty governance meetings Improvement Programme.	Improvement Plans		
	• *poor management of the therapeutic environment.*	Capital prioritisation process SSL Service Agreement Forum CQC well-led and unannounced visits.	Contract KPIs CQC inspection reports Ligature Risk assessments Environmental Risk Assessments.		
	• *insufficient focus on prevention and early intervention.*		Independent annual assessment against the 68 NHS Core Standards for EPRR.		
	• *limited co-production with services users and their families.*	Patient Safety Advisory Group Patient Stories.	FFT Scores		

	• *insufficient staff with the correct skill set*	Ward Accreditation Programme Improvement Programme Improvement Plans <u>Governance Forums</u>: • Clinical Governance meetings • Directorate/Specialty governance meetings Safety Huddles <u>Professional Codes of Conduct</u> • NMC Code • GMC Good Medical Practice Guide. • HCPC Standards of Conduct, Performance and Ethics. • Code of Conduct for NHS Managers.	<u>Exception reports</u>: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports <u>Internal inspection and review reports</u>: <u>Data sets</u>: • 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		

		Health and Social Care Act 2008 (amended 2014 – Part C).	Assurance Reports to QPES Committee and Board.		
	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	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	

target risk score.					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	October 2023	• Ensure robust confirm and challenge, enable meaningful escalation and support and timely intervention into local areas of required improvement.	
	BAF02/QPES /003	Desk top review of local Clinical Governance processes	Deputy Director of Nursing /Company Secretary	October 2023	• Standardise the approach to local governance arrangements ensuring consistent and robust assurance to Board.	

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 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**	2nd June 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. • Clinical service structures,	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 Summit's are in their early conception and may not be adopted well by Divisions/services.	

	• 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.	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.	

	• 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**			
	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	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.

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**	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.				

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.	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.

		• Expert by Experience Reward and Recognition Policy. • 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	BAF04/QPES /001	Review and refresh of the family and carer pathway	Associate Director for Allied Health	Mar 2024	Families and carers will be routinely identified, and better supported or involved in care planning as appropriate.	

to achieve target risk score.			Professions and Recovery			

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 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**	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.				

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 neighbourhood 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.

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**	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.				

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.
			• 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”.
					• 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.	• Urgent care transformation plan including:
		  ○ 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.
				• Highlight and escalation reporting into BSOL 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-	**Brief risk description**			

	Risk ID	
	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**	**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.				

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	• 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	• Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways • Needs assessment for BSOL is not up to date, which	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	

	Not being involved in system wide developments and initiatives e.g. development of place, wider health inequalities work etc Not having service user voice to inform transformation and development plans	CAMHS, eating disorders and perinatal provider collaboratives • Partner in West Midlands Provider Collaborative • 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	weakens our intelligence about our population and needs	• Board Committees • Trust Board	
	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-	**Brief risk description**			

	Risk ID	
	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.

FPP BAF

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
Title of risk	Failure to focus on and harness the wider benefits of digital improvements.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	2	8	**Date**	2nd June 2023
		Risk Appetite	Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)				

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*		*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*		*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.**

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**	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.				

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
Actions being implemented to achieve target risk score.	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.	
	BAF02/FPP/ 002	Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust	tbc	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)*
11th May 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.

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**	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.				

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.* • *Inadequate financial controls.* • *Cost pressures are not managed effectively.*	• 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.
	• *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	• Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations,	• HFMA sustainability audit has identified a number of development areas that would improve

			pipeline for delivery of savings.	including any shortfall in savings delivery.	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.	Lead	date	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.

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**	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.				

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.*	• 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.	• Operational pressures negatively impacting on staff capacity to fully implement these controls. • Self-assessments, accreditation and self- certification processes aren`t strong. • Governance around	• 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.

	• *Excessive emphasis on compliance leading to a `tick-box` culture.* • *Poor perception of compliance leading 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*	• Staff training and awareness sessions to tackle poor behaviour around compliance. • Strengthen the internal control systems and processes. • Regular horizon scanning for cases of non-compliance. • 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.	compliance is weak. • Controls have not been embedded.		• The culture of BAF not fully developed and embedded.

	strengthening decision making.				
	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	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	31/09/2023	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	20/12/2023	This action will create a better understanding and help reduce the likelihood and impact were the risk to materialise.	

target risk score.	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.

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	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.				

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.	• *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.*	• 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.*

		• Multi-partner Hub. • Better engagement with partners and shared governance arrangements. • Establishment of Memorandum of Understandings. • Clarity around collaboration with VCFSE organisations. • Implementation of Data Sharing Agreements.	• *Newly relationships take 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.	

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.

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**	**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.				

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		• 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.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	**Inherent Risk Rating**	4	5	20	People Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date**	**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.				

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. • 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.

Executive Lead	Executive Director of Strategy, People & Partnerships.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Inability to modernise our people practice.	**Inherent Risk Rating**	4	5	20	People Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	3	9	**Date**	**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.				

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 concerns raised by staff.	• 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.

		• 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.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Inherent Risk Rating**	4	5	20	People Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	2	4	8	**Date**	**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.				

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. • Staff Survey results improving to top quartile performance.	• 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, 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 target risk score.	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.	
	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.

9.4. 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 July 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		
	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		

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.

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		
	BAF2-CoCo/02	Attendance at the VCFSE Collective and Panel Meetings which take place monthly	JW	Dec 2023		
	BAF2-CoCo/03	Multi-agency engagement in decision forming groups for MHPC.	All Chairs Monthly	Dec 2023		

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.

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		
	BAF3-CoCo/002	Building the commissioning and transformation hub.	JW	Dec 2024		

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.

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	***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;**				
BAF4-CoCo	• *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		
	BAF4-CoCo/02	Workforce consultation surrounding a proposed Commissioning & Transformation Hub.	JW	Aug 2023		

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.

Key:

	On track to delivery on time
	Completed
	Outstanding or delayed

9.5. Draft Board Risk Appetite Survey Monkey

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	**9.5**		
Paper title	**Draft Board Risk Appetite Survey Monkey**		
Date	2 August 2023		
Author (s)	David Tita (Associate Director of Corporate Governance / Interim Company Secretary)		
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:

On the back of the presentation of a suggested risk appetite statement for the Trust, the Board after some discussion at its Strategic Development Session on 5th July agreed for monkey survey to be designed and circulated for members to provide some inputs on their preferred risk appetite category for the different type of risks which may materialise as the Trust pursues its operational and strategic objectives.

The GGI defines risk appetite as 'the amount and type of risk that an organisation is prepared to pursue, retain or take` in pursuit of its strategic objectives, hence, risk appetite is key to achieving effective risk management as it represents a balance between the potential benefits of innovation and the threats that change inevitably brings. Risk appetite should therefore be at the heart of an organisation's risk management strategy – and indeed its overarching strategy and should thus be designed, ratified, and owned by the Board as well as its implementation monitored for assurance.

The Orange Book argues that risk appetite provides a framework which enables an organisation to make informed management decisions, hence, by defining its risk appetite an organisation clearly sets out both the target and acceptable risk score it may be willing to accept in pursuit of its operational and strategic objectives. The Orange Book further advises that in designing a risk appetite framework, an organisation should consider its values, norms, the sector in which it operates, its culture, governance, decision making processes and level of risk maturity.

This risk appetite monkey survey will provide an opportunity for members to select the risk

appetite category and corresponding score while considering the assigned risk appetite description that best aligns with their preferred level of risk, they will recommend the Trust could accept in pursuit of its operational and strategic objectives.

Once the Board approves this survey, it will be implemented and the risk appetite category with the highest selection will be adopted, however, where there is no clear preferred category, a suggested one with be noted for further discussions and ratification by the Board.

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. REVIEW and SCRUTINISE the structure and content of the monkey survey.

3. APPROVE this monkey survey for implementation.

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 monkey survey report in its current shape and form hasn`t been previously discussed at any meeting, however, the ideas which have enabled its design were discussed and debated at the last Strategic Board Development which held on 5th July 2023.

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)*

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)*
GGI – Good Governance Institute

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).	

Instructions: Please read through the different risk appetite categories and select the one that best aligns with the level of risk you will recommend the Board should accept in pursue of its operational and strategic objectives. There is also a free text box for each table should you wish to provide a rationale for your choice or to provide some comments.

1.

Type of Risk	**Quality & Safety**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	We have no appetite for decisions that may have an uncertain impact on quality and safety outcomes.	We will avoid anything that may impact on quality and safety outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	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.	We are prepared to accept the possibility of a short-term impact on quality and safety outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality and safety where there may be higher inherent risks but the potential for significant longer-term gains.
Further comments					

2.

Type of Risk	**Reputational**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk					

tolerance & target risk scores.		2 - 4	6 - 8	9 - 10	12
Description of Risk appetite category	Zero appetite for any decisions with high chance of repercussion for organisations' reputation.	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Appetite for risk taking limited to those events where there is little chance of any significant repercussion for the organisation.	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Appetite to take decisions which are likely to bring additional Governmental / organisational scrutiny only where potential benefits outweigh risks.
Further comments					

3.

Type of Risk	**People**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Priority to maintain close management control & oversight. Limited devolved authority. Limited flexibility in relation to working practices. Development investment in standard practices only.	Decision making authority held by senior management. Development investment generally in standard practices.	Seek safe and standard people policy. Decision making authority generally held by senior management.	Prepared to invest in our people to create innovative mix of skills environment. Responsibility for noncritical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.
Further comments					

4.

Type of Risk	**Finance**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Avoidance of any financial impact or loss, is a key objective.	Only prepared to accept the possibility of very limited financial impact if essential to delivery.	Seek safe delivery options with little residual financial loss only if it could yield upside opportunities.	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Prepared to invest for best possible benefit and accept possibility of financial loss (controls must be in place).
Further comments					

5.

Type of Risk	**Regulatory**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	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.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.

Further comments	

6.

Type of Risk	**Strategy**				
Risk appetite category	**Averse**	**Minimal**	**Cautious**	**Open**	**Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Guiding principles or rules in place that limit risk in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 5+ year intervals.	Guiding principles or rules in place that minimise risk in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 4-5 year intervals.	Guiding principles or rules in place that allow considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 3-4 year intervals.	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 2-3 year intervals.	Guiding principles or rules in place that welcome considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 1-2 year intervals.
Further comments					

7.

Type of Risk	**Operations**				
Risk appetite category	**Averse**	**Minimal**	**Cautious**	**Open**	**Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Defensive approach to operational delivery - aim to	Innovations largely avoided unless essential. Decision making authority held by	Tendency to stick to the status quo, innovations generally avoided unless necessary.	Innovation supported, with clear demonstration of	Innovation pursued – desire to 'break the mould' and challenge

	maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority.	senior management.	Decision making authority generally held by senior management. Management through leading indicators.	benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
Further comments					

8.

Type of Risk	**Data and Information Management**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Lock down data & information. Access tightly controlled, high levels of monitoring.	Minimise level of risk due to potential damage from disclosure.	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Accept need for operational effectiveness in distribution and information sharing.	Level of controls minimised with data and information openly shared.
Further comments					

9.

Type of Risk	**Governance & Legal**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**

Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Avoid actions with associated risk. No decisions are taken outside of processes and oversight / monitoring arrangements. Organisational controls minimise risk of fraud, with significant levels of resource focused on detection and prevention.	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.	Willing to consider actions where benefits outweigh risks. Processes, and oversight / monitoring arrangements enable cautious risk taking. Controls enable fraud prevention, detection and deterrence by maintaining appropriate controls and sanctions.	Receptive to taking difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements enable considered risk taking. Levels of fraud controls are varied to reflect scale of risks with costs.	Ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking. Levels of fraud controls are varied to reflect scale of risk with costs.
Further comments					

10.

Type of Risk	**Digitalisation/Technology**				
Risk appetite category	**Averse**	**Minimal**	**Cautious**	**Open**	**Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	General avoidance of systems / technology developments.	Only essential systems / technology developments to protect current operations.	Consideration given to adoption of established / mature systems and technology improvements. Agile principles are considered.	Systems / technology developments considered to enable improved delivery. Agile principles may be followed.	New technologies viewed as a key enabler of operational delivery. Agile principles are embraced.

Further comments	

11.

Type of Risk	**Transformation/Projects and Quality Improvement**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Defensive approach to transformational activity - aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority. Benefits led plans fully aligned with strategic priorities, functional standards.	Innovations avoided unless essential. Decision making authority held by senior management. Benefits led plans aligned with strategic priorities, functional standards.	Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Plans aligned with strategic priorities, functional standards.	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.	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. Plans aligned with organisational governance.
Further comments					

12.

Type of Risk	**Security**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**

Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	No tolerance for security risks causing 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 in official sites etc.	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.	Limited security risks accepted to support business need, with appropriate checks and balances in place: • Adherence to FCDO travel restrictions • Vetting levels may flex within teams, as required • Controls managing staff and limiting visitor access to information, assets and estate. • Staff personal devices may be used for limited official tasks with appropriate permissions.	Considered security risk accepted to support business need, with appropriate checks and balances in place: • New starters may commence employment at risk, following partial completion of vetting processes • Controls limiting visitor access to information, assets and estate. • Staff personal devices may be used for official tasks with appropriate permissions.	Organisational willingness to accept security risk to support business need, with appropriate checks and balances in place: • New starters may commence employment at risk, following partial completion of vetting processes • Controls limiting visitor access to information, assets and estate. • Staff personal devices permitted for official tasks
Further comments					

13.

Type of Risk	**Property & Environment**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk		**2 - 4**	**6 - 8**	**9 - 10**	**12**

scores.					
Description of Risk appetite category	Obligation to comply with strict environmental policies or policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Recommendation to follow strict environmental policies or policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Requirement to adopt arrange of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Application of dynamic environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements.
Further comments					

14.

Type of Risk	**Commercial**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Zero appetite for untested commercial agreements. Priority for close management controls and oversight with limited devolved authority.	Appetite for risk taking is limited to low scale procurement activity. Decision making authority held by senior management.	Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
Further comments					

15.

Type of Risk	**Partnerships & Provider Collaboratives**				
Risk appetite category	○ **Averse**	○ **Minimal**	○ **Cautious**	○ **Open**	○ **Eager**
Correspondent risk tolerance & target risk scores.		**2 - 4**	**6 - 8**	**9 - 10**	**12**
Description of Risk appetite category	Avoid actions with associated risk. No decisions are taken outside of processes and oversight / monitoring arrangements for the Partnership or Provider Collaborative.	Willing to consider low risk actions which support delivery of priorities and objectives of the Partnership or Provider Collaborative. However, processes, and oversight / monitoring arrangements must be in place to enable limited risk taking.	Willing to consider actions to support the achievement of the Partnership or Provider Collaborative where the benefits outweigh the risks. Processes, oversight / monitoring and scrutiny arrangements to enable cautious risk taking.	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.	Ready to take 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 support informed risk taking.
Further comments					

9.6. Questions from Governors and Public

9.7. 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.

Date & Time of Next Meeting

4 October 2023, 09:00-12:30