BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Board of Directors Public Meeting 09.00, Wednesday 6 December 2023 Uffculme Centre AGENDA				
Ref	**Item**	**Purpose**	**Report type**	**Time**
	Service User Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 4 October 2023**	Approval	Enc	09.35
5	**Matters arising from meeting held on 4 October 2023**	Assurance	Enc	
6	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	09.40
7	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.50
8	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Director of Operations*	Assurance	Enc	10.00
	People			
9	**Staff and Service User Stories 2023 Report** *Phil Gayle, Chair*	Assurance	Enc	10.20
10	**Board Site Visit Feedback Report** *Phil Gayle, Chair*	Assurance	Enc	10.30
11	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.40
12	**Guardian of Safe Working Hours Quarterly Report** *Shay-Anne Pantall, Guardian of Safe Working Hours*	Assurance	Enc	10.50
	Sustainability			
13	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.00
14	**Trust Five-Year Strategy: Mid-Year Update Report** *Patrick Nyarumbu, Director of Strategy, People and Partnerships*	Assurance	Enc	11.10
15	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.20
16	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.30
17	**SSL Quarterly Report** *Shane Bray, SSL Managing Director*	Assurance	Enc	11.40
	Quality			
18	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	11.50
19	**Patient Safety Incident Response Framework Plan** *Steve Forsyth, Interim Chief Nurse*	Approval	Enc	12.00
20	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	12.05
21	**Living the Trust Values** *Sue Bedward, Non-Executive Director*		Verbal	12.15
22	**Board Assurance Framework reflections**		Verbal	12.20
23	**Any other business**		Verbal	12.25
24	**Questions from Governors and members of the public**			
Close by 12.30 **Date and Time of Next Meeting: Wednesday 7 February 2024, 09.00-12.30**				

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 4 October 2023, 09.00,
Plymouth Room, Uffculme Centre

Present	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Steve Forsyth	SF	Interim Chief Nurse
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnership
	Monica Shafaq	MS	Non-Executive Director (via MS Teams)
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Jane Clark	JC	Associate Director of AHP and Recovery (item 17 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Alison Jowett	AJ	Professional Lead for Dietetics (item 17 only)
	Zobia Khalil	ZK	Assistant Psychologist, Dementia and Frailty (item 1 only)
	Lisa Pim	LP	Deputy Director of IPC, Patient Safety and Clinical Quality/Governance (items 14-16 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
Observers	Three governors and two members of staff observed the meeting in person.		

Ref	Item
1	**Staff Story** ZK attended to share her experience as an Assistant Psychologist in Older Adults services, including her time on the inpatient ward during the second wave of the pandemic. ZK had started a Masters in Psychology, which had given her the opportunity to join the Trust on a placement. ZK had now been with BSMHFT for three years. ZK reflected on the importance of diversity of roles and staff within psychology, as this supported holistic approaches to patient treatment. ZK commented that she always felt respected at work and enjoyed the trust and autonomy from managers to implement new ideas, which helped her to grow in confidence and ability to make positive changes. ZK was currently looking at health inequalities within the Older Adults service, and the quality of data held on this area. There were challenges within the service, and limited funding often impacted on vulnerable patients with regards to patient transport. ZK reflected that loneliness was the key issue faced by older adults, and the team was thinking differently about how community groups could be utilised to provide more support. A carer support pack was also under development to support carers. ZK noted that in a more digital world post-pandemic, some older service users feel more removed and there is a need to think about access to services and support groups for people who may not be able to access services in that way. FA commented that she was interested to hear about different models of care being reviewed, and asked how the spiritual side of recovery was considered. ZK replied that more work was needed to fully embed this into wards and the recovery approach, and more understanding of service user spiritual needs would be needed. RFW reflected that a lot of quality improvement had been mentioned, and asked ZK what she felt was associated with being motivated and feeling enabled to implement her ideas. ZK was grateful to managers and supervisors for the trust and autonomy and felt that working directly with service users to understand their needs was crucial to her understanding and further development of the role. PN commented on retention and the potential for staff to find other opportunities within the organisation; ZK was asked if there was anything else that could be done to retain staff. ZK reflected that having the opportunity to develop, implement ideas and have support from managers and supervisors was key. Staff were keen to help

	make positive changes and consideration of development opportunities within the job was a good way to do this. Feeling trusted and able to change things for the better was very important. The Board thanked ZK for attending and sharing her story.
2	**Apologies for absence** Bal Claire, Non-Executive Director, and Linda Cullen, Non-Executive Director.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of the Board meeting held on 2 August 2023** The minutes were approved as a true and accurate record, subject to the following amendments: • Inclusion of concerns raised regarding community waiting times and the potential impact on the deterioration of patients' conditions. • Clarification that there had been a proportionate reduction in programme activities due to flexible working arrangements.
5	**Matters arising** All matters arising were updated.
6	**Chair's Report** The Board received the report for information.
7	**CEO and Director of Operations Report** Key points were highlighted as follows: • There was a clear theme of quality improvement across the organisation this month, with a lot of enthusiasm from a number of teams to make positive changes, particularly within clinical governance. • Community Hubs welcomed seven meet and greet facilitators, which would become integral to the Hubs' front of house offer. • The Integrated Community Care and Recovery (ICCR) team continued to support all directorates with conversations around health and wellbeing, equality, diversity and inclusion, and bullying and harassment. • Recruitment within Secure and Defender Health was improving, with five new staff joining the prison, two international staff starting in secure services, and seven psychology assistants recruited. • Sixteen new staff had also started across the acute wards. • The Trust had received positive feedback from system partners on support provided with patient flow and pressures across the ICB. This support continued for winter planning. • The first Silver Sunday had been held, and was a successful event. • A 72-hour period of industrial action was currently underway. The Board thanked everyone who was working so hard to ensure this could take place safely. Industrial action was having an impact, particularly with levels of demand rising. • Community Mental Health teams received a focused CQC inspection in August, which had raised a number of concerns. Service leads were working towards immediate improvement action plans and audits were in place. • RFW was pleased to note the continued commitment to quality improvement, and specifically thanked the Deputy Medical Director for Quality and Safety for championing this work. • Development of the BSOL Mental Health Provider Collaborative Strategy continued with partners to drive the Health Needs Assessment and Experience of Care campaign.

	• RFW noted the horrific actions of Lucy Letby and the devastating impact on families and colleagues. Considerations would be made as to how NHS organisations review and implement recommendations and make changes to mitigate any potential risks. RFW advised that many changes have been made since 2016 into patient safety, including the development and implementation of the Patient Safety Incident Response Framework. • The Trust had held its Annual General Meeting on 26 September, which had been a successful event. • RFW advised the Board that Sarah Bloomfield, substantive Chief Nurse, would not be returning to the role. A recruitment process would be undertaken. WW commended the comprehensive report, noting the positive focus from divisions on quality improvement, and increased workforce. WW asked about plans for staff for the winter period, when considering increased infection rates. RFW responded that the Deja Flu campaign had been launched, and the Trust was looking to become a Covid vaccination site; the Trust was also working with primary care colleagues who were offering weekend vaccination clinics, and usual hand washing routines and guidance were in place. SF advised that national guidance had been received and implemented, with at risk staff proactively contacted for their vaccinations. SF noted that Governors were encouraging the Trust to become a Covid vaccination site. WW asked if any feedback had been received from the CQC regarding their latest visit. RFW responded that high level feedback had been given, with two section 29a notices issued. The final report had not yet been received. RFW commented that there was disappointment, particularly relating to integrated care and medicines management, and teams were working hard to reiterate the importance of these processes. Immediate action had been taken to ensure that medicines management protocols were in place and adhered to. Work was also underway to ensure risk assessments were kept up-to-date in a meaningful and prioritised way. WW commented on the industrial action which was affecting the whole NHS and impacting on service delivery; there were also financial implications with reliance on bank and agency staff. PG asked whether there was a contingency plan in place to manage the impact this was having and how it would be managed in the future. RFW responded that there were fantastic people in the team who were stepping up to support service users. The cost of industrial action was being recorded, with the majority of spend related to step-up arrangements. There was a risk that people were waiting longer for appointments and becoming more unwell, and the Trust would need to consider how this was recorded and quantified. WW asked what the Trust had planned for Black History Month. RFW confirmed that staff were actively being encouraged to talk about their experiences, with information and events being advertised to the organisation through Connect. Asian heritage celebrations had taken place, and a BSOL ICB event dedicated to Black History Month was taking place next week. PG asked about international recruitment and why people withdrew from the process. PN advised that some did not pass the required examinations, others were unable to commit due to family, and some had accepted offers elsewhere. PN noted that eleven staff had already started with the Trust, with a further five due to begin in the next few months. It was recognised that support needs to be more bespoke and processes improved to support international staff into the country and the Trust. VD added that daily rotas were reviewed according to patient need, with the e-rostering system utilised to manage workforce gaps. SF advised that fewer mental health nurses were entering the country, and the Trust was working with NHS England to achieve the target by linking with other organisations.
8	**Finance, Performance and Productivity Committee Assurance Reports** The Board received assurance reports from August and September meetings. The common theme from both meetings related to achievement of the year-end breakeven position and challenges related to out of area placements. The Committee was assured that work had already begun on budget setting for 2023/24, and the Medium-Term Financial Plan. The Committee had also considered the Emergency Preparedness, Resilience and Response Report. PG asked if there were any concerns around the achievement of the breakeven position, and if there were any risks associated. DT advised that flexibility was available to achieve the breakeven position at year-end, and was

	confident that it would be achieved. However, transformational change was needed in order to achieve the year-end target for 2024/25. This would include digital opportunities, and transforming the way the Trust worked; the electronic Shared Care Record across BSOL would be a key part of this. VD also highlighted digital achievements that were already implemented, particularly that all wards at the Trust were paper-free. DT noted that reviewing digital innovations with partner organisations would be required, along with implementing initiatives that would keep service users well in the community and their own homes. RFW reflected that the Board may need additional information on work underway to address out of area placements. VD advised that a number of workstreams were established, including a single point of access, implementation of locality arrangements, length of stay and delayed transfers of care, clinical oversights, and utilisation of all capacity. Grant Thornton had been commissioned to support the development of a plan, which was now being implemented. FA added that there was scrutiny around patient management, with an improved position being reported.
9	**Finance Report** The Board received the report. Key points were highlighted as follows: • The month five position showed a deficit of £533k, which was adverse to the breakeven plan. • Budget setting work was underway for 2024/25; efficiency targets would be challenging and a quality improvement approach would be taken to address this. RFW confirmed that the Trust had been clear that a vacancy freeze would not be implemented. • Capital expenditure to date was £2.8m, which was £2.5m ahead of plan due to progression of works. PG queried the progression of the capital departmental expenditure limit (CDEL); DT advised that conversations and work continued, and a lot of opportunities created through networks. However, it was ultimately a national decision. PG asked about the increase in run rate as documented in the report; additional information would be provided. **Action**
10	**Integrated Performance Report** The reported highlighted a number of issues that had been discussed under other items on the agenda. The Board also noted that inappropriate out of area arrangements continued to be monitored and managed, and the significant level of demand for beds remained a key challenge, with more spend on beds than there was funding available.
11	**Emergency Preparedness, Resilience and Response Annual Report** The Board received the report for assurance, noting that the Trust would maintain its position of partial compliance for 2023/24. Work was ongoing to address areas of non-compliance, however capacity issues within the team were impacting on the completion of many of the actions.
12	**People Committee Assurance Reports** The Board received assurance reports from August and September meetings. RFW queried appraisal rates and whether there was assurance that the new system was now in use. PN advised that weekly meetings were taking place to monitor this and ensure the improvement plan was on track. WW asked if there was a clear timescale in place to bring together an overall plan for WRES/WDES/Model Employer and Equality, Diversity and Inclusion data. PN noted that the Committee had received information on a gap analysis that had taken place, but further assurance was required on how and when gaps would be addressed. Some of this would be a cultural shift and would take some time. PN also highlighted that the Committee had heard a staff story about domestic abuse and reflected on how colleagues must look after each other.
13	**Quality, Patient Experience and Safety Committee Assurance Reports**

	The Board received assurance reports from August and September meetings, noting work ongoing against CQC actions to ensure improvement against all areas. The Committee had received assurance on safer staffing and the utilisation of the Mental Health Optimising Staffing Tool (MHOST), along with implementation of SafeCare and e-roster systems. SF advised that a detailed discussion on the implications of the Lucy Letby case would be held and patient safety actions monitored through the Committee and the new Patient Safety Incident Response Framework.
14	**Patient Safety and Experience Report** The Board received the report for assurance, noting the management of root cause analyses and serious incidents. The Board was advised of themes arising from serious incidents, including the need to embed multi-disciplinary team approaches across the organisation, and the importance of the interface between Home Treatment Teams and Community Mental Health Teams. These themes had supported the development of the Patient Safety Incident Response Plan, which would be presented to Board in December. **Action** WW asked about the implementation of the Pharmacy Clozapine Team; LP advised that timescales for this had been provided, however additional assurance would be sought to ensure the team was fully in place. RFW commented that the closure of serious incidents was a shared responsibility, and queried whether closure of complaints also needed to be considered in the report. LP noted that a comprehensive dashboard had been developed to provide assurance on all aspects of patient safety. PG asked about the dissemination of safety messages, and whether weekly bulletins from the Chief Nurse and Medical Director could be considered to raise the profile of the importance of patient safety. RFW advised that patient safety alerts were in place, but frequency and format would be reviewed. SF noted that a newsletter was also circulated, however this could be more frequent. LP advised that a number of quality improvement projects were monitored on a quarterly basis at Quality, Patient Experience and Safety Committee. A quality improvement day was planned, and a quality management system under development to collate QI plans. SF commented that information on quality improvement was shared across the organisation through Connect, and could be shared as good news stories.
15	**Safeguarding Annual Report** The Board received the report for assurance.
16	**Infection Prevention and Control Annual Report** The Board received the report for assurance.
17	**Allied Health Professionals Strategy** The report provided an overview of the AHP workforce, and the achievements of the Strategy from 2020-2023. The Strategy focused on delivering personalised recovery and optimising wellbeing, with AHPs placed to deliver meaningful care dependent on pathways and service user need. RFW commended the development of a pipeline of AHP staff through apprenticeships, and noted that there was a commitment from the Board to enable teams to think differently about staffing composition, pathways and arrangements for the organisation. JC advised the Board that apprentices were a key part of the Strategy, and were often recruited from local communities. Apprenticeships at the Trust attracted a lot of interest. WW asked about the future of the Strategy, and how the Board could support this. JC reflected that the most effective support would be to link the AHP Strategy to the overall Trust Strategy, to continue to work with clinical services, and support staff in the best way possible. JC commented that transformative approaches were supported by the Trust, and there were opportunities to review clinical pathways and remain innovative. WW queried vacancy rates; JC advised that it had previously been an issue, however significant improvement had been reported. Once apprentices were in the Trust, they tended to stay and were fully embedded in the organisation and its culture.

18	**Guardian of Safe Working Hours Report** The Board received the report for assurance, noting particularly that referrals had increased; the Board agreed that this was positive improvement as doctors felt more able to speak up.
19	**Board Assurance Framework** The Board received the BAF for information, noting that there had been a recommendation to increase *BAF02/QPES* risk score from 12 to 16, reflective of work currently being undertaken on the Mental Health Act.
20	**Commissioning Board Assurance Framework** The Board received the BAF for information and assurance.
21	**Board Committees Effectiveness Report** The Board received the report, noting that there were no surprises with regards to the strengths and weaknesses of committee arrangements. There had been improvements made, however more work was needed to ensure greater effectiveness. Responses to the surveys had been low, however lessons had been learned about the best way to structure the surveys to capture views. Terms of Reference reviews had been undertaken, and an increase in non-executive director membership from two to three had been implemented across all committees to ensure resilience.
22	**Remuneration Committee Annual Report** The Board received the report for assurance.
23	**Risk Appetite Framework** The Board ratified the risk appetite framework, and agreed that a fuller Board discussion would take place when it was due for review.
24	**Risk Management Policy** The Board **approved** the policy.
25	**Questions from members of the public** • The Board was asked if there would be a further challenge to the ICB about offering more than four dates to provide the Covid vaccination to patients. RFW confirmed that there would be. • The Board was also asked to carefully consider the integration of workforce, as discussed under the Allied Health Professionals Strategy. RFW confirmed that this would be looked at. • FA was asked if the fines levied under the Guardian of Safe Working Hours Report was a typical figure. FA replied that there was a consistent increase in exception reports, however it was difficult to benchmark with other trusts as there was so much variance. • Information on risk management and the Board Assurance Framework was suggested for greater awareness at Council of Governors.
26	**Any other business** None.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**

Finance Report	Additional information on run rate would be provided to the Chair.	DT Dec 23	Completed
Patient Safety and Experience Report	The Patient Safety Incident Response Plan would be presented to Board for approval.	SF Dec 23	Completed
Risk Appetite Framework	The Board ratified the risk appetite framework.		
Risk Management Policy	The Board approved the policy.		

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**		
Agenda item	6		
Paper title	Board Assurance Framework		
Date	6 December 2023		
Author (s)	David Tita – Associate Director of Corporate Governance		
Executive sponsor	David Tomlinson, Executive Director of Finance		
Executive sign-off	☒ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

The Trust`s Board Assurance Framework demonstrates how risks linked to the delivery of the Trust`s strategic objectives are mitigated and managed thereby providing a structured source of assurance to the Board that related BAF risks are being effectively and robustly managed in line with best practice. The BAF also serves as a tool for the Board to interrogate and assure themselves that the Trust`s systems, processes and infrastructure for managing risks is agile, comprehensive, aligned, enterprise-wide, inclusive, effective, robust and fit-for-purpose.

Members of Board Committees are effectively using the BAF in driving discussions and deliberations at their meetings as well as it in drawing out and testing the depth, bandwidth, scope and level of assurance generated from the various reports they do receive and review. Hence, members of QPES, the People Committee and FPP at their last meeting reviewed the BAF and recommended a collaborative multi-stakeholder approach (incorporating EDs, NEDs and relevant colleagues) to reviewing and updating it in view of their next meetings in January 2024. This is very important as most risks on the BAF could crystallise across multiple services, hence, a multi-stakeholder approach to reviewing the BAF will facilitate shared learning, completeness, inclusivity, more joined-up thinking, integration and better dissemination and triangulation of intelligence in mitigating and managing such risks.

The main significant addition to the BAF since its last review by the Board is the inclusion of the new risk appetite categories following the recent approval and ratification of the Trust`s risk appetite framework. The plan is to present the updated BAF to the Board in February 2024 for review, scrutiny, oversight and assurance.
Appendix 1: BSMHFT Board Assurance Framework.

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

The Board is requested to:

1. ***NOTE and ENDORSE*** *the ongoing piece of work on reviewing and updating the BAF.*
2. ***GAIN ASSURANCE*** *that the BAF has been updated in line with best practice and is being appropriately used in driving discussions, debates and conversations at relevant meetings.*

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 version of the updated BAF has previously been considered at the following Board Committees: -

- People Committee
- FPP
- QPES

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
ED – Executive Director
NED – Non-Executive Director

Defining levels of assurance:

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

OUR 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 as of December 2023

Table 1a: QPES BAF summary showing movements in risks since last review:

Risk Ref.	Title of Risk	Executive Lead	Oversight Committee	Lead or Doer	Current risk score	Movements in risk score
			QPES BAF			
BAF01/ QPES	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/Lead, recovery, service user, carer & family experience/AD for Allied Health Professions & Recovery.	12	⟷
BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance.	16	↑
BAF03/ QPES	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/ AD of Clinical Governance.	16	⟷
BAF04/ QPES	Potential failure to implement a recovery focus model across our range of services.	Executive Director of Operations	QPES	Assoc. Dir. for Allied Health Professions & Recovery/ Lead, recovery, service user, carer & family experience / AD of Operations	12	⟷
BAF05/ QPES	Potential failure to be rooted in communities and tackle health inequalities.	Executive Director of Operations.	QPES	AD of EDI/ Head of Community Engagement/ ADs of Operations.	16	⟷
BAF06/ QPES	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	Executive Director of Operations	QPES	ADs of Operations	16	⟷
BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental	Executive Director of Operations	QPES	Head of Strategy, Planning and Business Development/	16	⟷

	health services across our systems			ADs of Operations		
FPP BAF						
BAF01/ FPP	Failure to focus on and harness the wider benefits of digital improvements.	Executive Director of Finance	Chief Information Officer (CIO) Joint Dir ICT & Programmes	Finance, Performance & Productivity Committee.	12	⟷
BAF02/ FPP	Potential failure in the Trusts care of the environment regarding implementation of the Green Plan	Executive Director of Finance	Dir. of Operations SSL	Finance, Performance & Productivity Committee.	6	⟷
BAF03/ FPP	Failure to operate within its financial resources.	Executive Director of Finance	Deputy Dir. of Finance	Finance, Performance & Productivity Committee.	16	⟷
BAF04/ FPP	Potential failure to comply with the requirements of Good Governance.	Executive Director of Finance	AD Corporate of Governance	Finance, Performance & Productivity Committee.	15	⟷
BAF05/ FPP	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Executive Director of Finance	Deputy Dir. of Commissioning & Transformation	Finance, Performance & Productivity Committee.	16	⟷
People Committee BAF						
BAF01/ PC	Potential failure to shape our future workforce.	Executive Director of Strategy, People & Partnerships	People Committee	AD OD	16	⟷
BAF02/ PC	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI & OD	16	⟷
BAF0 3/PC	Inability to modernise our people practice.	Executive Director of Strategy, People & Partnerships	People Committee	Head of People & Culture	16	⟷
BAF04/ PC	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI	16	⟷

1b. BSMHFT BAF Heat Map

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

Appendix 1: Details of BSMHFT BAF

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	Quality, Patient Experience and Safety Committee	
Title of risk	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	**Current Risk Rating**	3	4	12		
		Target Risk Score	3	2	6	**Date added**	**02nd June 2023**
		Risk Appetite	**Cautious:** 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.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF01/QPES	**There is a risk that the Trust may fail to explore and respond to incident data in appropriately optimising the role and benefits that EBEs, patient safety partners and driving improvements in service user experience of care.** This may be caused by: -				
	• Inability to effectively collate and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover. • An overwhelmed workforce unable to embrace new and innovative ways of working. • Lack of a cultural shift	• Community transformation • The design of a Community engagement Framework being led by the ICB. • QI Programmes with our EBE`s. • Ongoing work around preventative needs and stigma. • The developing	• Changes in the Policy landscape and the creation of ICBs and system working. • Challenges around workforce as genuine engagement	• Quarterly reports on participation and engagement presented at Trust Clinical governance and QPES. • QI Reports • Executive oversight of the engagement activities.	• Lack of regular and frequent governance reporting and oversight. • Inability to integrate and effectively use data in reporting. • Lack of EBE Strategy • Patient safety partners

	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.	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. • Recruitment of 5 Patient Safety Partners	requires sufficient and consistent staff.		are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised.

	This may or result in: -	
	• A reduction in quality care. • Service users not being empowered. • Services that do not reflect the needs of service users and carers. • Service provision that is not recovery focused. • Increased regulatory scrutiny, intervention, and enforcement action. • Failure to think family. • Inequality across patient population. • Workforce that is not equipped or culturally competent to support populations and colleagues. • Failure to provide resources that support health, wellbeing, and growth. • Lack of engagement. • Reactive rather than proactive service model. • Increased service demand.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/QPES /001	Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	
	BAF01/QPES /002	Better integration of Community engagement and patient experience.	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	

	BAF01/001 QPES	Identify a clear strategy for the next 12 months on how we will use EBE's to inform improved patient experience outcomes	AD for AHP and Recovery/ Head of Community Engagement.	31st Dec 2023	New action	
	BAF01/002 QPES BAF02/ QPES	Ensure a robust Induction and education package that enables our New Patient Safety Partners to feel fully prepared for role.	AD for AHP and Recovery/ Head of Community Engagement with support from Head of Patient Safety.	31st Dec 2023	New action	
	BAF01/003 QPES BAF02/003 QPES	Identify a clear strategy for the next 12 months on how we will use Patient Safety Partners to inform improved patient safety outcomes	AD for AHP and Recovery/ Head of Community Engagement with support from Head of Patient Safety.	31st Dec 2023	New action	
	BAF01/003 QPES BAF02/003 QPES	Identify a clear strategy for the next 12 months on how we will use EBEs to inform improved patient safety and experience outcomes	AD Clinical Governance with support from Head of Patient Safety.	31st Jan 2024	New action	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
15.05.2023	We have been doing some engagement with refugees which has resulted in the Therapeutic model. Community engagement team have a well-developed a creative Art development programme in partnership with the Art programme across the city.
30.6. 2023	A quarterly report from the Participation and Experience team is now being reported to both Trust Clinical Governance and QPESC.

27.09.2023	Five Patient Safety partners have now been successfully recruited and are undergoing induction currently. With the implementation of PSIRF in the next few weeks there will need to be a clear strategy for the implementation of the role including phased inclusion at relevant meetings, input into learning responses and ensuring the voice of the SU is understood and considered. Action Leads have been identified and a meeting with leads will be arranged to discuss requirements and agreed timescales.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	3	4	12	Quality, Patient Experience and Safety Committee	
Title of risk	Failure to focus on the reduction and prevention of patient harm and at enhancing its safety culture.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	2	6	**Date added**	02nd June 2023
		Risk Appetite	**Cautious:** 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.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF02/QPES	***There is a risk that the Trust may fail to focus on the reduction and prevention of patient harm and at enhancing its safety culture.*** *This may be caused by: -*				
	• *lack of implementation of a quality improvement process* • *unwarranted variation of clinical practice outside acceptable parameters* • *insufficient understanding and sharing of excellence and learning in its own systems and processes*	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	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Learning from Deaths Reports. • Community Deaths Reports. • Medical	Learning for improvement: • 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.	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 candour for moderate harm

		Group (PSAG). • patient satisfaction 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	Examiner Reports. • NHS Digital Quarterly Data. • Commissioner and NED quality visits. • Gap in MHA Action Plan oversight arrangements from CQC inspections	• 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.	incidents. Gaps in assurance audit and NICE compliance to QPES and Board. Embedding learning from Sis, complaints, and incidences. Development of Trust Quality Strategy.
	• *lack of self-awareness of services that are not*	Clinical Governance meetings	Improvement Plans oversight	Standardized QPESC agenda item enabling	Inconsistency in what type of information is

	delivering.	Directorate/Specialty governance meetings Improvement Programme.	Inconsistency in approach of local CGC arrangements	escalation reporting to Trust CGC Triple A reporting to QPES from CGC	reported/escalated to Trust CGC by local CGCs
	• *poor management of the therapeutic environment.*	Capital prioritisation process SSL Service Agreement Forum CQC well-led and unannounced visits.	Gap in MHA Action Plan oversight arrangements from CQC inspections Absence of Mental Health Committee.	Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting Health and Safety committee reporting and oversight of Ligature and Environmental Risk Assessments Audits Results CQC Steering Group – oversight of Action Planning	Trust focus on MHA compliance at CGC is broad – no current assurance framework for how action plans following MHA inspections are monitored/completed as completely devolved to local divisions. Current CQC Report is very inspection focused and does not encompass the broader CQC/regulatory compliance agenda. Whilst reporting on Ligature and Environmental RA is in place – there is not a robust accountability framework in place for how actions from the assessments are overseen/managed at Divisional level with stratification of associated risk at trust level.

	• *insufficient focus on prevention and early intervention.*	Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation. Rich QI resource and draft strategy PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data tracking/themes and trending and adoption of a QI approach to resolution.		QMS update reporting to QPES QI reporting to Trust CGC and QPES Safety Summit Reporting is included in the Patient Safety Report to Trust CGC, QPES, and Board Independent annual assessment against the 68 NHS Core Standards for EPRR.	QMS is in its early adoption stage and requires trust-wide commitment and resource to embed Rich QI resource is currently under utilised for Priority1 QI Workstreams Safety Summit Framework requires strengthening Lack of upward reporting from PSAG to Trust CGC QI Strategy to be approved.
	• *limited co-production with services users and their families.*	Patient Safety Advisory Group Patient Stories.	PSAG do not send exception reporting to QPESC	FFT Scores Exception reports: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports Internal inspection and review reports: Data sets: • PALS contacts data	

				• Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board.	
	• *insufficient staff with the correct skill set*	Improvement Programme Improvement Plans <u>Governance Forums</u>: • Clinical Governance meetings • Directorate/Specialty governance meetings Safety Huddles Professional Codes of Conduct NMC Code GMC Good Medical Practice Guide. HCPC Standards of Conduct, Performance and Ethics.			
	This may result in: -				

	• Failure to meet population needs and improve health. • Variations in care. • Unwarranted incidents. • Less safe care.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/QPES /001	Implementation of PSIRF by October 2023 strengthening the wholescale approach to understanding and sharing of excellence and organisational learning.	Interim AD of Nursing & Governance	October 2023	• Includes detailed data analysis of trust wide patient safety datasets. • Identifies Safety priorities for the Trust to focus on for the last 12 months detailed analysis. • Resultant outcomes from PSIRF implementation will be a Patient Safety Incident Response Plan and Policy.	

	BAF02/QPES /002	Review of Trust processes that apply a performance management approach to key Quality/Governance KPIs at Divisional level	Deputy Director of Nursing /Company Secretary/ Associate Director of Nursing and Governance	October 2023	• Ensure robust confirm and challenge, enable meaningful escalation and support and timely intervention into local areas of required improvement.	
	BAF02/QPES /003	Comprehensive Review of Governance Arrangements from Ward to Board – TOR will be approved including methodology of approach – to be presented to ET and QPESC.	Deputy Director of Nursing /Company Secretary Associate Director of Nursing and Governance	February 2024	• Standardise the approach to local governance arrangements ensuring consistent and robust assurance to Board.	
	BAF02/QPES/004	Robust oversight and assurance framework will be devised and implemented to ensure organisational oversight of actions from MHA inspections.	Associate Director of Governance	January 2024	• Framework will provide structure and clarity around oversight of MHA implementation and related actions. This will help to prevent the risk.	
	BAF02/QPES/005	CQC Report and Trust Steering Group will be reviewed and amended to provide comprehensive assurance of compliance with CQC framework and regulatory compliance overall.	Associate Director of Governance	Dec 2023	• Will ensure clear line of sight on CQC framework and regulatory compliance, enabling robust scrutiny, challenge, and support where required	
	BAF02/QPES/006	Draft QI Strategy to be approved.	Deputy Medical Director for Patient Safety and Quality and Associate Director of	January 2024	• Will enable QI resource to be allocated most usefully to the organisation alongside being a key function of the QMS. • Will assure the Board of QI approach and embedding QI	

			Governance		culture into the organisation.	
	BAF02/QPES/007	Revised Safety Summit framework to be completed.	Associate Director of Nursing and Governance	January 2024	• Forms part of the assurance to the board of a learning culture and aligns with PSIRF methodology.	
	BAF02/QPES/008	Monthly PSAG Upward Report to be shared with QPESC for noting/questions.	Associate Director of Nursing and Governance	November 2023	• Ensures oversight from QPESC of the discussions, emerging themes, and risks from PSAG	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27th Sept 2023	Due to deep dive review by the Associate Director of Nursing and Governance new emergent hazards have been identified that later the risk rating of this BAF risk from 9 to 16. Broadly these are identified as; • Whilst a quarterly MHA report is delivered to QPESC there is an absence of a robust framework to monitor and report upon CQC MHA inspections *action planning* leading to a lack of oversight that actions from these inspections are completed robustly. This could lead to a higher risk of lack of learning at local and trust level and patients being at risk of harm and reputational damage to the trust • Whilst the CQC report is action plan focused, there are gaps in reporting more widely on the CQC framework. alongside regulatory compliance more broadly to QPES. This highlights a noted gap in oversight and assurance to QPESC and the Board leading to a higher risk of lack of learning at local and trust level • Whilst reporting on Ligature and Environmental RA is in place – there is not a robust accountability framework in place for how actions from the assessments are overseen/managed at Divisional level with stratification of associated risk at trust level. Areas of Achievement. Safety priorities identified – approved at PSAG, and Executive Team. To be shared through Trust Committees CGC and QPES in October and up to Board. Draft Patient Safety Incident Response Plan and Policy prepared. To be shared through Trust Committees CGC and QPES in October and up to Board. PSIRF Operational delivery plan prepared in draft.

	Suite of new Quality Metrics for Directorate Deep Dives prepared and shared with CNO, COO, DOF, and Head of Performance. Pending comments. TOR for Governance Review has been prepared including options appraisal for delivery. Cohesive working arrangements between Safeguarding and Patient safety have been strengthened including shared learning as a standardised agenda in PSAG.

	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	2	2	4		
		Risk Appetite	**Open:** We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.			**Date added**	2nd June 2023
						Date reviewed	**27th Sept 2023**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
	There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance. This may be caused by: -						
BAF03/QPES	• Inability to effectively use time resource in driving improvements and safety. • Failure to use QI approaches to develop pathways to improve access to services. • Inability to develop and embed an organizational learning and safety culture. • Inability to review the Trust`s safety culture so as to identify	• SI oversight Group • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set	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. No organisational	• 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		The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. The Safety Summits are in their early conception and may not be adopted well by Divisions/services.	

	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.	agendas to address learning activity. • Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Implementation of Learning from Excellence (LFE). • PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support. • Freedom to speak up processes. • Cultural change workstreams including Just	wide reporting of LFE metrics.	and Board. • Updates on PSIRF Implementation to QPES and Board.	

		Culture. • NHS staff survey			
	• Variations in safety culture across the organisational at Divisional and Service Level. • Inconsistencies in governance arrangements at Divisional and corporate level.				
	This may result in:				
	• A culture where staff feel unable to speak up safely and with confidence. • Failure to learn from incidents and improve care. • A failure to develop pathways of care within the Integrated Care System. • Increased regulatory scrutiny, intervention, and enforcement action. • Insufficient understanding and sharing of excellence in its own systems and processes. • Lack of awareness of the impact of sub-standard services. • Variations in standards between services and partnerships. • Demotivated staff. • Missed opportunities for System Engagement.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	There is no current CRR	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	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. • Resultant outcomes from PSIRF implementation will be a Patient Safety Incident Response Plan and Policy.	
	BAF03/QPES /002	Organisational Safety Culture Assessment will be completed, and Divisional led action plans put into place to address safety culture concerns.	Interim AD of Nursing & Governance	October 2023	• Baseline of understanding will be achieved. • Divisional level ownership and engagement will be ensured.	
	BAF03/QPES /003	PSAG Agenda and Cycle of Business will be reviewed and strengthened.	Interim AD of Nursing & Governance	July 2023	• Will support cross organisational learning across a broad suite of topics, specialisms, and services.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
02/06/2023	New risk which has just been added.
27/09/2023	PSIRF update as above. - Options appraisal to support organisational safety culture assessment has been devised for presentation to ET.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement a recovery focus model across our range of services.	**Inherent Risk Rating**	4	4	16	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** 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.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF04/QPES	**There is a risk that the Trust may fail to implement a recovery focus model across our range of services.** This may be caused by: -				
	Lack of opportunities for service user participation. Lack of employment opportunities for those with lived experience.	• BSOL Provider Collaborative Development Plan. • Experience of Care campaign.	Family and carers pathway not consistently applied or suitable for all services.	• Integrated performance dashboard. • BSOL MH performance	Having a strong service user/carer voice across all of our governance forums.

	Lack of support for and involvement of families and careers.	• Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Family and carer pathway. • BSOL peer support approaches. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Recovery training part of fundamental training		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.	
	This may result in: -				

	• Inferior and poor care. • Lack of equity for service users across our diverse communities. • Ineffective relationships with key partners. • Lack of continuity of care and accountability between services. • Negative impact on service user access, experience and outcomes. • Negative impact on service user recovery and length of stay/time in services.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF04/QPES /001	Review and refresh of the family and carer pathway	Associate Director for Allied Health Professions and Recovery	Mar 2024	Families and carers will be routinely identified, and better supported or involved in care planning as appropriate.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Updating access to information policy by service users and carers and following a QI co-production approach.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to be rooted in communities and tackle health inequalities.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** 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.			**Date reviewed**	**27th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF05/QPES	**There is a risk that the Trust may fail to be rooted in communities and tackle health inequalities.** This may be caused by: -				
	Lack of engagement with our local communities. Services that are not tailored to fit the needs of our local communities or aligned to local services. Lack of understanding of our population, communities and health inequalities data. Not working together to tackle inequalities across the BSOL system Inadequate partnership working leading to barriers between services e.g., primary care, social care.	• Data with Dignity sessions. • Divisional inequalities plans. • PCREF framework • Synergy Pledge. • Provider Collaborative inequalities plans. • System approaches to improving and developing services. • Community Transformation Programme – now in year 3 of	• Divisional inequalities plans not fully finalized for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day	• Integrated performance dashboard. • BSOL system mental health performance dashboard. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering Group. • Reach Out	

	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	implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work. • Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighborhood teams. • Development of community collaboratives. • Community engagement team	job. • Recruitment and retention	governance structures. • Local FPP and CGC meetings. • Highlight and escalation reporting into Strategy and Transformation Board. • Performance Delivery Group “deep dives”. • Highlight and escalation reporting into BSOL MHPC Executive Steering Group.	
	This may result in: -				

	• Some communities being disengaged and mistrustful of the Trust. • Negative impact on service user recovery and length of stay. • Increased local and national scrutiny. • Increased risk of incidents due to inappropriate physical environments. • Poor reputation with partners. • Negative impact on service user access, experience and outcomes.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/QPES /001	Work ongoing to keep down capital costs of major developments, e.g. assessing potential use of a modular build.	Deputy Director of Estates / Associate Directors of Operations	Mar 2024	Affordable capital plans with identified funding.	
	BAF05/QPES /002	Quality improvement approaches being embedded to support transformation.	Head of Quality Improvement / Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF05/QPES /003	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF05/QPES /004	Support for development and implementation of divisional health inequalities plans from EDI team	Jas Kaur / Associate Directors of Operations	Oct 2023	Services will understand their current gaps and have actions in place to improve access, experience, and outcomes.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Co-produce approach with patients and carers and Voluntary Sectors and have devised a plan to integrate our patients successfully in the Communities.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** 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.			**Date reviewed**	**27th Sept 2023**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
BAF06/QPES	**There is a risk that the Trust may fail to implement preventative and early intervention strategies which can help enhance mental health and wellbeing.** This may be caused by: -						
	Demand for services exceeding our capacity to deliver good quality, timely care. . Lack of admission alternatives, including full range of crisis support services. Waiting times to access Solar services in Solihull. Waiting times to access Birmingham Healthy Minds.	• 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		• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.	

	Inadequate support for our service users with mental health co-morbidities e.g., 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.
				Transformation Board.
				• Performance Delivery Group "deep dives".
				• 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.				

Executive	Executive Director of		Impact	Likelihood	Score	Oversight Committee

	Linked risks on the CRR-Risk ID	**Brief risk description**
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc. due to the lack of AMHP availability, particularly out of hours.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF06/QPES /001	Quality improvement approaches being embedded to support transformation.	Head of Quality Improvement / Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /002	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	Oct 2023	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /003	Review of MHPC provider collaborative governance, including terms of reference and reporting and escalation flows.	Associate Director of BSOL MHPC	Sept 2023	Appropriate oversight and assurance.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
02/06/2023	New risk which has just been added.

		Inherent Risk Rating	4	5	20	Quality, Patient Experience and Safety 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.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**26th** June 2023.
		Risk Appetite	**Open:** 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.			**Date reviewed**	**27th Sept 2023**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
BAF07/QPES	**There is a risk that the Trust may fail to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.** This may be caused by: -						
	Not thinking as a system in developing priorities and improvement plans Lack of appropriate partnerships Ineffective partnerships e.g., lack of trust, collaboration, engagement, being seen as equals etc. Pathways and interfaces that are fragmented not joined up – both internally and externally Not being involved in system wide developments and initiatives e.g., development of	• Trust is a representative on key system groups e.g., ICB Board, Place Committees, Inequalities Committee. • Lead provider for BSOL mental health provider collaborative. • Lead provider for Reach Out (secure care) and a partner in CAMHS, eating disorders and	• Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about our population and needs.	Reports on system and partnership activity to: • WM Provider Collaborative Board • Provider Collaborative governance structures (BSOL and specialist services) • Operational Management Board • Strategy and Transformation Board • Board Committees			

	place, wider health inequalities work etc. Not having service user voice to inform transformation and development plans	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.		• 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-Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF07/QPES /001	Refresh Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Sept 2023	We will have a clear direction of travel, with our gaps identified and ambitions articulated to address the gaps and respond to our opportunities.	
	BAF07/QPES /002	Develop implementation plan for Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Dec 2023	We will have a coherent plan of how we are going to strengthen our partnership working.	
	BAF07/QPES /003	Commission Needs Assessment	Associate Director of BSOL MH Provider Collaborative	End Dec 2023	We will understand the needs of our core population and its diverse communities and can make sure our strategies and plans address these.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
26/06/2023	New risk which has just been added.
27/09/2023	Board session held on 6 September, led by P. Nyarumbu to discuss direction of travel for elements of the Partnerships Strategy. Further work to be undertaken following the session and feedback to be incorporated into the current draft strategy. Agreed that completion will be put back pending this. High level implementation plan is included in the draft strategy.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to focus on and harness the wider benefits of digital improvements.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023
		Risk Appetite	**Open:** Systems / technology developments considered to enable improved delivery. Agile principles may be followed.			**Date reviewed**	**19th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF01/FPP	*There is a risk that the Trust may fail to focus on the digital agenda and to harness the wider benefits of digital improvements.* *This may be caused by: -*				
	• *Teams and individuals don't know how to engage around the digital ask.* • *Teams and individuals don't know the art of the possible.*	The Trust has a System Strategy Group that has representation from the • Director of Finance • Chief Clinical Information Officer, • Chief Nursing Information Officer, • Chief Information Officer, • The Head of IT, • The Head of R&I, • The Head of Informatics, • L&D, • Estates,	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	

		• Governance, • Operations • 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.		FPP with CIO.	
	• *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 all new business	• 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

		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- **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.	**BAF01/FPP/ 001**	Wider communication across the Trust regarding the Systems Strategy Group, including its role.	James Reed / Carl Beet	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	
	BAF01/FPP/ 002	Raise awareness of the ability for the Systems Strategy Group to help in service redesign and re-imagining service delivery. Start with Senior Leadership Team meeting and professional user groups	James Reed / Carl Beet / Shaun Kelly	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
12/06/2023	This is a new risk which has been recently added.
19/09/2023	Updates to FPP have taken place in line with the quarterly cycle, 9 comms articles have gone out in the last quarter lifting the profile of digital projects and services featured in the weekly brief. The Digital strategy is in draft and has been shared with FPP and circulated through wider meetings as part of a general digital awareness. We have dedicated snap comms for all things digital and have used the snap comms to promote campaigns on cyber awareness, general digital updates, and system upgrades. We have expanded the use of the virtual agent / chat bot “Ask Jake” which now covers the majority of password resets in the organisation and we are looking to expand that in to other departments such as HR and Estates.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure in the Trust's care of the environment regarding implementation of the Green Plan	**Inherent Risk Rating**	3	3	9	Finance, Performance & Productivity Committee	
		Current Risk Rating	3	2	6		
		Target Risk Score	3	2	6	**Date added**	8th June 2023
		Risk Appetite	**Open:** Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.			**Date reviewed**	**12th Sept 2023**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
BAF02/FPP	There is a risk that the Trust may fail to meet national and regional sustainability, net zero carbon and its green plan objectives. This may be caused by: -						
	• *Management of vacant properties.* • *Management of Owned, Retained, PFI and landlord facilities.*	• Shareholder, Liaison, Contractor and Operational Management Team Meetings and Committees are all in place to ensure communication, Service delivery, and physical aspects and priorities are delivered to meet all quality requirements.	• 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 Department	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities		• 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 across the Trust to maintain momentum on the	

		• Operational and Strategic Health and Safety Committee, 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.	delivery and Clinical/ Nursing service commitment making sustainability and net zero carbon part of our BAU.	Managers. • Multi-disciplinary Trust Sustainability Group including SSL, 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	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.

				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. • 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.	• 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.

		• PFI Lifecycle Programme. • PPM, reactive and planned works • Delivery of the Trust Green Plan and the built in Action Plan			
	• *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. • Provision of food from Conventional in-house compliant facilities. • Operational and Strategic Water Management Groups. • Infection Control Committee.	• 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.	
	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- circa February 2024	The development of a business case will allow the planning of lifecycle/ maintenance responses on Reaside premises and ultimately address the replacement of the premises supporting safe, and sustainable care environment.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
11/05/2023	Full review of all 31 Estates and Facilities Risks, 12 Risks accepted and closed these will be reviewed annually to ensure circumstances

	and mitigation remains in place. The remaining 19 Risks have been re-assessed for content, mitigation, likelihood, and impact.
12/09/2023	Strategic Trust Sustainability/ Green Meetings BAU. Works underway to draft achievement against NHS E MOU. Comms Plan for Autumn/ Winter 23 underway. Liaison with Trade Unions on information and details for Green initiatives.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Failure to operate within its financial resources.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	09/06/2023
		Risk Appetite	**Open:** Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.			**Date reviewed**	**19th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF03/FPP	*There is a risk that the Trust may fail to operate within the financial resources available to it.* *This may be caused by: -*				
	Poor financial management by budget holders *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 pipeline for delivery of savings.	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 controls and performance.

				including any shortfall in savings delivery.	
	This may result in: -				
	• *Trust not meeting its financial targets limiting available funds for investment in patient pathways.*				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.			
	112	The Trust does not secure the growth funding we require.			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF03/FPP/ 001	HFMA Sustainability Audit identified over 50 actions, that would lead to improvements in financial controls as well as savings delivery – these are updated and reported through Audit Committee.	Deputy Director of Finance	Each action has a different implementation date but expectation all completed by 31/3/24	Action will mitigate the impact of the risk were it to crystallise.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
25/04/2023	25 actions confirmed closed through April Audit Committee for HFMA Sustainability Audit.
01/09/2023	Communications issued to whole Trust re financial position – number of initiatives implemented to increase controls including Vacancy Control Panel and Investment Oversight Group. Work ongoing to identify further opportunities for efficiencies and work by KPMG at system level now being finalised which offers some further options

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to comply with the requirements of Good Governance.	**Inherent Risk Rating**	5	5	25	Finance, Performance & Productivity Committee	
		Current Risk Rating	5	3	15		
		Target Risk Score	2	2	4	**Date added**	25/04/2023
		Risk Appetite	**Minimal:** 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.			**Date reviewed**	**19th Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF04/FPP	There is a risk that the Trust may fail to comply with the requirements of Good Governance such as compliance with regulatory provisions, the Nolan Principles, corporate governance codes and best practice. This may be caused by: -				
	Lack of good intelligence on the current governance arrangements from Ward to Board. *Regulatory burden and pressures including ad hoc requests from regulators.* *A fluid regulatory landscape.* *A non-compliance mindset or mentality.* *A weak governance infrastructure.*	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	Operational pressures negatively impacting on staff capacity to fully implement these controls. Self-assessments, accreditation and self-certification processes aren`t strong. Governance around compliance is weak.	Inspection reports. Compliance audits. Self-assessment, accreditation and self-certification reports. External visit reports. Peer Reviews. Board Assurance Framework Report.	Poor learning from previous regulatory inspections. Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. Peer review not very regular. The culture of BAF not fully developed and embedded.

	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 strengthening decision making.*	compliance. 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.	Controls have not been embedded.		
	This may result in: -				

	• *Regulatory action – penalty, notice etc.* • *Reputational damage to the Trust.* • *Poor patient care, safety and experience.* • *Loss of some business operations.* • *Legal actions in some extreme cases.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	1049	Failure to recruit and retain staff to enable safe staffing levels could result in a breach of HCSA regulation 18 (staffing). Risk of increasing reliance on agency and temporary workforce, will result in poor continuity of care and impact on safer staffing requirements.
	950	There is a risk that CMHT caseloads will continue to be above 35 which will breach regulation 18 HSCA (RA) Regulations 2014 Staffing. Caused by CMHT having 3 workstreams being: primary care talking therapies, memory drug prescribing & monitoring and core secondary mental health provision. This may result in higher risk of clinical incidents, increase in staff sickness, poor work-home-life balance, service users not receiving a quality service and increased waiting lists and waiting times for service users.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF04/FPP/ 001	To design a SOP to underpin the process for capturing, monitoring, review, scrutiny and governance oversight of external visits and externally commissioned reports registered.	David Tita	30/10/2023	The SOP will help reduce the likelihood of the risk materialising.	
	BAF04/FPP/ 002	Review of the Trust`s governance arrangements from `Ward to Board`.	David Tita & Lisa Pim	31/03/2024	This action will create a better understanding and help reduce the likelihood and impact were the risk to materialise.	
	BAF04/FPP/ 003	Review of the Trust`s Risk Management arrangements.	David Tita	20/12/2023	This action will create a better understanding and help reduce the likelihood and impact were	

					the risk to materialise.	

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	This is a new risk that has been recently added and is being appropriately mitigated and monitored.
19/09/2023	ToR for the review of the Trust`s governance arrangements have been finalised and are progressing through governance for approval and implementation. ToR also include a schedule for undertaking the governance review and an options appraisal reflecting potential options that have been considered and a recommendation of the preferred option. Timescales for delivering the various actions have been reviewed to align with the ToR.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	Oversight Committee	
Title of risk	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	2	6	Date added	2nd June 2023
		Risk Appetite	**Open:** 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.			Date reviewed	**22nd Sept 2023**

Reference / Risk ID or Number	Risk Description	Controls *Things in place to address the cause*	Gaps in Controls What are the weaknesses in the controls?	Assurances *Triangulated evidence that the controls are in place, being followed, and making a difference*	Gaps in assurance What are the weaknesses in the assurance?
BAF05/FPP	*There is a risk that the Trust may fail to harness the opportunities and dividends provided by partnership working within the system and collaborative space in delivering high quality patient-centred mental health services to the local population of Birmingham and Solihull.* This may be caused by:				
	• *Inability to embed BSOL Mental Health Provider Collaborative*	• MHPC governance architecture. • Reach Out governance architecture. • Appropriate contractual arrangements – procurement, dispute resolution, suspension and termination, decommissioning, and conflicts of	• *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.*

		interest policies. • Enhanced relationships with partners. • Multi-partner Hub. • Better engagement with partners and shared governance arrangements. • Establishment of Memorandum of Understandings. • VCFSE collective and Panel embedded into governance structure in the Collaborative. • Implementation of Data Sharing Agreements.	. • *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	• 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	• Delays in getting signed agreements.

		• Memorandum of Understanding.		• Auditable process for decision-taking • Consistent attendance at CoCo Sub-Committees	
	• *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 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	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.	

target risk score.	BAF05/FPP/003	Multi-agency engagement in decision forming groups for MHPC.	All Chairs Monthly	Dec 2023	This action will create awareness and help reduce the likelihood and impact were the risk to crystallise.	
	BAF05/FPP/004	Ownership of new and emerging risks and reporting within the Collaborative	JW	30/11/2023	This action will create awareness and help reduce the likelihood and impact of the risk were it to crystallise.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	Not applicable at this moment as risk has been newly identified.
28/09/2023	• There have been two workshops facilitated by Korn Ferries with the CYP Transformation Boards in both Birmingham and Solihull to support a re-set of the Boards including the positioning within the MHPC Governance Architecture. • Continued engagement with the VCFSE forum. • Multi-agency working groups have been established to take forward the commissioning of the Health Needs Assessment and Campaign to support the development of the BSOL MHPC Strategy.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to shape our future workforce.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.			**Date reviewed**	**21st Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF01/PC	There is a risk that the Trust may fail to deliver its ambition to shape its future workforce. This may be caused by: -				
	• *Inability to deliver the commitments of our workforce plan.* • *Difficulties with recruiting and retaining staff.* • *Staff shortage with demand outstripping supply.* • *A shrinking UK workforce market and the lack of long-term planning by government as enough staff aren`t being trained.*	Embedding of a values-led culture: • Values and Behavioral Framework • Restoration and Recovery Group • NHSE&I Quarterly Pulse Check Survey • National Annual Staff Survey • Friends and Family Test • Leavers surveys	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. • Staff survey results still reflect some gaps.

		(exit questionnaires) Health & Wellbeing offer Model Employer	Recruiting but not retaining colleagues	• Staff Survey results improving to top quartile performance.	
	• *Less attractive pay for some staff groups.*	Management of the workforce market: ICS workforce programme to manage demand and competition in the system in collaboration with partners. Membership of the ICS People Committee. Assertive recruitment to areas with chronic vacancy challenges. National payment mechanisms and banding panels. Remuneration Committee. Recruitment Policy and processes. Stabilisation Plan Retention Plan		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population • Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover • Analysis of exit interviews. • % staff who leave for a higher banded job.	• Falling to reassurance rather than assurance
	This may result in: -				

	• Failure to recruit a workforce that supports the values of the organisation. • Support the progression and development of the workforce. • An underperforming workforce. • Failure to represent the profile of the organisation within the workforce. • Sustained patterns of inequality and discrimination. • High turnover • Non-compliant behaviours. • Employee relations cases.	
	Linked risks on the CRR-Risk ID	**Brief risk description**
	1058	Shrinking supply of mental health nurses nationally. Additionally, Difficulties in recruiting to and retaining Band 5 Registered Mental Health Nurse and shortage of experienced Band 6 Registered Mental Health Nurses continues to be a challenge (4x4=16)

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/PC/001	Deliver our workforce plan through: Increasing workforce supply to address workforce gaps across the organisation.	Head of Workforce Transformation	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF01/PC/002	Progressing the retention activities and improve our turnover rate.		Apr 24		
	BAF01/PC/003	Support delivery of service specific recruitment and retention plans.		Apr 24		
	BAF01/PC/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		Apr 24		
	BAF01/PC/005	Develop and roll out a package of First Line Management training that supports all aspects of the role and is supported by an action learning set infrastructure	Head of People & culture	Sep 23	Providing bespoke training packages to support managers.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Work predominately in this area is progressing as planned. Volumes in relation to INR has not been achieved as projected, however this is being addressed. Despite continuous IA around junior doctor and consultant pay, recruitment to consultant posts has increased. Retention is healthy within the Trust, priority is with attraction and onboarding. Score remains the same.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.			**Date reviewed**	**22nd Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF02/PC	There is a risk that the Trust may fail to deliver its ambition of transforming its workforce culture and staff experience. This may be caused by: -				
	• *Inability to deliver and embed staff engagement programmes.* • *Inability to improve staff engagement scores to the NHS staff survey.* • *Inability to provide a comprehensive Health and Wellbeing offer.*	• Roffey Park Leadership Programme • Active bystander training • Flourish programme. • Enough is Enough campaign. • Staff Survey • Pulse check • Patient Safety Incident response framework • Health & Wellbeing offer • HR Toolkit training	• Limited attendance at training programmes • Limited sustainability of ALS • No adherence to principles of Flourish. • Not accessing health & wellbeing offers	• Values based 360-degree feedback for senior leaders. • FTSU quarterly reports to committees. • HR casework tracker. • Staff survey results are improving in some areas. • HR KPI reports • Bespoke health & Wellbeing survey.	• Falling to reassurance rather than assurance.

	This may result in: -	
	• Lack of recruitment • Reduce trust and confidence in communities. • Unmotivated workforce. • Increased bullying and harassment claims. • Increased sickness • Increased turnover	
	Linked risks on the CRR- Risk ID	Brief risk description
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/PC/ 001	Provide continuous support to operational divisions in improving the experience of our workforce.	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF02/PC/ 002	Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme.	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF02/PC/ 003	Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes	AD OF EDI and OD	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional factors have been highlighted that add to the risk without increasing the score

Executive Lead	Executive Director of Strategy, People & Partnerships.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Inability to modernise our people practice.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	3	9	**Date added**	**2nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.			**Date reviewed**	**21st Sept 2023**

Reference / Risk ID or Number	Risk Description	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF03/PC	There is a risk that the Trust may fail to modernise its people practice in ensuring the achievement of its operational objectives. This may be caused by: -				
	• *Inability to deliver digital solutions.* • *Inability to foster a psychologically safe environment.*	• Staff survey • Pulse check • Reflective HR casework • Transforming culture sub-committee • Systems strategy board • A range of digital platforms through which colleagues	• Colleagues not completing surveys. • Capacity to undertake this work. • Low trust and confidence.	• 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	• 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.

		can escalate and feed in centrally. QI Projects to address some of the concerns raised by staff. Research and benchmarking against what good looks like. Working with ICS partners to identify shared digital solutions. Use of integrated digital solutions e.g. Digital passports.	• Lack of digital infrastructure. • 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.	• Digital Staff management system.	
	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
		Develop a range of digital solutions to	Head of People	Apr 24	Periodic set of actions to identify and	

Actions being implemented to achieve target risk score.	BAF03/PC/001	streamline or automate people processes	& Culture		address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF03/PC/002	Ensuring that ESR holds accurate and credible workforce data	Head of People & Culture	Apr 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Progress in relation to developing a range of digital solutions for our people processes has been slow due to staffing shortages, however some local work has been completed. Work is underway to address the accuracy within our ESR data and this now will be overseen by an internal workforce systems group. Score has not changed.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Current Risk Rating**	4	4	16		
		Target Risk Score	2	4	8	**Date added**	**6th July 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.			**Date reviewed**	**22nd Sept 2023**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF4-PC	There is a risk that the Trust may fail in addressing racism and discrimination both behavioral and systemic across people and process. This may be caused by: -				
	• lack of focus on an enabling a anti racist, anti-discriminatory culture. • Inability to change processes that enhance discrimination. • Lack of focus on identifying and addressing workforce inequalities. • Lack of focus on identifying and addressing health inequalities.	• Values and Behavioral Framework. • FLOURISH • Data with Dignity. • Divisional Reducing Inequalities Plans. • Restorative Learning and Just Culture programme. • No Hate Zone. • Community Collaborative.	• Colleagues not engaging in controls set. • Lack of local accountability. • Not following values and behaviors framework.	• Values-based recruitment. • Workforce Race Equality Standard. • Workforce Disability Equality Standard. • Model Employer • NHSE High Impact Actions. • Pay Gap • Public Sector Equality Duty Report. • Reducing Health Inequalities Program • Patient Carer Race Equality Framework.	• Gaps in ensuring appropriate capacity and resource is assigned and maintained to mitigate the risk. • Gaps currently in maintain pace and sustainability of positive changes. • Gaps in ensuring measurements are fit for purpose, particularly relating to health inequalities.

				• Staff Survey results improving to top quartile performance. • EDI Improvement plan	• 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.
22/09/2023	Additional assurance available from the NHS EDI Improvement plan, score remains

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	7
Paper title	**CHAIR'S REPORT**
Date	6 December 2023
Author	Phil Gayle, Chair
Executive sponsor	Phil Gayle, Chair

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

Executive summary & Recommendations:

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

Reason for consideration:

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

Previous consideration of report by:

Not applicable.

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

Select Strategic Priority

Financial Implications *(detail any financial implications)*

Not applicable for this report

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

Not applicable for this report

Equality impact assessments:

Not applicable for this report

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

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

BOARD OF DIRECTORS CHAIR'S REPORT

1. INTRODUCTION

I am pleased to offer the Board a brief summary of my activities as Chair over the period since our last meeting, which was on 4th October 2023. Much of the focus over this period has been on continuing building relationships with stakeholders improving openness and transparency, particularly through data sharing which allows us all to understand the challenges to improving performance and associated outcomes as well as where we can improve, on a sustainable basis, across the health system working in partnership.

2. CLINICAL SERVICES

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

2.2 I have spent time visiting staff across Trust sites on a weekly basis and have been humbled by their dedication to delivering the best possible services.

2.3 Following on from my last report to the Board I am proud to highlight that staff from the Barberry have received personal letters of thanks and support from Mr Steve McCabe, MP, following his visit during September 2023.

2.4 I was honored to be able to join colleagues at our Recovery College Forum where I was pleased to be able to gain a greater understanding of the courses on offer and opportunities available for both staff and service users.

3. MPs

3.1 I was pleased to be able to visit the Lyndon Clinic, Solihull and meet local MP Mr. Saqib Bhatti, MP, where staff were able to showcase the services delivered. I also since my last report I had a meeting with Paulette Hamilton MP. Meeting our local MPs enables constructive conversations to take place to discuss how the whole health system can interact to assist their constituents to gain the best quality of care at the right time and in the right place. We have a few services located in a number of our MPs constituents and it is important to ensure we have their support particularly where significant investment is needed. This will become ever more essential as we deal nationally with financial constraints. Therefore, we need to ensure they fully understand both the benefits and dis-benefits that all the changes will have to their constituents, the Trust and the staff who provide the services.

4. PEOPLE

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

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

3.3 I am pleased to confirm that following a robust recruitment process, Thomas Kearny has been appointed as a Non- Executive Director. Thomas has formally joined the Board this

week having completed our Trust induction programme.

3.4 In the coming months I look forward to meeting with Sir Bruce Keogh, Chair, Birmingham Women's & Children's NHS Foundation Trust, and visiting their services to continue to develop partnership relationships.

3.5 I was pleased to be able to meet with Staff Side colleagues from a number of unions and discuss the support I can offer on a range of challenges. Further meetings are being arranged to be able to ensure positive working relations continue to develop.

3.6 I was pleased to meet with Rebecca Farmer, NHS England, to discuss the key areas of focus for the Trust moving into 2024.

4. QUALITY

4.1 I was pleased to be able to attend the NHS Provider Conference over two days in Liverpool during November and was joined by a number of Board colleagues. This years theme was Vital, representing the essential care the provider sector delivers, the deep commitment of staff, and the importance of ensuring our health service is sustainable for the future. I was pleased to be able to attend a number of sessions and here the Secretary of State for Health and Social Care share her vision for the NHS as we enter an election year, following a turbulent time of industrial action and immense pressures on the service.

4.2 As a Board we held our final strategic session for 2023 supported by NHS Providers where we focused on our Board composition and agreed our key areas of focus and key outcomes for the Board.

5. SUSTAINABILITY

5.1 I was pleased to be able to Chair the Council of Governors meeting in November 2023 where we welcomed new members of the Council and were assured the current elections for vacant posts are now at ballot stage with results being made available in January 2024.

A number of our long-standing Governors have come to the end of their terms and so we thanked;

Dr Imran Waheed
Imran joined us on the Council at the end of 2022 following the elections process for a Medical Governor. During his time on the Council Imran has been a great presence and voice for medical staff, however competing clinical demand has impacted his ability to be able to gain as much momentum as he had hoped. Imran has recently been appointed as Deputy Medical Director and so has taken the decision to stand down from his Governor role. I am sure you will all join me in wishing Imran all the very best as he embarks on this leadership role and thank Imran for his tenure as a Governor.

Jim Chapman:
Jim has sadly come to the end of his third term as a Governor. Over the years Jim has been a really valued member of the Council who has always offered support in developing and strengthening our partnership with the University. Over the years Jim has supported the Trust in ensuring students get the best possible experiences when working with the Trust and has always explored new and innovative avenues for improvements. Over recent months Jim has been a great support and buddy to a number of our Governors and has always taken the time to check in and ensure his Governor colleagues are OK.
I am pleased to announce that Rob Mapp will join the Council as our stakeholder Governor As Jim's replacement. Key 1:1 meetings will be arranged in the coming weeks.

Vic Fewster:
Since our last meeting Vic has started in her substantive role within the Trust and therefore has had to formally resign from her Governing role. I want to acknowledge and to thank Vic for her dedication to the governing body over the years and for always representing her constitution in the best possible manner. Vic's input and challenge have driven change and developed services in line with best practice for our service users. I am sure you will all join me in wishing Vic all the best in her new role and I look forward to being able to continue to work with her.

5.2 I can confirm our Council of Governor Board development sessions have been developed and agreed for the coming year. These sessions will allow the core development of the Council of Governors. The first session took place in August 2023.

5.3 I chaired the third Remuneration and Nomination Committee for 2023 where we approved the recruitment process for the Chief Nurse taking place in December 2023.

5.4 I chaired an Extraordinary Board in November 2023 where the Board held a focused discussion in relation to the increasing financial pressures supported by key finance colleagues where we reviewed additional saving options.

PHIL GAYLE
CHAIR

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**Item 8**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	6 December 2023
Author	Vanessa Devlin and Roisin Fallon-Williams
Executive sponsor	Roisin Fallon- Williams

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

Executive summary

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

Reason for consideration

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

Paper previous consideration

Not Applicable

Strategic objectives

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

Financial implications

Not applicable for this report

Risks

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

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

CHIEF EXECUTIVE and DIRECTOR of OPERATION'S REPORT

PEOPLE

Doctors Industrial Action

There has been no industrial action by Junior Doctors or Consultants since 04/10/23. The mandate covering industrial action of junior doctors is until 28/02/24. For Consultants it is until 26/12/23, however a new ballot to renew the mandate opened on 06/11/23 and closes on 18/12/23. This would cover any action between 01/01/24 – 17/06/24. A re-ballot of SAS doctors also opened on 06/11/23 and will close on 18/12/23.

A new pay offer has been made to NHS Consultants and will now be put forward by the BMA to its members via a referendum. The result of the referendum is not expected until late January and we are informed there will be no strike action by consultants until that result is known. The offer reduces the number of pay points from eight to four and reduces the number of years it takes a consultant to reach the top of the scale by five years. The starting pay for new consultants and to the top pay point would be increased. If accepted the changes will be implemented in April 2024 but backdated to January 2024.

Medical Support Workers

Unfortunately, we received some disappointing news about the NHSE funding approved for 12 new Medical Support Workers whereby this funding is no longer available due to significant financial challenges across NHS systems created by industrial action in 2023/24. The recruitment process had not commenced and we will continue to seek funding streams to develop this role further in BSMHFT.

Changes to Higher Trainee (Specialist Registrar) 2nd tier on call rotas

Agreement has been reached to change from the current system of 3 on call Specialist Registrar rotas to 2 full shift Specialist Registrar rotas, with additional weekend cover. from 06/02/24. This rota pattern will better match the work intensity and is anticipated to reduce the Guardian of Safe Working fines currently levied when Specialist Registrars do not receive their contractual rest.

Staff Survey

The national staff survey period closed on Friday 24th November 2023. Thank yo to all colleagues who took the time to complete the survey. Thank you also to John Travers and all local senior leadership teams for the support and encouragement they provided to colleagues across the Trust to have their say and complete the survey. We will as usual receive the results from this years survey in early 2024.

CLINICAL SERVICES

Summary

The post pandemic period has presented service areas with challenges in particular in terms of filling staff vacancies and increasing demand on services. Innovative and creative solutions have been considered with attractive offers and benefits of joining the Trust also now a feature. Despite these challenges colleagues are committed to delivering as high-quality services as possible, always aiming for as easy access as

achievable for all service users. The following report is a high-level summary of the activities of each service areas over the past couple of months.

Integrated Community Care and Recovery (ICCR)

Over the past 5 years our Community Mental Health Teams (CMHT) have seen a significant increase in caseloads. We are also experiencing an increase uptake in activity in our Neighbourhood mental health function, who have seen over 14000 patients in the past 12 months. It is evident from our extended mental health offer at primary level, that there is a greater need in our communities' post Covid for mental health support.

As shared in previous reports our clinicians, particularly our doctor, psychological therapist and duty clinicians within CMHT have raised concerns regarding the increasing demand and capacity. We continue to review this as part of our community transformation work as well as in our system locality working.

Despite the high levels of need in our community our CMHTs receive over 85% positive responses via our Friends and Family Tests, some examples of these are below:
"The team gave me hope for myself".

"Doctor spends time listening to you, feel they understood me. Never had a service like this, who do take the time and who do actually care "

"The appointment was explained at the beginning, and I was made to feel welcome and was reassured at every stage".

Our CMHT's had a targeted Care Quality Commission (CQC) inspection in August 2023. The immediate concerns noted have been promptly addressed, with a significant improvement in performance which is now at, 98% for Care Programme Approach Plans, 94% for Care Programme Approach Risks Assessments, 81% for Care Support Plans and 86% Care Support Risk Assessments.

Quality audits of these documents are also now fully underway along with medicines management audits with the support of our pharmacy team. All audit activity will be reported via local Clinical Governance Committees. Deep dive work is underway to review waiting times and other key performance indicator data, to ensure the service is as efficient as is possible and that we impact positively on measures where we can.

ICCR have been working closely with partners across Birmingham supporting the Community Collaborator Developments and testing the Integrated Neighbourhood Teams (INT). We have supported pilots in the West and East of the city and are awaiting evaluation of these pilots. The INT leads are seeking further support and staffing investment to roll out the pilot across South, North & Solihull, work is underway to explore how we can support this initiative.

Other services within ICCR are working through key objectives and challenges, there are no specific issues to highlight.

The ICCR leadership team continue to support and engage teams in discussions around staff health and wellbeing, equality, diversity, and inclusion and bullying and harassment. We are also ensuring we take just culture principles forward and are seeing a greater degree of learning and reflection amongst our teams and staff.

Secure Care & Offender Health (SCOH)

HMP Birmingham staffing is improving slowly, and the mental health team is now fully established. We continue to review and implement our plans to ensure that the service is

working to its full establishment across all the pathways. Pressure remains for primary care nurses, and we continue to support our partners in this area. An NHSE quality review has taken place, with feedback indicating a vast improvement compared with last year's visit. These included, staffing, culture, retention and good care delivery despite prison pressures. Issues were noted regarding prison enablement and estates. We look forward to receiving the report in the forthcoming months.

Secure inpatient services continue to experience qualified nursing vacancies across the men's and women's services. Continuous recruitment is taking place with new students and internationally educated nurses taking up posts in the division. Ward managers and Clinical Nurse Managers/Matrons are meeting daily on each site to prioritise work and assess any shortfalls. Support takes place between sites and ward managers and matron's are working within numbers where necessary, along with our psychology and occupational therapy professions colleagues supporting activities on wards.

The Enhanced Reconnect business case has been submitted to commissioners. This is a psychologically led service helping those who are high risk, complex and are considered to be in an actual/ potential counter terrorism risk situation post prison. The service is designed to support individuals to reconnect and re-engage with their communities over an 18-month period. We anticipate receiving feedback in the forthcoming month for the submission.

Acute and Urgent Care

We continue to focus and implement our plans to support safe staffing on all of our acute wards, with a spotlight supporting our managers with their rota management. Our Home Treatment Teams are also reviewing their establishments, as they collate their data and clinical activity in order to meet the current demand.

In our central area we have recruited to all our registered nursing vacancies on 4 of the 5 wards, with a focus now on our remaining or staff, which will include looking after their wellbeing.

As part of our 5-point productivity plan to drive down our inappropriate Out of Area placements, we are implementing a locality working model. The Locality Model is being implemented across the Central and West areas. Taking a quality improvement approach, the model continues to be tweaked and lesson learning aspects are discussed in our monthly meetings to ensure that we improve the service delivery. The model is due to be rolled out in the South, North & Solihull in December/January. Early results are reporting, a decrease in the delayed transfers of care, quicker and more timely admissions for complex service users in the community, along with a reduction in individuals being placed in inappropriate out of area provision.

Our productivity plan also focuses on our Delayed Transfer of Care (DTOC) as there are a number of concerns regarding barriers to enable a safe service user transfer/discharge. Scrutiny of these takes place in the localities as well as at system level with ICB colleagues. We are currently in the process of pulling together an 'invest to save plan', which will enable us to continue with this focused work, throughout the winter.

We are working with West Midlands ambulance Services (WMAS) and West Midlands Police (WMP) to support direct access to our Psychiatric Decision Unit (PDU) as an alternative to A&E. This will only be applicable to service users who do not require a physical clinical intervention. We are currently in the process of undergoing joint training to access all the IT systems required. This work also links to our 'call before you convey' offer, which will be moving to 24hours from 4th December 2023. All these initiatives will further enhance our mental health urgent care response offer, both in and out of core

hours.

Our focused work continues with regards to Learning Disability & Autism (LDA) awareness, with a focus on our inpatient and urgent care pathways. We held a very successful training day in November for senior leaders across acute and urgent care, involving Experts by Experience and ICB colleagues, this enabled us to confirm and agree our service user pathways. The outputs and learning from the event will be shared wider across the Trust.

In November we celebrated our first patient council involving (13 out of 16 wards) which yielded positive results and great feedback from those involved. This was also shared at one of our committees with wider Board members as our service user story. One of our experts by experience who presented stated:

'All of my feedback is really positive, having the service users give real time feedback was very refreshing".

The coffee morning held at one of our female inpatient wards was said to be particularly valued by service users, and this has motivated both service users and staff to explore a similar offer on their wards.

Specialties, Frailty & Dementia

The Perinatal Service has recently hosted a visit from NHSE Perinatal and Young Peoples team and are on track to meet the NHSE Long Term Plan ambitions for perinatal services by March 24.

Members of the service recently spoke at the NHSE National Perinatal webinar on achieving the long-term plans and have since been approached by a number of different systems to advise on delivering our successful care models. The service was recently mentioned in an article by a Birmingham Women's hospital patient, who stated that, "I also received support from the Birmingham and Solihull Mental Health NHS Foundation Trust Perinatal Mental Health Service, who were phenomenal and were a vital help to me."

Four International Nurses have been recruited across our older adult inpatient wards, Bergamot, Rosemary, and Reservoir court. All wards continue to experience an increase in levels of required nursing observations due to high levels of acuity. The recent Band 6 Leadership Day across the Frailty and Dementia wards was well received and there are plans to continue with a programme of further clinical and leadership updates.

The Meriden Family Programme had a successful 25th Anniversary conference in October with over 100 delegates in attendance. The free conference focused on the implementation of Behavioural Family Therapy (BFT). There were speakers from Japan, Iraq, Australia, New Zealand, Canada and the UK who spoke and delivered workshops regarding their experiences of delivering and receiving BFT.

The Bipolar Service are working in collaboration with the Transformation Programme to deliver a programme of work to enhance existing pathways and improve care and outcomes for individuals with a diagnosis of bipolar or psychosis. This will formally commence in December.

Across the older adult CMHT's, the Collaborative has commenced work with Hall Green Health Centre beginning with the introduction of Cognitively ICA (a 5-minute computerised cognitive assessment tool) into Primary Care to improve dementia referrals to our services. Hall Green Health have already identified 40 Service Users, who will require a Memory Assessment by using the cognetivity test. Our memory assessment service

(MAS) is currently reporting long waiting list of up to 9 months. We are theerfore extending clinical hours to address this as well as exploring additional funding to extend this further.

The North HuB CMHT Post Dementia Diagnostic Education Collaborative, has commenced work within Birmingham Hospices to deliver the post diagnostic support groups for people and carers of those diagnosed with dementia in line with NICE guidance. The programme covers a host of different subjects each week such as Dementia, Power of Attorneys, Medication, physical health, benefits. Two cohorts have now been completed which have been very successful. The first cohort at the end of the 12 weeks have remained in touch and have gone on to form their own support group.

Birmingham Talking Therapies welcomed 13 newly qualified staff, 15 trainees and 4 apprentices in October. A robust action plan is now in place to support the team to address their waiting times, access, and achievement of the 18,602 target by March 23/24. The Employment Advice element within Talking Therapies have now received 120 referrals since going live at the end of September 23.

Op Courage Veterans are holding a regional team development day with all partners in November as part of their ongoing staff engagement and continuous service improvement model.

Staffing levels across the specialty areas within the Barberry Centre are now improving with less reliance on bank and agency usage, although high levels of vacancies remains, which are being addressed via our recruitment and retention plans. The Eating Disorders team have commenced a day group programme and are beginning several other initiatives with support from the Collaborative. The Neurosurgery team are currently seeking support from the QI team to enable them to reduce their waiting lists, despite the waits they continue to receive consistently good Friends and Family feedback. The Deaf Service are now finalising the care pathway review work and holding a safety summit in November following several recent safeguarding issues.

Within Arts Psychotherapy the SCHEMA RCT (Secure Care Evaluation of Manualised Art Psychotherapy), which seeks to reduce the frequency and severity of interpersonal conflict and personal distress has recruited its first participants within the Tamarind services. This is the team's first steps towards becoming a research active team. There has been some fantastic feedback this month from a mother of a service user who reported:

'Hannah, Art Therapist at Longbridge CMHT assisted my daughter to explore and express her feelings around death through Art Therapy. There isn't anything that could have been improved upon, Art Therapy is very important to people who are facing end of life. It allows the individual to feel free to express themselves through art.'

SUSTAINABILITY

2023-24 Funding

The Trust along with system partners have been working hard over the last couple of weeks to meet a national requirement to relook at the financial position with the aim of securing a break-even position by the end of the financial year. NHS England have been working with the Government to identify additional funds to offset the cost of industrial action that providers have faced this year – the share for Birmingham and Solihull was £25m. With this additional funding, and a review of plans and financial opportunities in each organisation is being undertaken to determine how we might reach a balanced position by the end of the financial year.

Birmingham and Solihull (BSoL) Mental Health Provide Collaborative Update

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

Key activities include:

- Workshops with both Children and young people (CYP) Transformation Boards to re-set their roles and accountabilities into the provider collaborative.
- A workshop was held with the VCFSE (Voluntary, Community, Faith & Social Enterprise) Panel on the 14 November 2023. The aim of the workshop was to connect and foster positive working relationships, define what great collaboration should look like, bring to life the challenges and opportunities being faced by the collaborative and identify key commitments and milestones.
- The MHPC were part of the VCFSE Collective event held on the 28 November 2023 which focused on the development of a future approach to commissioning and contracting with the Voluntary, Community, Faith & Social Enterprise Sector.
- Work has commenced around the review of Section 117 processes with Local Authority partners, this includes reviewing the Memorandum of Understanding which underpins the principles of delivery for Section 117

NHS Providers Board Development Session

The Board took part in the last of a series of development sessions with NHS Providers on 15 November.
The sessions focused on Board composition and effectiveness, and reflections on how the Board is operating. Comparisons were made from when the sessions first began in January 2022, with some incredible positive improvements and a real feeling of cohesion and togetherness.

There were some further developments identified by members of the Board, particularly in relation to strengthening accountability and governance processes to deliver results.
The Board is committed to continuous improvement and will be focusing on developments with the Senior Leaders Forum, divisions and teams.

How can we make better use of digital?

We have recently approved the Trust Digital strategy and in October held a Board development session looking at the digital environment and the opportunities that a greater awareness and use of Digital could afford us. We have been working with senior leaders to look at what services need to look like in the future and need to bring these two pieces of work together to see how we develop the digital ask to help deliver the digital strategy and the future state of our services.

We are recognised as a digital exemplar in the NHS and have access to a large amount of data to support our staff and services, we will be bringing the ask to a future senior leaders event to explore what we can do with the data we hold and what additional data we need from our organisation and other organisations to better inform their support of staff and patients. We will ask how we can augment the services to improve outcomes?
What could services do different if it was better supported by a digital offering?
And what are the repetitive tasks that could be automated?

The outcome of the session should allow us all to better understand the digital offer, what we can do differently and garner greater support for a better digitally enabled future.

QUALITY

CQC

We continue to make progress against the actions that were developed in response to the Must and Should Do findings of the Core and Well-led inspections that took place in October and December 2022 with the majority of actions completed or track to be.

Currently we have the following overdue actions:

- Must Dos – 5 in Acute Care, 1 in Home Treatment, 1 in Steps to Recovery and 2 in Dementia and Frailty
- Should Dos – 1 in Acute Care, 1 in Steps to Recovery, 1 in Urgent Care and 1 in Specialties

They are overdue either due to the Compliance team not being satisfied with the evidence submitted to demonstrate completion or in the case of training figures, some teams not meeting the lower threshold of compliance. Updates on this action plan are shared with the CQC at the 2 monthly Engagement meeting.

CMHTs were inspected in August 2023 and prior to the publishing of the report, the Trust was issued with two Section 29A notices around Care Plans and Risk Assessments and Medicines Management – we submitted action statements to the CQC on how these issues would be addressed and updates have shown improvement in practice in all of the areas identified in comparison to the findings at the inspection.

The CMHT report will be published on November 29th and the Trust will need to submit its action plan in response to the findings by December 5th. The Head of Regulatory Compliance is working with the Service leads to ensure this deadline is met. CMHTs were given a rating of Requires Improvement with their previous rating in 2017 being Good.

In early October the CQC conducted a further inspection of Acute Care, Secure Care and Steps to Recovery inpatient services to review the conditions imposed by the Section 31 issued in January 2021. Initial high-level feedback indicates that there is evidence to show that the Trust has met the condition on ligature risks however the evidence for care plans was mixed. This report should be available early December 2023.

LEADERS IN MENTAL HEALTH ACHIEVEMNETS AND CELEBRATIONS

HSJ names Marimouttou Coumarassamy as one of the 50 most influential Black, Asian and minority ethnic people in health

Mr Coumarassamy – widely known as Coumar – is the deputy director of operations at Birmingham and Solihull Mental Health FT but is perhaps even better known for his work setting up the British Indian Nurses Association, representing one of the largest groups of overseas nurses in the UK.

He founded the group in 2020, as an offshoot of the British Association of Physicians of Indian Origin, and with support from chief nursing officer Dame Ruth May. BINA aims to support nurses arriving from the Indian subcontinent and to help them progress in their careers. This year he launched a petition calling for an independent inquiry into whether

injustices were suffered by ethnic minority staff during the pandemic – many of the health workers who have died are from this group.

Congratulations on this incredible recognition Coumar.

Psychiatrist of the Year

A huge congratulations to Dr Fabida Aria, who was awarded Psychiatrist of the Year.

The Royal College of Psychiatrists Awards celebrate the nation's best and brightest teams and individuals in our field. Taking place every year, hundreds of individuals flock to London for the prestigious awards ceremony.

An inspiring role model to many, Dr Fabida Aria won the Psychiatrist of the Year accolade for her exceptional passion in her roles as a Consultant Psychiatrist and Executive Medical Director at the Trust.

Fabida was presented her prestigious award by Professor Sir Stephen Powis, National Medical Director of NHS England.

Specialty Doctor/ Associate Specialist of the Year

A huge congratulations to Dr Ishtiaq Ahmad.

An Associate Specialist in Old Age Psychiatry for the past 27 years, and a Speciality and Specialist (SAS) Clinical Tutor for the past 13 years at the Trust, Ishtiaq continuously dedicates his life to improving both his patients' and colleagues' experiences in the Trust.

I am absolutely thrilled that such dedicated employees have been recognised for their hard work and commitment.

CAMEO 10 year anniversary celebration event

The CAMEO Service hosted their 10-year anniversary event on Wednesday, 8th November at HMP Foston Hall.
The event celebrated by hearing of an array of speeches, presentations and service users showcasing their work and achievements within their time at CAMEO.

Congratulations team.

Celebrating 25 Years of Family Intervention and The Meriden Family Programme

The Meriden Family Programme celebrated 25 years of service. The team celebrated by holding a conference where a number of staff gave presentations and raised awareness of the specialist areas. A special congratulations to the team.

Deputy Medical Director

Following a robust recruitment process I am pleased to confirm Dr Imran Waheed has been appointed as Deputy Medical Director. Congratulations Dr Waheed.
I want to take this opportunity to also thank Dr Giles Berrisford for his hard work and dedication during his time in this role.

LOCAL NEWS

Black History Month October 2023

During October we celebrated Black History Month in the UK, an event that has been celebrated nationwide for more than 30 years.
As a Trust we celebrated across sites which included a dedicated Listen Up Live session with several colleagues sharing what their culture means to them.
Throughout October we have been highlighting some of our colleagues in a series of special features. We identified unsung heroes who live our Trust Values and are committed, no matter their role, to help and improve the experiences of our colleagues, service users and patients within Team BSMHFT. and recognised staff by shining a spotlight on individuals achievements.

Our Trust charity, Caring Minds, helped fund Black History Month celebrations at Tamarind. The funding helped to provide meaningful therapeutic activities for our service users, family, friends, carers, and colleagues whilst celebrating Black History Month.

The day involved traditional music, drums, dancing, and delicious authentic food available for all to enjoy.

Freedom To Speak Up Month October 2023

Freedom to Speak Up brings positive change.

In Freedom to Speak Up Month I'm pleased to share an example of how raising a concern bought positive change. Our Freedom to Speak up Guardians regularly visit clinical areas and earlier this year they met with some of the Trust's Trainee Nursing Associates (TNA) at Ardenleigh. The TNAs were uncomfortable undertaking one to one level 3, therapeutic observations with patients. They felt that this was contrary to what they were being taught at university as well as worrying about what would happen if anything went wrong. They also found the Supportive Observations Policy difficult to interpret as there was no reference made to TNAs or Registered Nurse Degree Apprenticeship (RNDA) students.

Emma Randle, one of our Freedom to Speak Up Guardians raised this concern with Interim Chief Nurse, Steve Forsyth who asked for a review of the policy. Following this, the Trust made important changes to the policy recognising that there should be standardised guidance for all student nursing roles across all the directorates. This reassured the TNAs who now have clear guidance around observations and their role in them.

Birmingham and Solihull ICB Chief Delivery Officer Recruitment

The recruitment process for the Birmingham and Solihull ICB Chief Delivery Officer is now underway and I am pleased to be involved in this process.

Midlands and East CEO Network

I am pleased to Chair the Midlands and East CEO Network on a bi- monthly basis. We met recently to discuss key challenges and pressures and have taken action as a group to write to escalate concerns regarding waiting times to the Mental Health Lead for NHS England. The group has identified a number of opportunities that will be explored in the new year.

NATIONAL NEWS

New Secretary of State Health UK- The Rt Hon Victoria Atkins MP appointed

Victoria Atkins was appointed Secretary of State for Health and Social Care on 13 November 2023.

She was previously Financial Secretary to the Treasury between 27 October 2022 and 13 November 2023, and Minister of State at the Ministry of Justice and Minister for Afghan Resettlement between September 2021 and 6 July 2022.

Victoria led the Ministry of Justice's work on prison operations and policy, youth justice, tackling violence against women and girls, and rape and serious sexual offences.

CQC The State of Health Care and Adult Social Care In England 2022/23

During October 2023 the CQC released The State of Health Care and Adult Social Care In England 2022/23 report summarising that the year has been a turbulent one for health and social care. In addition to the ongoing problem of 'gridlocked' care highlighted in last year's State of Care, the cost of living crisis is biting harder for the public, staff and providers – and workforce pressures have escalated. This combination increases the risk of unfair care, where those who can afford to pay for treatment do so, and those who can't face longer waits and reduced access.

The full report can be found at the link below:
State of Care 2022/23 - Care Quality Commission (cqc.org.uk)

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	Item 9
Paper title	**STAFF AND SERVICE USER STORIES 2023 REPORT**
Date	6 December 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 provides an overview of both staff and service user stories throughout 2023.

Reason for consideration:

To provide assurance on the actions taken following both staff and service user stories.

Previous consideration of report by:

Not applicable.

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

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

Financial Implications *(detail any financial implications)*

Not applicable 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)*

Not applicable for this report

STAFF AND SERVICE USER STORIES 2023 REPORT

1. INTRODUCTION

I am pleased to offer the Board of Directors a summary of both the staff and service user stories we have been privileged to hear throughout the year.

We have heard from a range of divisions throughout the year with highlights noted as:

- Challenges across secure sites including the development of Highcroft and Reaside
- ICT challenges remained a key concern in relation to RiO access
- ESR management has been a challenge with developments made on the system being complex and not user friendly
- Positive feedback from trainee staff from both medical and corporate divisions
- Staff feel supported by the Board and are able to raise issues and concerns
- Positive feedback from a range of staff groups being supported to develop within roles
- Improvement in out of areas noted with the development of the community transformation

As a Board we have supported staff through a range of opportunities to address the concerns that were raised throughout staff stories.

The development of Highcroft and Reaside continues with a dedicated steering group leading on the developments. This is chaired by our Executive Director of Finance. Financial challenges remain a key issue with external funding bids being support by the Board.

The Board are proud to confirm the Trust has been recognised as a Digital Exemplar, leading the way for ICT developments across the NHS. This has had a positive impact on the ICT challenges that were raised to the Board in public.

ESR training has been rolled out across the Trust to support staff in making the system user friendly. Developments continue with the People Directorate leading on this with regular reporting into the People Committee.

The positive feedback received has been inspiring and has allowed the Board to review areas of good practice and feed these into other areas across the Trust.

As part of the focus for the Board we also receive stories from service users, this allows the Board to reflect on how the services delivered impact those receiving our services. Katheirne Allen,

This year we have only heard from one service user who was able to share their experiences of our eating disorder services.

Challenges within the inpatient eating disorder services and the restrictions for service users to be able to take control of their routines were raised. With 24 hour care it is difficult for service users to have any rest bite and this can significantly impact on those who suffer with sensory challenges.

The Board heard how eating disorder services are focused primarily on the physical goals to be achieved and there is little mental health support for service users.

Following the challenges raised the Board have been to visit the service on numerous occasions to be able to review what can be done to support the concerns noted. There has since been a service user focus group developed to allow the Trust to address key concerns with service users leading the change.

The Board has now also secured the funding for a Food Management Manager who will support the service in reviewing best practice in line with support from registered mental health staff to ensure the recovery process for our service users is holistic.

As a Board we look forward to continuing to receive these stories to allow us to focus on key areas that require our support.

PHIL GAYLE
CHAIR

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	Item 10
Paper title	**BOARD SITE VISIT FEEDBACK**
Date	6 December 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 provides assurance on Board visibility throughout 2023.
Reason for consideration:
To provide assurance Board visibility.
Previous consideration of report by:
Not applicable.
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)*
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)*
Not applicable for this report

BOARD SITE VISIT FEEDBACK

1. INTRODUCTION

I am pleased to offer the Board of Directors a summary of the Board service visits throughout 2023.

As a Board we remain committed to ensuring we are visible across all sites throughout the year. This year we have developed a schedule to ensure all Board Directors and Governors have the opportunity to visit sites.

I am pleased to be able to confirm that this year each site has had at least two visits from members of the Board. This time has allowed us to see first hand the challenges that our staff are facing on the front line and has allowed teams the time to showcase the delivery of excellent services.

Some of the key highlights have been noted as:

- *Very busy service, big caseloads*
- *Hardworking teams*
- *Issues re capacity due to staff shortages*
- *Need to employ temp staffing, high quality retire and return staff*
- *Manager working hard to boost morale, address well being*
- *Issues re inter team transfer response times and waiting lists*
- *Issue for team re recent messaging re changes to working from home and flexibility*
- *A great overview of the service and the types and demographics of service users*
- *The positive team dynamic was the stand-out highlight of the visit and this was through a combination of both the people and the environment*
- *Access to beds. This has the single most negative impact on the service user experience and outcomes*
- *Issuing of warrants appeared to be an issue*
- *The activity of 'case busts' is a great way of gaining knowledge and refining/developing the way in which the team deal with individual cases*

All visit feedback is reviewed with the relevant Executive Director and appropriate actions taken. The teams are informed off all actions taken and this is regularly report through the Board Committees for assurance purposes.

The visit plan for 2024 has been developed alongside the proposal for Board members to go 'back to the floor' where we will all be scheduled to work alongside staff on shifts. This time will allow us to determine the challenges and recognise the hard working staff.

I have personally been privileged to be able to visit a site a week and this has been humbling. I am very pleased to be the Chair of Birmingham and Solihull Mental Health NHS Foundation Trust.

PHIL GAYLE
CHAIR

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**22 November 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Integrated Performance Report • Transforming our Culture and Staff Experience Report • People Strategy • Deep Dive: Staff Survey Engagement • Staff Networks Report • International Recruitment Report • People Committee Integrated Action Plan
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • A particular gap in workforce was highlighted; the Trust remained below trajectory for recruitment of **registered mental health nurses**. The Committee would receive further information on plans to review the approach in January. • The Committee noted some improvements in **bank and agency spend**, with clear progress being made to reduce the reliance on both clinical and non-clinical agency use. There was still work to do to ensure a sustainable, embedded approach, but the Committee commended the efforts of teams.
Assure:	• The Committee was assured that a steady increase in appraisal performance had been reported. • The Committee commended the work that was ongoing to appoint international nurses to the organisation; additional funding had been made available to recruit 20 further nurses to the Trust, meaning that the Trust had welcomed 60 international nurses to the team. • Positive feedback from Staff Networks was received. It was agreed that regular attendance from Staff Network Chairs would be welcomed. • Plans for continued communication and feedback to staff on the actions arising from the staff survey provided assurance. The Staff Survey was due to close on 24 November, with the Committee noting a current 46.77% response rate.
Advise:	High levels of stress and anxiety had prompted a deep dive into sickness data, with a focus on qualified and unqualified nursing staff to explore and understand the reasons. The MHOST tool highlighted a number of areas of work to be undertaken before workforce skill mix and establishments could be determined, including work required to implement consistent approaches to annual leave, sickness reporting,

	and training across wards. A broader review would take place to include Forward Thinking Birmingham colleagues. The Committee heard from the Charity about a partnership with **Help Harry Help Others**, and how the Trust could utilise the partnership for monthly celebration events such as LGBTQ+ month in February and International Women's Day in March. Further conversations would be undertaken to review how the partnership would work, and how it could also potentially link to the Staff Networks.	
Board Assurance Framework	Improvements continued to ensure a fully embedded Board Assurance Framework, with positive feedback to date. The Board Assurance Framework would be reviewed regularly and begin to inform and focus agendas, strategic goals and risk registers. A quarterly review process would be implemented to monitor improvements, prominent issues, risk reductions and increases over time.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Kat Cleverley Company Secretary	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**18 October 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Integrated Performance Report • Transforming our Culture and Staff Experience Report • Freedom to Speak Up Report • Public Sector Equality Duty Report • SafeCare and Check and Challenge Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Capacity issues within the **Freedom to Speak Up Guardian** team were raised; the inability to recruit support was having an increased impact on strategic focus and caseload management. • A gap had been identified around support for BAME staff who were raising concerns related to **bullying and harassment**. Additional work would be undertaken with the Learning and Development team to explore the best way to address the concerns. • Continued use of **bank and agency staff** remained a key risk for the organisation, with a significant challenge to achieving the vacancy target noted. Ongoing recruitment initiatives were in place, however general staff shortages and the scale of the challenge was acknowledged. • The Committee heard from the Birmingham Healthy Minds team and was inspired by the **wellbeing activities** that had been undertaken. The Committee considered the potential need for a budget to replicate these initiatives across the organisation, and noted that the Health and Wellbeing Group would be capturing learning to inform an improvement trajectory for the Trust.
Assurance:	The Committee was assured that appraisal and fundamental training compliance had improved, and managers and colleagues continued to be supported. The Committee approved the publication of the Public Sector Equality Duty Report, and commended the work that was ongoing.

Advise	The Committee discussed plans to refine the Integrated Performance Report to ensure greater clarity and focus. The Committee was advised that the CQC were currently on site to review the Trust's section 31 and 29a notices.	
Board Assurance Framework	The Committee discussed the need to integrate the BAF more clearly in agendas.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Kat Cleverley Company Secretary	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Board of Directors		
Agenda item	12		
Paper title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2023-24 Q2)		
Date	6 December 2023		
Author (s)	Dr Shay-Anne Pantall, Guardian of Safe Working		
Executive sponsor	Dr Fabida Aria, Executive Medical Director		
Executive sign-off	☒ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

Quarterly reports to the Trust Board are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

- No immediate safety concerns were raised during this quarter.
- 13 unique exception reports were raised during this quarter, of which 57% related to breaches of rest requirements for non-resident on call working.
- 9 fines were levied against the Trust for breaches in safe working hours, a 50% increase compared to Q1.
- A change to on call working patterns is still being negotiated with Higher Trainees.
- No exception reports raised during this quarter was closed within 7 days.
- The number of outstanding reports carried forward has been halved, from 18 to 9.
- There are delays in exception reports being reviewed for Core Trainees which need to be addressed.
- The number of vacant shifts continues to be high, but reducing (363 compared to 452 in Q1). The majority of gaps were due to post vacancies. All on call locum vacancies during this period were filled.
- Work is ongoing to help facilitate cultural change to support our doctors in training in raising issues.

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

The Board is requested to note this report and the progress that has been made in encouraging postgraduate doctors in training to raise concerns. This report is for assurance to the Board that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions are being taken in response to concerns raised.

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

appropriate):
☐ Substantial Assurance ☒ Reasonable Assurance ☐ Limited Assurance ☐ No Assurance
Previous consideration of report by: (If applicable)
N/A
Strategic priorities (which strategic priority is the report providing assurance on)
PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users
Financial Implications *(detail any financial implications)*
Fines have been levied by the Guardian of Safe Working on 9 occasions in this period, totaling 8 hours payment at enhanced rates.

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
No new risks identified.
Equality impact assessments:
No concerns
Engagement *(detail any engagement with staff/service users)*
• I met with postgraduate doctors in training at their Trust induction on 3 August 2023 as part of the presentation about Raising Concerns • Guardian of Safe Working attendance at Trust Rep Development Half-Day Training • Exception reports and themes are discussed in the Junior Doctors Forum on a regular basis. The meeting planned for 4 October 2023 was cancelled due to planned industrial action by Consultants and junior doctors. The data from Q2 will be presented at the meeting in December 2023. • Doctors in training have bimonthly trainee council meetings. The meeting is open to all doctors in training in our Trust. • The Guardian of Safe Working Hours is invited to regular stakeholder meetings for the Trainee Raising Concerns QIP. • Collaboration with the trainee-led Exception Reporting Working Group • I have met with postgraduate doctors in training on an individual basis where this has been necessary. • I have regular meetings with the Freedom to Speak Up Guardians. The following are planned to improve engagement: • Refresher training for Educational Supervisors and ST tutor regarding rota rules and exception reporting – in progress • Updates to information held on Connect regarding the Guardian of Safe Working and Exception Reporting – in progress
Acronyms *(List out any acronyms used in the report)*
GoSW – Guardian of Safe Working FY – Foundation Year

GPVTS – General Practice Vocational Training Scheme CT – Core Trainee ST – Speciality Trainee JDC – Junior Doctor Contract JDF – Junior Doctor Forum QIP – Quality Improvement Project

Defining levels of assurance:

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

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

July – September 2023

High level data

Number of doctors / dentists in training (total): 103

Number of doctors / dentists in training on 2016 TCS (total): 103

Amount of time available in job plan for guardian to do the role: 1 PA per week

Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
CT1-3	4	3	1	6
ST 3-6	14	10	21	3
GPVTS	0	0	0	0
Total	18	13	22	9

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	4	3	1	6
ST North	1	1	1	1
ST South	12	3	14	1
ST Solihull/East	0	0	0	0
ST Forensic	1	6	6	1
Total	18	13	22	9

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	0
CT1-3	0	0	1	6
ST3-6	0	0	21	3
GPVTS	0	0	0	0
Total	0	0	22	9

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 14 exception reports were raised in total; one was a duplicate and has not been included within the data hence there were 13 unique exception reports within Quarter 2. One report related to educational opportunities missed due to insufficient staffing and needing to cross-cover for a vacant post.

Of the 12 exception reporting relating to working hours; 7 related to breaches of continuous rest requirements overnight during non-resident on calls, 2 related to inability to take natural breaks and 3 related to working overtime, including one for working longer than prospective hours during non-resident on call. One exception report for breach of continuous rest also noted a second breach of safe working hours within the same submission, for not achieving minimum rest requirement of 8 hours within a 24 hour on call period.

c) Work Schedule Reviews

Status (6 exception reports - figures include 5 exceptions carried forward);

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	4 (1 L1, 3 L2; 4 pending)
ST3-6	2 (2 L1; 1 pending, 1 completed)
GPVTS	0
Total	0

4 pending work schedule reviews relating to CT1-3 trainees have been addressed directly by the Guardian of Safe Working with the affected doctor, with no further action to be taken. The exception reports have not been closed on Allocate however due to a technical issue.

d) Locum bookings and vacancies

Locum bookings JULY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	9	9	79.50	79.50
Rota 2	8	8	74.50	74.50
Rota 3	31	31	305.00	305.00
Rota 4	16	16	148.00	148.00
Rota 5	20	20	188.50	188.50
Rota 6	19	19	161.50	161.50
ST4-6 North	16	16	240.00	240.00
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 Sol/East	21	21	376.00	376.00
ST4-6 South	3	3	48.00	48.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	19	19	191.00	191.00

Rota 2	8	8	73.50	73.50
Rota 3	4	4	33.00	33.00
Rota 4	15	15	121.00	121.00
Rota 5	16	16	156.50	156.50
Rota 6	15	15	129.50	129.50
ST4-6 North	4	4	52.00	52.00
ST4-6 Rea/Tam	5	5	88.00	88.00
ST4-6 Sol/East	18	18	336.00	336.00
ST4-6 South	12	12	165.50	165.50
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	21	21	200.50	200.50
Rota 2	7	7	69.00	69.00
Rota 3	1	1	4.50	4.50
Rota 4	18	18	168.50	168.50
Rota 5	11	11	117.00	117.00
Rota 6	15	15	167.00	167.00
ST4-6 North	5	5	76.50	76.50
ST4-6 Rea/Tam	3	3	46.00	46.00
ST4-6 Sol/East	15	15	264.00	264.00
ST4-6 South	5	5	65.00	65.00
Total	101	101	1178.00	1178.00

Locum bookings JULY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	103	103	957.00	957.00
ST4-6	43	43	720.00	720.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	77	77	704.50	704.50
ST4-6	39	39	641.50	641.50
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	73	73	726.50	726.50
ST4-6	28	28	451.50	451.50
Total	101	101	1178.00	1178.00

Locum bookings JULY 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	100	100	1138.00	1138.00

COVID	3	3	36.00	36.00
Sickness	20	20	213.00	213.00
Off Rota	14	14	138.00	138.00
Acting Up Consultant	9	9	152.00	152.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	10	10	45.00	45.00
Vacancy	48	48	669.00	669.00
Sickness	24	24	242.00	242.00
COVID 19	3	3	36.00	36.00
Off Rota	25	25	277.50	277.50
Paternity Leave	3	3	36.00	36.00
Emergency Leave	1	1	16.00	16.00
Bereavement	1	1	12.50	12.50
Training	1	1	12.00	12.00
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	28	28	382.50	382.50
Sickness	27	27	235.00	235.00
COVID 19	10	10	105.00	105.00
Off Rota	35	35	439.50	439.50
Emergency Leave	1	1	16.00	16.00
Total	101	101	1178.00	1178.00

Data specifically relating to locum bookings to cover periods of industrial action has not been provided.

Fines levied

Rota	July 2023	August 2023	September 2023
SHO 1-6	0	0	1
ST South	3	1	0
ST Forensic	1	0	3

9 fines have been levied in Q2 totaling 8 hours payment at enhanced rates. 7 fines were related to breaches of core rest requirements for overnight working for doctors working non-resident on calls (not achieving a minimum of 5 hours consecutive rest between 22:00 and 07:00), 1 for breach of total rest requirements within a 24 hour period (minimum 8 hours rest not achieved) and 1 for overtime whilst on call, exceeding maximum shift length of 13 hours.

Ideas for disbursement will be discussed and agreed at the Junior Doctor Forum. Suggestions noted from other Trusts including funding a buddy scheme for IMG trainees, provision of hot food for on call doctors for a fixed period of time and social events for postgraduate doctors in training.

Issues arising

The number of exception reports raised continues to increase, demonstrating positive engagement with exception reporting particularly by ST doctors. The majority of exception reports related to breaches of core rest requirements overnight during non-resident on calls. 7 out of 9 fines levied in Q2 were relating to this contractual breach, 57% of which related to the Forensic ST rota. This change in reporting suggests a change in workload on the Forensic rota overnight. This issue has been raised with the Clinical Director for Secure Care and Offender Health and discussed in the Forensic Joint Consultant Meeting. A further meeting is planned.

Alternative rota patterns for the other ST rotas (North, South and Solihull/East) have yet to be implemented as discussion remains ongoing with the Higher Trainees and Medical Workforce. It is anticipated that reducing the rotas from three to two during weekdays will come into effect from February 2024. Rota gaps on the ST Solihull/East rota currently remain high due to vacancies.

The number of outstanding exception reports has been halved over Quarter 2 from 18 to 9, despite the increase in new reports being raised. 4 of the outstanding reports have been discussed with the doctor in training and resolved but cannot currently be closed on the system. All new exception reports raised by ST doctors in this quarter have been addressed and closed by the ST Tutor, Dr Helen Campbell. The time to review and close reports however persists above 14 days from submission; common causes for delays include further information being required, delays in arranging review meetings due to trainee or supervisor leave, need for clarification from the Guardian of Safe Working and delay in doctors accepting the outcome of the review discussion on Allocate.

There continue to be delays in the review and closure of exception reports raised by Core Trainees. The trainee-led Quality Improvement Project addressing issues with raising concerns is currently exploring potential change ideas to improve supervisor engagement in the process.

There continues to be a high number of shift vacancies, although reducing over the course of Q1 from 146 in July 2023 to 101 in September 2023. The largest proportion of the vacant shifts have been due to post vacancies. Industrial Action by junior doctors took place in July, August and September 2023; data specifically relating to locums required to cover during the strike period has not been provided by Medical Workforce. All vacant shifts in this period were filled, primarily by internal locums.

Work is ongoing to encourage postgraduate doctors in training to raise concerns with regards to their working hours and training experience. Information relating to raising concerns and the exception reporting process is part of the Trust induction for junior doctors. The information available on Connect continues to be updated and vignettes have been developed by the Exception Reporting Working Group working as part of the Trust-wide trainee-led QIP addressing Trainees Raising Concerns.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. 13 unique exception reports were raised during this quarter, of which 57% were related to breaches of rest requirements for non-resident on call working. 9 fines were levied against the Trust for breaches in safe working hours, a 50% increase compared to Q1. A change to on call working patterns is still being negotiated with Higher Trainees.

No exception reports raised during this quarter was closed within 7 days, but the number of outstanding reports carried forward has been halved. There are delays in exception reports

being reviewed for Core Trainees.

The number of vacant shifts continues to be high, but reducing (363 compared to 452 in Q1). The majority of gaps were due to post vacancies. All on call locum vacancies during this period were filled.

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

Questions for consideration:
Ongoing support from senior leaders in encouraging raising concerns through use of exception reporting system is appreciated.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Board of Directors**
Agenda item	**13**
Paper title	**Integrated Performance Report**
Date	6 December 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 (** now significantly improved **)
  - Talking Therapies services – service users seen within 6 and 18 weeks
  - Out of area bed days
  - Referrals over 3 months with no contact
  - Delayed transfers of care
  - CIP delivery
  - Temporary staffing
- People
  - Bank and agency fill rate
  - Appraisals
  - Vacancies
  - Sickness absence

At the October 2023 FPPC meeting, members requested further updates and additional detail on key factors affecting performance, actions and improvement trajectories for several metrics. These requirements have been shared with the relevant service and corporate area leads who have provided the updates for each area. In addition, this has also been discussed at the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. The updated details are included as part of the improvement plan updates detailed in Appendix I and summarized in the main report.

In addition, as requested at the October FPPC meeting, the main report has been revised to include additional summarized detail regarding the areas for improvement provided by the

relevant Leads for accessibility and clarity on key issues and actions planned.

FPPC to note that the Trust's Performance Management Framework has been reviewed and a number of improvements are being made, including:

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

Further details are provided in the following Appendices:
Appendix I – Performance metrics improvement plans
Appendix II - Performance Framework update (covering PDG and Service Area Deep dives)
Appendix IIa – Urgent & Acute Care Deep Dive – Productivity Plan Update
Appendix IIb – Secure & Offender Health Care Deep Dive summary
Appendix IIc – Specialties Deep Dive summary

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


compassionate
inclusive
committed

Integrated Performance Report

Context

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

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

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

- Inappropriate Out of Area Bed Days
- Talking Therapies – service users seen within 6 and 18 weeks
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months (** now significantly improved **)
- Delayed Transfers of Care
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

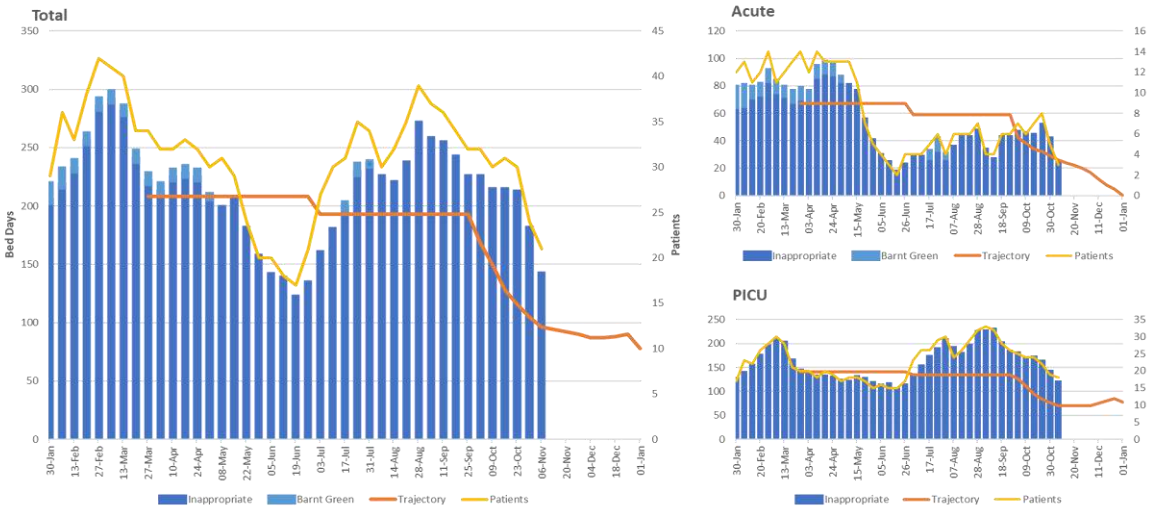
The above areas have been considered by the Performance Delivery Group and in deep dive meetings with Service Areas on an ongoing basis. Relevant Leads have provided an update on each area. Appendix 1 provides an update against improvement trajectories for these metrics.

Due to the level of detail within the overall performance report, at the October 2023 FPPC meeting, members asked that the report below provides greater summarised detail on the key issues. The report content below has therefore been revised to address this feedback.

Performance in October 2023

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

Inappropriate Out of Area Bed Use – Some process improvements have helped us address underlying issues, but the level of demand and increased delayed transfers of care has impaired our ability to eliminate use of out of area beds. Since July 2023 (872 bed days), an upward trend has continued, with the month of October at 1006 bed days, in total 43 inappropriate out of area placements. More recently weekly data for November shows an improvement in usage of PICU beds in particular and use of acute beds at lower levels compared to previous months – see the graphs below.



In summary the recent action plans being taken forward include:

- the implementation of the Locality model workstream which supports across all of the workstreams in terms of supporting demand management, reducing LOS and optimising capacity.

  The locality model has been implemented in East with planned roll out to other Localities following further clinically led discussions in each area. The principles of the locality model being implemented include:

  - HTT/Inpatient/PLT/CMHT are locally accountable and responsible for bed flow.
  - All admissions to locality beds are offered 'choice and alternatives' to inpatient admission by HTT.
  - HTT will be responsible for early discharge from local wards and have authority to admit into the beds.
  - Localities collaborate with each other to support capacity and demand for beds.
  - Joint care planning and risk assessment.

  Positive early improvement has been observed in East following implementation as follows:

  - Bed waiting list reduced from >10 to 0
  - OAA – >10 pts in acute to 3pts
  - 37 patients gatekept
  - 20 admissions to locality beds
  - 14 admissions avoided
  - 0 out of area acute admissions
  - Step down plans for OOA PICU and appropriate acute OOA

- Reducing delayed transfers of care that are not in the Trust's immediate control remain an ongoing challenge impacting on bed capacity available to support repatriation or admission to local Trust beds. In October there were 36 patients in adult acute wards whose discharge was delayed largely due to social care. A 'system' wide strategic meeting is being established to support the routine daily and weekly DTOC management discussions that take place regarding individual patient needs.

- The Clinical Oversight Group is in the process of being established and in the interim, discussions have commenced in some wards by clinical leads to understand the challenges and barriers at a ward level regarding length of stay and discharge management/step down options that the oversight group can help to mitigate and progress.

Talking Therapies waits – Trust performance remains below the national waiting time standards for 6 weeks (75%) and 18 weeks (95%). Based on the service recovery plan the 6 week standard is not expected to be met till January 2025 and the 18 week standard is planned to be met by end of June 2024. Both recovery plans are heavily reliant on recruitment plans. Staffing challenges within the service have significantly impacted on ability to carry out activity at the levels required.

Progress in staffing levels: More recently progress in line with the recovery plan around staffing has progressed with 8 PWP workers and 5 B7 qualified psychological therapists commenced in October. In addition, 8 PWP trainees and 7 Higher intensity trainees have also commenced. Embedding the new staff into their new roles will take time and the impact therefore on activity recovering will not be immediate but will support progress in the medium term.

In addition, two key senior supporting posts have also now been recruited to, i) Step 2 service lead will be instrumental in providing valuable oversight of step 2 interventions and aligning the pathway as well as promoting community engagement and networking with our Neighbourhood Mental Health Teams in primary care. ii) The clinical development lead will support the team to screen referrals and identify barriers to recovery planning. The role also has a focus on access and waiting times management.

Additional capacity is also being sourced through Xyla (a digital service) and letters are being sent out to service users to see if they would like to be seen by the service.

New referrals not seen within 3 months – FPPC will be aware of the improvement plans being taken forward in adult and older adult CMHTs. Due to challenges in both services in particular around managing high caseload levels and staffing challenges, the ability to see new patients has not progressed. Further discussions have been held in October within the respective service areas and plans have been reviewed and revised in light of existing challenges.

ICCR Adult CMHTs - The revised trajectory submitted is based on achieving a 20% reduction in new referrals not seen within 3 months by the end of January 2024. October 2023 is at 851 service users. The revised action plan is based on the following work:

Short Term plan - focus on reducing existing high DNA rates for first appointments, reviewing data accuracy & validating the data, discharging back appropriate service users to the GP based on risk assessments and re prioritising appointments required. The new Neighbourhood mental health function (NMHT) is now the front door to CMHTs to triage and refer appropriate patient s to CMHTs.

Medium Term plan – Achieve full recruitment to the 5 NMHTs by May 2024. Engage Talking Therapies services to divert referrals from NMHTs thus creating capacity for the NMHT to take on low level CMHT cases (the service lead indicates that 70% of referrals to the NMHT function are for presentations of depression & anxiety who should be signposted to talking therapies as the correct service to meet the service user's needs) and reducing DNA rates for first

appointments to 20% by May 2024.

Older Adult CMHTs – their action plan will focus on reducing long waits in the first instance and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024.

Progress will continue to be reviewed in light of existing challenges including staffing levels and increasing referrals and caseloads, with additional pressure on caseloads from the service having to hold onto service users being prescribed anti dementia medication due to the inability to discharge these service users to GPs and patients with a stable serious Mental Illness (SMI) not being discharged as there are no appropriate alternative services and GPs not taking on the long-term prescribing requirements.

The recovery plan is focused on staffing and increasing capacity and leadership within existing teams. Staffing challenges in Solihull Older Adult CMHT will begin to ease with 8 new starters and 2 people awaiting start dates to join the service.

As part of the service area's workforce transformation plan to focus on:

- new roles are being explored and include multi-disciplinary based approaches, ANP Role to be fully utilised in all hubs, ACP Role to be explored as a clinical developmental opportunity offering career progression, MHWB workers in post and more to train.
- Retention - Manageable jobs - continue caseload reviews, explore more consistent models of capacity and demand in CMHTs looking at impact of new roles, Leadership development.
- Staff Engagement: Work on Pathways – improved Clarity re Clinical Offer and Team Purpose, Work on capacity and demand for manageable workloads.
- Health inequalities – older people under-represented in the workforce.

CPA with formal review in last 12 months - Performance has been on a gradually improving and upward trend and following the implementation of recovery plans within adult and older adult CMHTs, performance has reached 95.3% in October 2023 just above the target of 95%.

Delayed transfers of care (DTOC) - bed days lost to DTOC have been on an increasing trend, with the latest position at 8.86%. The main drivers for this are both adult and older adult acute services. DTOCs in Acute & Urgent Care is at 12.1% (36 patients) and in Older Adult Services at 15.2% (20 patients). The main reasons for the delay are lack of social care availability and waits for nursing home placements.

Quality the detailed position on these metric areas is discussed at QPES and agreement has been reached with the Clinical Governance Lead that the commentaries will be added to the FPPC report which has not been routinely taking place. This is planned to take effect from next month's report. A summary of the key changes in the metric position are outlined below.

- Incidents resulting in harm (others) have reduced this month to 10.8% from 15.7%
- Incidents resulting in harm (patients) has increased to 23.4% from 18.5%
- Ligature with no anchor point was at 37 compared to 27 the previous month.
- Patient Assaults increased to 41 compared to 27 the previous month which is 2.2 per 1000 bed days.

People Workforce measures – There is a significant adverse variance against most of the set performance standards. Improvement plans are being taken forward for these areas and the detail of the plans are outlined in Appendix 1.

- Staff sickness levels have increased to 6% in October and remain above the improvement trajectory of 5.3%.

- HR clinics continue to run across divisions, supporting managers to manage sickness.
- The Health, Wellbeing and Attendance Policy will be launched in November.
- Launch of the new training for sickness absence for line managers.
- Working with Occupational health Provider to explore targeted intervention to support staff with anxiety, stress and depression.
- Deep dives are planned and will commence into reasons for sickness for staff groups (nursing at a starting point).

- Bank and Agency fill rate increased to 88.6% from 85.2%

- A detailed agency reduction programme is in progress working in conjunction with 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.

- Staff Appraisals at 78.9% and remain below the trajectory of 89.7% for October 2023.

- A task and finish group in place to review and address any emerging themes or barriers.
- From November 2023, additional support for operational areas has been offered to hot spot areas to include, VBA demonstration, ESR support, SMART card access.

- Staff vacancy level is at 11% and remain above the improvement trajectories set.

- Flexible working initiatives are being rolled out throughout the recruitment process
- the Trust's newly updated Recruitment Panel Guidance to be communicated – EDI focus
- BSMHFT recruitment fair is being planned for November 29th to incorporate every discipline.
- Funding has been agreed for 60 international nurses, whilst 48 are active in the system.
- Currently, our time to hire from authorisation to start date is 87.41 days. This has reduced from 98 in September.

Sustainability (detail in finance report). Summary below:

- Capital Expenditure for 7 months to October is well ahead of plan, reflecting work that was in hand as we moved into 2023/24
- Cash remains above £60m (highest ever figure at £88m)
- CIP YTD efficiencies are £7.2m against £8.6m plan, improved on trend. Insufficient pipeline of potential savings.
- Agency YTD expenditure remains well above NHSE ceiling of 3.7% of pay bill, though October spend at £819k is lowest since Apr-23. Key issues - level of medical staff expenditure (£3.9m), particularly in ICCR on key staff vacancies.
- Operating Surplus - YTD deficit of £426k against plan of breakeven, little change in month, Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

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

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

October 2023

Performance

CPA 7 day FU	83.8% ↓
CPA with Formal Review last 12 mths	95.3% ↑
Data Quality Maturity Index (DQMI)	97.1% ↑
Delayed Transfer Bed Days	1412 ↓
Delayed Transfer, percent of bed days	8.9% ↓
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	47.5%
IAPT seen in 18 weeks	74.9% ↓
IAPT seen in 6 weeks	46.9% ↓
Out of Area Bed Days	1006
Referrals over 3 mths with no contact	3568 ↓

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People

Bank & Agency Fill Rate	88.6%
Fundamental Training	92.6% ↓
Rolling 12m Turnover	8.2% ↑
Staff Appraisals	78.9% ↓
Staff Sickness	6.0% ↓
Staff Vacancies	11.0% ↓

Quality

Absconsions from inpatient units	4
Commissioner reportable incidents	0
Community confirmed suicides	0
Community suspected suicides	0
Failure to return	16 ↑
Incidents of self harm	186
Incidents resulting in harm (other)	10.8% ↑
Incidents resulting in harm (patients)	23.4% ↘
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	37
Ligature with anchor point	0
Patient assaults	41
Patient assaults / 1000 OBD	2.2

Sustainability

CAP Ex	£384k
Cash	£88,356k ↑
CIP	£1,525k ↑
Info Governance	94.4%
Monthly Agency	£819k ↓
Operating Surplus	-£75k ↓
SOF rating	3 ↑

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

Integrated Performance Dashboard

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division
A: All

A: All

Measure	Latest Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
CPA 7 day FU	95.00	88.9%	84.5%	89.6%	90.0%	88.0%	83.8% ↓
CPA with Formal Review last 12 mths	95.00	88.7%	90.7%	91.6%	93.7%	94.3%	95.3% ↑
Data Quality Maturity Index (DQMI)	95.00	96.9%	97.3%	97.4%	97.4%	97.8%	97.1% ↑
Delayed Transfer Bed Days		1068	1237	1184	1228	1163	1412 ↓
Delayed Transfer, percent of bed days		6.8%	8.0%	7.4%	7.7%	7.6%	8.9% ↓
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	47.8%	48.7%	47.1%	42.1%	43.5%	47.5%
IAPT seen in 18 weeks	95.00	79.9%	79.6%	76.3%	83.1%	80.5%	74.9% ↓
IAPT seen in 6 weeks	75.00	41.1%	42.5%	34.4%	43.4%	43.0%	46.9% ↓
Out of Area Bed Days	616.00	863	575	872	980	1071	1006
Referrals over 3 mths with no contact		3414	3359	3378	3393	3474	3568 ↓

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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

Division

A: All

A: All

Measure	Latest Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Staff Vacancies		12.2%	12.2%	12.6%	12.4%	11.7%	11.0% ↓
Staff Sickness	4.28	5.0%	4.3%	4.6%	5.4%	5.5%	6.0% ↓
Staff Appraisals	90.00	70.7%	72.9%	76.0%	76.9%	77.6%	78.9% ↓
Rolling 12m Turnover		9.7%	9.6%	9.1%	8.8%	8.4%	8.2% ↑
Fundamental Training	95.00	91.5%	91.1%	92.5%	92.8%	92.6%	92.6% ↓
Bank & Agency Fill Rate		89.0%	85.5%	87.3%	87.2%	85.2%	88.6%

Top Line Commentary (Trust level)

KEY CONCERNS

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

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

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Integrated Performance Dashboard

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Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Absconsions from inpatient units		2	7	5	2	2	4
Commissioner reportable incidents		8	5	7	7	2	0
Community confirmed suicides		0	0	1	0	0	0
Community suspected suicides		3	2	2	4	0	0
Failure to return		16	16	15	5	10	16 ↑
Incidents of self harm		173	134	200	186	182	186
Incidents resulting in harm (other)		13.3%	14.0%	12.7%	14.1%	15.7%	10.8% ↑
Incidents resulting in harm (patients)		13.1%	12.4%	14.0%	16.3%	18.5%	23.4% ↘
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		18	18	29	20	27	37
Ligature with anchor point		0	4	3	0	0	0
Patient assaults		59	66	58	49	27	41
Patient ssaults / 1000 OBD		3.1	3.6	3.0	2.6	1.5	2.2
Physical restraints		294	241	214	250	217	190
Physical restraints/ 1000 OBD		15.7	13.1	11.2	13.1	11.9	10.0
Prone restraints		86	68	56	71	63	52
Prone restraints/ 1000 OBD		4.6	3.7	2.9	3.7	3.4	2.7
Reported incidents		2483	2460	2497	2287	2249	2516 ↑
Staff assaults		140	137	94	101	109	91
Staff assaults / 1000 OBD		7.5	7.5	4.9	5.3	6.0	4.8

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	
CAP Ex		£308k	£1,378k	£200k	£402k	£346k	£384k	
Cash		£68,246k	£78,199k	£82,736k	£80,904k	£83,895k	£88,356k	↑
CIP		£483k	£825k	£1,457k	£759k	£1,670k	£1,525k	↑
Info Governance		94.6%	96.0%	92.6%	95.0%	94.8%	94.4%	
Monthly Agency		£941k	£935k	£956k	£1,143k	£851k	£819k	↓
Operating Surplus		£352k	-£122k	£156k	£90k	-£36k	-£75k	↓
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

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Birmingham and Solihul
Mental Health
NHS Foundation Trus

CPA 7 day FU

Divisions

Statistical Process Control (SPC)

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	88.9%	84.5%	89.6%	90.0%	88.0%	83.8%
B: Acute and Urgent Care	90.8%	87.3%	91.9%	92.8%	87.6%	83.2%
C: ICCR	81.3%	76.5%	92.9%	83.3%	66.7%	82.4%
D: Secure Serv & Offender Health	75.0%	83.3%	66.7%	66.7%	87.5%	83.3%
E: Specialties	90.9%	76.9%	81.8%	92.3%	100.0%	87.0%

Commentary

National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2023, performance has been below 95% and below the lower control limits. October 2023 is at 83.78%, the lowest rate in the last 12 months.

This relates to 24 outstanding follow ups from 148 discharges in October of which, 1 patient was discharged to FTB, attempts were made to see 2 patients but were unsuccessful, 2 patients discharged to prison, 2 patients were discharged to a Community hospital and in one case there was contact with staff, 1 patient was discharged to an acute hospital and contact was with staff only, 1 patient went missing whilst on leave and was seen on the date of discharge, 1 patient was discharged to their GP and no follow up took place, 1 patient was discharged to a care home and contact was with staff only, 5 patients were discharged to other mental health services, 2 patients were seen outside 7 days and 6 cases have been followed up but data entry has yet to be updated. When Rio data entry has been completed for these 6 cases, compliance will increase to 88.44%. Of the 24 exceptions, it should be noted that 20 service users were in the care of another service and therefore not isolated. In total, 17 were adult acute service users, 3 in ICCR, 3 in

)

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Oct-2023

CPA 7 day FU

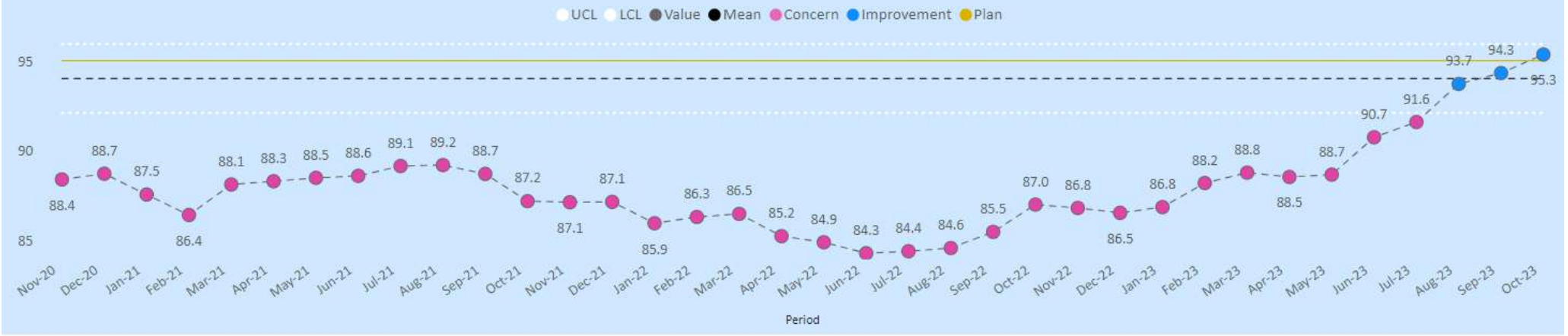
Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2023, performance has been below 95% and below the lower control limits. October 2023 is at 83.78%, the lowest rate in the last 12 months. This relates to 24 outstanding follow ups from 148 discharges in October of which, 1 patient was discharged to FTB, attempts were made to see 2 patients but were unsuccessful, 2 patients discharged to prison, 2 patients were discharged to a Community hospital and in one case there was contact with staff, 1 patient was discharged to an acute hospital and contact was with staff only, 1 patient went missing whilst on leave and was seen on the date of discharge, 1 patient was discharged to their GP and no follow up took place, 1 patient was discharged to a care home and contact was with staff only, 5 patients were discharged to other mental health services, 2 patients were seen outside 7 days and 6 cases have been followed up but data entry has yet to be updated. When Rio data entry has been completed for these 6 cases, compliance will increase to 88.44%. Of the 24 exceptions, it should be noted that 20 service users were in the care of another service and therefore not isolated. In total, 17 were adult acute service users, 3 in ICCR, 3 in older adults and 1 in secure services.
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. Late data entry has also affected performance this month with 6/24 patients being discharged to another trust and 6 cases which have been followed up but the contacts not yet entered onto RIO. Late data entry within services is an ongoing factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD.
C: What are the implications and consequences?	Early follow up of patients post discharge prioritised by HTT is 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. The contract requirement is to monitor 3 day follow up and although there is a lower threshold of 80%, this is also not being met and is affected by the issues highlighted above.
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 Rio now enables staff to see whether the patient has been seen, but we will still be required to complete a 3 day follow up form to capture this data. The shared care record can also be used for those discharged to the care of local trusts to check whether patients have been seen.
E: What do we expect to happen?	We expect 7 day follow up standard of 95% and 3 day follow up standard of 80% to be routinely maintained with HTTs acting on the daily discharge notification received and contacts being recorded in a timely way.
F: How will we know when we have addressed issues?	Standard is being maintained with minimal or no input required from the information team to review data entry.

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths

Divisions

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	88.7%	90.7%	91.6%	93.7%	94.3%	95.3%
B: Acute and Urgent Care		100.0%			100.0%	100.0%
C: ICCR	88.5%	90.7%	91.4%	93.8%	94.3%	95.1%
D: Secure Serv & Offender Health	98.0%	97.8%	97.8%	98.0%	98.3%	98.6%
E: Specialties	76.6%	77.8%	82.9%	87.1%	87.8%	94.6%

Commentary

Performance has been on a gradually improving and upward trend since January 2023 with performance improving from 86.8% in January to 95.3% in October 2023 just above the target of 95%. The improving trend is a result of the improvement action plans implemented for service users in the adult and older adult CMHTs. FPPC has been provided with monthly updates on these action plans to achieve 95% by October 2023.

Adult CMHT account for 48%, older adult CMHT for 4.8%, Secure for 16% and AOT for 25% of the total outstanding.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths

Oct-2023

Question	Answers
A: What has happened?	Performance has been on a gradually improving and upward trend since January 2023 with performance improving from 86.8% in January to 95.3% in October 2023 just above the target of 95%. The improving trend is a result of the improvement action plans implemented for service users in the adult and older adult CMHTs. FPPC has been provided with monthly updates on these action plans to achieve 95% by October 2023. Adult CMHT account for 48%, older adult CMHT for 4.8%, Secure for 16% and AOT for 25% of the total outstanding.
B: Why has it happened?	A backlog was created due to COVID which minimised the ability to carry out face to face contacts. Recovery plans within adult and older adult CMHTs were put in place as these were the services where the main back log volumes have been. Both service areas have made significant improvements, with October position for the Trust at 95.3%, with adult CMHTs at 93.3% and older adult CMHTs at 94.78% 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. However, there has been continued focus on this area and good progress has been made. Specialties: Face to face contacts are increasing, however, caseloads of care coordinators are currently very high (some CPNs have 50+ against an ideal maximum of 35) it is felt that the scheduling and recording of formal CPA reviews has not been as robust as it should be. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There has been a small improvement this month despite the challenges.
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 to book appointments in advance of the 12 months expiring. As part of the recovery plans adult and older adult CMHTs have been reviewing those service users who reviews are outstanding to see if they still require to be on CPA or can be stepped down. As part of the wider transformation work step down options also being reviewed include transferring service users appropriately to Talking Therapies or to the new Neighbourhood Mental Health Teams in primary care. ICCR: The division are holding twice monthly meetings with clinical service managers supported by the Information team to review the data team for all data for CMHTs. Clinical service managers take back the exceptions to their teams to ensure that they are addressed in a timely manner. It is anticipated that adult CMHTS will reaching 95% by end January 2024. The number of CPA reviews due in the next couple of months have been shared with the service to allow them to start planning future CPA reviews. 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 has been significant staffing challenges within Solihull HUB and a number of agency staff have commenced and have taken over the caseloads which has enabled CPA reviews to be undertaken. A list of the CPA reviews due in future months has been shared with the service to allow these to be planned. A revised trajectory has been set to reach the 95% target within the CMHTS by end January 2024.
E: What do we expect to happen?	ICCR and Specialties: As part of the improvement plans in place from March 2023 for adult and older adult CMHTs, the plans were based on achieving the 95% standard by the end of September 2023. Whilst this was not achieved, both service areas have made significant improvements, with October position for the Trust at 95.3%, with adult CMHTs at 93.3% and older adult CMHTs at 94.78%
F: How will we know when we have addressed issues?	When the 95% standard is maintained on a regular basis providing evidence of a systematic approach being in place to proactively review caseloads and book appointments in advance to avoid the 12 month review timeline expiring.

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	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	1068	1237	1184	1228	1163	1412
B: Acute and Urgent Care	485	562	633	757	698	821
D: Secure Serv & Offender Health	248	229	201	162	112	177
E: Specialties	335	446	350	309	353	414

Commentary

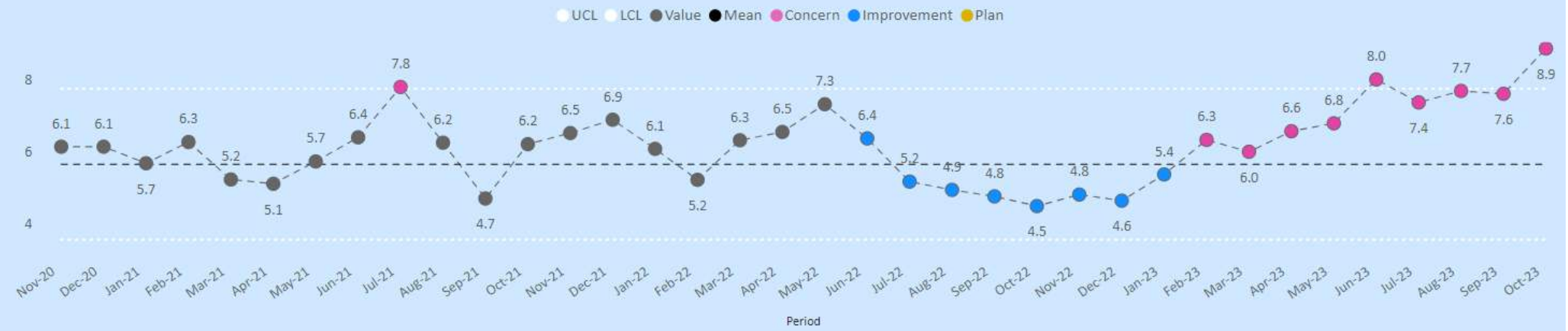
Since the beginning of January this year, bed days lost to DTOC were at 954 bed days and have been on an increasing trend, with the latest position at 1412 bed days. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this increase. DTOCs in the acute and urgent care service since January 2023 have risen from 106 bed days to 821 as at October 2023. This represents 36 patients and the main reasons for the delay is lack of social care support and awaiting non acute care. Older Adult services at the beginning of January were at 72 bed days and are now at 321. This represents 20 patients currently experiencing a delay to their discharge and the main reasons for the delay are awaiting nursing home placements.

Delayed Transfer, percent of bed days

Divisions

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	6.8%	8.0%	7.4%	7.7%	7.6%	8.9%
B: Acute and Urgent Care	7.3%	8.6%	9.2%	11.0%	10.6%	12.1%
D: Secure Serv & Offender Health	3.9%	3.7%	3.1%	2.5%	1.8%	2.8%
E: Specialties	12.3%	16.3%	12.5%	11.6%	13.5%	14.6%

Commentary

Since the beginning of January this year, bed days lost to DTOC were at 5.4% and have been on an increasing trend, with the latest position at 8.86%. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this. DTOCs in the acute and urgent care service since January 2023 have risen from 4.8% to 12.1% as at October 2023. This represents 36 patients and the main reasons for the delay are lack of social care availability. Older Adult services at the beginning of January were at 9% and are now at 15.2%. This represents 20 patients currently experiencing a delay to their discharge and the main reasons for the delay is awaiting nursing home placements.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer Bed Days

Oct-2023

Question	Answers
A: What has happened?	Since the beginning of January this year, bed days lost to DTOC were at 954 bed days and have been on an increasing trend, with the latest position at 1412 bed days. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this increase. DTOCs in the acute and urgent care service since January 2023 have risen from 106 bed days to 821 as at October 2023. This represents 36 patients and the main reasons for the delay is lack of social care support and awaiting non acute care. Older Adult services at the beginning of January were at 72 bed days and are now at 321. This represents 20 patients currently experiencing a delay to their discharge and the main reasons for the delay are awaiting nursing home placements.
B: Why has it happened?	The main reasons for the delays across both services include lack of social care support and awaiting nursing home placements which also requires social care input. These are system wide challenges and partnership working is taking place with local authority and ICS colleagues daily and weekly to review current barriers to discharge for each individual patient. However it is recognised that the ability of partners to aid timely discharge of service users is a continual challenge due to availability of appropriate alternatives. 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 operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. 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. Regular discussions with colleagues in the ICS and local authorities to assist in addressing the 'system' wide challenges and identifying alternatives to aid discharge for service users waiting for social care and nursing home placements. More recently a 'system' wide DTOC task and finish group has been established to support partnership discussions to assist in facilitating discharges.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Delayed Transfer, percent of bed days

Oct-2023

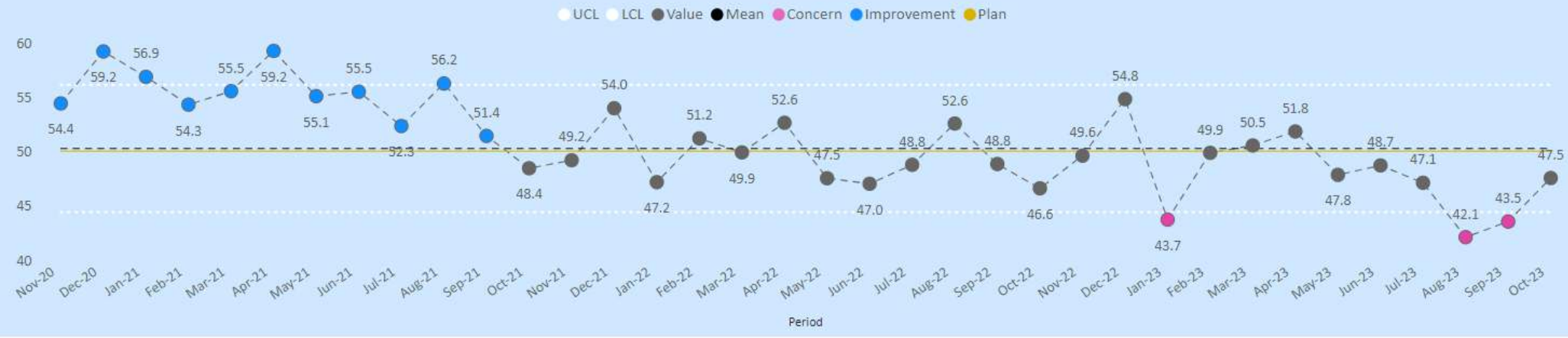
Question	Answers
A: What has happened?	Since the beginning of January this year, bed days lost to DTOC were at 5.4% and have been on an increasing trend, with the latest position at 8.86%. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this. DTOCs in the acute and urgent care service since January 2023 have risen from 4.8% to 12.1% as at October 2023. This represents 36 patients and the main reasons for the delay are lack of social care availability. Older Adult services at the beginning of January were at 9% and are now at 15.2%. This represents 20 patients currently experiencing a delay to their discharge and the main reasons for the delay is awaiting nursing home placements.
B: Why has it happened?	The main reasons for the delays across both services include lack of social care support and awaiting nursing home placements both outside of immediate Trust control. These are system wide challenges and partnership working is taking place with local authority and ICS colleagues daily and weekly to review current barriers to discharge for each individual patient. However it is recognised that the ability of partners to aid timely discharge of service users is a continual challenge due to availability of appropriate alternatives.
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 operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting is in place 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. Regular discussions taking place with colleagues in the ICS and local authorities to assist in addressing the 'system' wide challenges and identifying alternatives to aid discharge for service users waiting for social care and nursing home placements. More recently a 'system' wide DTOC task and finish group has been established to support partnership discussions to assist in facilitating discharges.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT into recovery

Divisions

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	47.8%	48.7%	47.1%	42.1%	43.5%	47.5%
E: Specialties	47.8%	48.7%	47.1%	42.1%	43.5%	47.5%

Commentary

The MTR rate has fluctuated and largely meets the 50% national target. MTR is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. October 2023 position below the 50% target at 47.53%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT into recovery

Oct-2023

Question	Answers
A: What has happened?	The MTR rate has fluctuated and largely meets the 50% national target. MTR is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. October 2023 position below the 50% target at 47.53%.
B: Why has it happened?	The MTR rate has fallen outside of the control limits following the changes made to the way the data is recorded as outlined within the waiting times commentary. The target for recovery is 50% of all patients who complete a course of therapy. A course of therapy in NHS TT terms is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria, even if they dropped out, or declined treatment before the expected conclusion of the treatment. As a consequence of this change, we had anticipated that the recovery rate would be impacted and initially reduce. This is because more patients are being included in the recovery calculation who are not completing a course of treatment and are being discharged above caseness. The service significantly increased referrals to a digital partner, Xyla, around July this year. They have sent around 150 referrals over a month or so. Over the last couple of months, those referrals are starting to be discharged and it has been noticed that Xyla are not achieving as high a recovery rate as our therapists do, within BHM. The recovery rate of those being discharged whist allocated to a Xyla therapist for August – Oct is 40.7%, 40.8% and 41.1% respectively. As the numbers being discharged each month are now higher, this is having a more significant impact on our overall recovery rate.
C: What are the implications and consequences?	Service users needs are not being met and the national 50% standard is not being met.
D: What are we doing about it?	As a consequence of the recording change, we anticipated that the recovery rate would initially reduce. The service is looking closely at the data to try to minimise any data quality issues. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the recovery rate. The Clinical lead for BHM is arranging a meeting with Xyla's clinical lead to discuss their recovery rates.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid MTR.
F: How will we know when we have addressed issues?	Maintain/exceed the 50% MTR rate.

IAPT seen in 18 weeks

Divisions

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Statistical Process Control (SPC)

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	79.9%	79.6%	76.3%	83.1%	80.5%	74.9%
E: Specialties	79.9%	79.6%	76.3%	83.1%	80.5%	74.9%

Commentary

Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. October 2023 position has increased to 74.46%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 18 weeks

Oct-2023

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. October 2023 position has increased to 74.46%.
B: Why has it happened?	The service has a large number of vacancies following staff leavers and retirements. Significant challenges have been faced around retention with staff leaving to take further training and work opportunities 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?	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?	The trajectory for 18 weeks was due to be met by November 2023, but progress has been slower than anticipated due to staffing challenges. New staff have commenced in October, and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes it will take time for the increased staffing to take effect. The service have therefore extended the 95% trajectory for 18 weeks to now be met by end June 2024 to align with recruitment and retention plans. A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach 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. 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. In October 2023 the impact of the new staff in post can be seen with an increase in contact levels being achieved. However as staff have just commenced in post, it will take time to build up to their full caseload numbers. This plan has progressed with, 8 PWP workers and 5 B7 qualified psychological therapists commencing in October. In addition, 8 PWP trainees and 7 Higher intensity trainees also commenced . Additional capacity 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 has commenced and will support the team to screen referrals and identify barriers to recovery planning and developing 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. Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate has been affected, falling to 42% in October and below the 50% national standard. The change in recording of activity has been applied to internal and external reporting.
	BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean that waits for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
E: What do we expect to happen?	The service expects to see a continuing improvement and to reach the 95% target by end June 2024 as the contacts undertaken by the new staff begin to come through. This will not be immediate due to working with service users to reach recovery and will take some months before progress through the data is visible.
F: How will we know when we have addressed issues?	The national standard of 95% is met and maintained.

IAPT seen in 6 weeks

Divisions

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	41.1%	42.5%	34.4%	43.4%	43.0%	46.9%
E: Specialties	41.1%	42.5%	34.4%	43.4%	43.0%	46.9%

Commentary

Performance has been on a gradual increasing trend for the last 12 months but remains below the 75% target. October 2023 position has increased to 46.58%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

Oct-2023

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months but remains below the 75% target. October 2023 position has increased to 46.58%.
B: Why has it happened?	The Talking Therapies 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 however has a large number of vacancies following staff retirements and leavers impacting on ability to carry out the required activity levels. 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 Talking Therapies 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?	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?	The trajectory for 6 weeks is not due to be met until January 2025, but progress has been slower than anticipated. New staff have commenced in October, and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes it will take time for this to come through into the data. A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach 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. The recruitment plan has progressed with, 8 PWP workers and 5 B7 qualified psychological therapists commencing in October. In addition, 8 PWP trainees and 7 Higher intensity trainees also commenced. 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. In October 2023 the impact of the new staff in post can be seen with an increase in contact levels being achieved. However as staff have just commenced in post, it will take time to build up to their full caseload numbers. Additional capacity 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 has commenced and will support the team to screen referrals and identify barriers to recovery planning and developing 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. Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate has been affected, falling to 42% in October and below the 50% national standard. The change in recording of activity has been applied to internal and external reporting.
D: What are we doing about it?	BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean s for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
E: What do we expect to happen?	The service expects to see a continuing improvement and to reach the 75% target by end January 2025 as the contacts undertaken by the new staff begin to come through. This will not be immediate due to working with service users to reach recovery and will take some months before progress through the data is visible.
F: How will we know when we have addressed issues?	The national standard of 75% is met and maintained.

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

Divisions

Statistical Process Control (SPC)

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	863	575	872	980	1071	1006
B: Acute and Urgent Care	863	575	872	980	1071	1006

Commentary

Inappropriate out of area bed days have been on an increasing trend since April 2022 reaching 863 bed days in May 2023. A reduction in June 2023 is observed (bed days at 575) due to the external bed capacity at Kings Norton being confirmed as being 'appropriate' by NHSE as these beds met the qualitative criteria that are required of local beds. Since July 2023, an upward trend has continued, with the month of October at 1006 bed days showing a slight downward trend. More recent weekly data for November shows a continuing improvement in reducing usage of PICU beds in particular.

There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 43 OOA placements, which is lower than the previous 3 months total number of placements. However, the Trust remains above the revised trajectory agreed with commissioners from April 2023 to March 2024 to reach 328 bed days by April 2024. The trajectory for October 2023 is 616 OOA bed days and the actual position is 1006 bed days.

Standard Operating Protocols (SOPs) have been agreed with NHSE following their review of bed capacity that is provide by the private sector. This enables a reclassification of such beds as being 'appropriate' as they meet the qual...

Detailed Commentary

Birmingham and Solihul Mental Healt
NHS Foundation Trus

Out of Area Bed Days

Oct-2023

Question	Answers
A: What has happened?	Inappropriate out of area bed days have been on an increasing trend since April 2022 reaching 863 bed days in May 2023. A reduction in June 2023 is observed (bed days at 575) due to the external bed capacity at Kings Norton being confirmed as being 'appropriate' by NHSE as these beds met the qualitative criteria that are required of local beds. Since July 2023, an upward trend has continued, with the month of October at 1006 bed days showing a slight downward trend. More recent weekly data for November shows a continuing improvement in reducing usage of PICU beds in particular. There is sustained pressure for adult male beds and PICU beds bringing the full month's number to 43 OOA placements, which is lower than the previous 3 months total number of placements. However, the Trust remains above the revised trajectory agreed with commissioners from April 2023 to March 2024 to reach 328 bed days by April 2024. The trajectory for October 2023 is 616 OOA bed days and the actual position is 1006 bed days. Standard Operating Protocols (SOPs) have been agreed with NHSE following their review of bed capacity that is provide by the private sector. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. The reclassification to date includes 10 Priory acute beds based in Willenhall, the MERIT beds, and from January 2022, PICU beds at Woodbourne Priory and 10 beds at the Active Care Group in Kings Norton from February 2023 and from April 2023, this also includes the beds at St Andrews in Northampton. Internal reporting reflects these changes (backdated to February 2023). However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHSE currently does not recognise these bespoke SOP arrangements agreed via NHSE. NHSE and Commissioners are aware of these issues and acknowledge that until this issue is resolved, there will be differences between national reporting using MHSDS as the data source and local Trust reporting.
B: Why has it happened?	NHS Benchmarking data confirms that BSMHFT has one of the lowest number of inpatient beds per 100,000 population indicating the need for additional capacity to meet the needs of the BSOL population. In addition, the service continues to face pressure on its inpatient capacity, with bed occupancy levels consistently at 95%, the inpatient admission and discharge ratio largely on a 1:1 basis, lengths of stay generally higher than other Providers due to high levels of acuity requiring a higher number of observations and the challenges of reducing delayed transfers of care, where the reason for the delay is not in the Trust's immediate control. DTOCs increased in October and accounted for 821 lost bed days, the highest number in the last 12 months. The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. These combination of these challenges and their inter dependencies continually impact on creating sufficient flow within the acute and urgent care pathway in particular to allow repatriation of out of area placements. Demand for both acute and PICU beds remains high resulting in patients being placed in units further away from Birmingham. Staffing has also remained a challenge in terms of sickness and vacancies levels.
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 available Trust 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 also 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 continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.

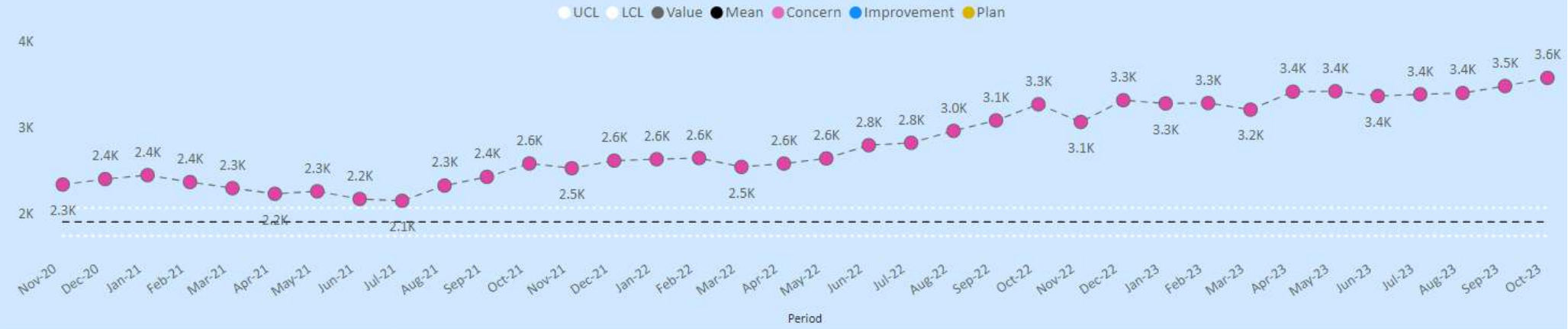
D: What are we doing about it?	An update on the project plan was shared at the Performance Delivery group in November 2023 outlining progress within the 4 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 4 workstreams are : Demand Management/Gatekeeping • In hours gatekeeping process has been mapped and agreed. Local discussions focusing on 'barriers to discharge' have identified system and partnership based actions to address identified need for more respite beds (aligned with localities), allocation of Social Workers in a timely manner, consideration of alternative locations for people to wait for Social Care assessments and planned review and better utilisation of day services. A review of HTT responsibilities and their establishment to identify ways of improvement is ongoing. Optimise capacity • The OOA Steering Group has stood down this workstream as the actions are part of daily management within the service to review demand and manage/create flow in capacity using available daily reports to facilitate actions required and monitor progress. Overall challenges and progress will be discussed at the OOA Steering Group. Locality model development • There has been positive progress in East, with the bed waiting list reducing and repatriation to locality beds from other localities & OOA starting to take place. Data requirements have been confirmed with the informatics team and the locality model has begun in West Locality and AOT with meetings being held with the South and North Locality to prepare for roll out of the model. New bed management function to support the locality model being developed. DTOC Workstream and length of stay • The OOA Steering Group has stood down this workstream as the actions are part of business as usual. However, due to the continual increase in delayed transfer of care (DTOC) that are outside of the Trust's control and require partnership actions, a separate DTOC group has been established to support these discussions. • The Clinical Oversight Group is in the process of being established, in the interim, discussions have commenced in some wards by clinical leads to understand the challenges and barriers at a ward level that the oversight group can help to mitigate and progress.
E: What do we expect to happen?	Monthly use of inappropriate out of area beds is expected to continue but reducing as the range of actions being taken forward get implemented and embedded and progress is made toward achieving the agreed trajectory of 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. Actions being taken forward by the workstreams begin to impact on creating capacity and flow to support repatriation of out of area placements.

Referrals over 3 mths with no contact

Divisions

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	3414	3359	3378	3393	3474	3568
C: ICCR	1303	1207	1202	1214	1268	1391
D: Secure Serv & Offender Health	127	140	149	152	154	160
E: Specialties	1731	1802	1834	1854	1898	1893

Commentary

The number of patients who have not been seen after 3 months of referral has yet to show improvement with the number at 3562, the same as September 2023 and the highest figure in the last 3 years. The number of referrals not seen within 3 months of referral has decreased in SOLAR and OAKS group therapy programmes, but has increased in Adult CMHTs, Memory Assessment Services and CAMHS Primary Mental health.
Neuropsychiatry service accounts for 24% and Adult CMHTs 24% of referrals open for over 3 months without a contact.

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Referrals over 3 mths with no contact

Oct-2023

Question	Answers
A: What has happened?	The number of patients who have not been seen after 3 months of referral has yet to show improvement with the number at 3562, the same as September 2023 and the highest figure in the last 3 years. The number of referrals not seen within 3 months of referral has decreased in SOLAR and OAKS group therapy programmes, but has increased in Adult CMHTs, Memory Assessment Services and CAMHS Primary Mental health. Neuropsychiatry service accounts for 24% 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 reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. However a backlog was created as a result. In addition, in line with available research, new demand is also arising as a result of the impact from Covid -19 resulting 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: Caseloads in CMHT have increased by 4000 patients since 2019 but there has not been an increase in CMHT medical staffing to meet the need for appointments. The service has high rates of DNA for first and follow up appointments meaning appointment slots not being utilised. Plans have been implemented to reduce DNA rates, actions include moving to opt out rather than opt in arrangements for our patients for text message reminders, a review of hybrid mail as many patients say they do not receive appointment letters, increasing the capacity of admin staff to complete telephone reminders, discharging patients, if appropriate after repeat DNAs. We also see numbers within this category of patients who are transfers from other teams so are being seen in other services . Future reporting will enable us to identify those service users who have had no contact at all from mental heath services. 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 patients 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 service users directly however, through carers were able to provide consultation and commence treatment, however these have remained on the waiting list. For all services, 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. There are long waiting times within neuropsychiatry with the longest waits for the Epilepsy service at 32 weeks and the shortest waits are for Huntington's at 14 weeks. The average therapy times are between 4-6 months.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

Oct-2023

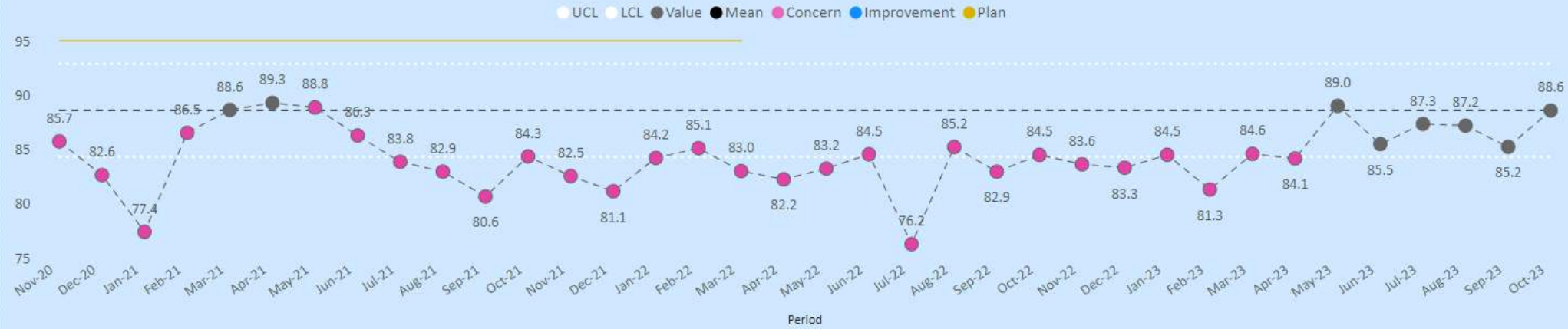
Question	Answers
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments prolonging their difficulties. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service
D: What are we doing about it?	ICCR: Are currently reviewing all CMHT activity via our twice monthly waiting list & KPI oversight meeting. Clinical service managers review the detail of waits and take away actions for their teams. These actions including cleansing the data, discharging or prioritising appointments for service users who do need an appointment with community mental health services . The new Neighbourhood mental health function (NMHT) are now our front door to CMHT. The NMHTs have seen over 11'000 patients over the past 12 months since inception and the majority of those service users are seen within 2-4 weeks. All referrals are now first screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. We envisage over the next 12 months as the NMHTs grow that this will have a significant impact on reducing waits and capacity within CMHT. The 5 NMHTs are at varying levels of staffing and are working through recruitment plans ,it is hoped that they will be fully recruited to be Mid year 2024 (May 2024) .In the medium term, a plan is in place that includes engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHT to take on low level CMHT cases (we have noted in NMHT data that 70% of referrals to our NMHT function are for presentations of depression & anxiety who should be signposted to talking therapies as the correct service to meet the service users needs), reducing DNA rates for first appointments to 20% by May 2024, reduce numbers not seen over 3 months by 20% by end January 2024.The Longer term plan is to achieve capacity within CMHTs and to achieve a 4 week wait by end of 2024. By end of 2024 we will have complete coverage of all PCNs and will therefore have greater impact on our ability to manage referrals effectively. 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. Due to immediate staffing pressures Older Adults did not initially have a trajectory set, but due to an improved staffing position they are aiming to achieving a 20% reduction in the 18 week plus cohort by the end of April 2024.
E: What do we expect to happen?	Within adult CMHTs we expect referrals for assessment to our Community mental health service to be reduced to meet the 4 week window as set out by the Long term plan, although this measure has not been implemented as yet we would hope to achieve this by end December 2024 when all new funding has been utilised to grow capacity in our community mental health services. We expect DNAs to be effectively managed and reduced to below 20% for both first appointments within 6 months (May 2024). The Neighbourhood function of our community mental health service is expected to divert activity for lower complexity work and to ensure referrals are signposted to correct services such as talking therapies rather than CMHT , this will lead to CMHT activity being reduced and support with ensuring timely access in the CMHT function. We will also be ensuring that NMHT data is included within the whole data set to give a complete picture for our Community mental health service. We are already noting that the majority of patients seen by the NMHT function are seen within 2- 4 weeks. Within older adult CMHTs we expect there to be some improvement in waiting lists, as staffing position has improved, however this remains challenging.
F: How will we know when we have addressed issues?	For adult services when we have reduced numbers being referred to the CMHT function and are seeing activity for the community mental health service (including NMHT function as a whole) and we have reduced the numbers not seen over three months by 20% by end January 2024. For Older Adults they would have seen a reduction of those waiting for more than 18 weeks by 20% by end April 2024.

Bank & Agency Fill Rate

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	89.0%	85.5%	87.3%	87.2%	85.2%	88.6%
B: Acute and Urgent Care	87.7%	84.0%	87.4%	87.6%	87.0%	88.4%
C: ICCR	94.9%	91.1%	92.9%	91.4%	88.3%	92.3%
D: Secure Serv & Offender Health	81.7%	76.5%	78.3%	79.2%	76.0%	80.9%
E: Specialties	92.4%	90.7%	92.4%	93.5%	92.6%	93.8%
F: Corporate	98.9%	98.0%	98.0%	96.0%	95.2%	98.6%

Commentary

The bank and agency fill rate decreased to 85.25% in September from 87.22% in August. The bank fill rate remained relatively stable, as did the agency fill rate. The fill rate breakdown by division is as follows:

Acute and Urgent Care –87%,

ICCR – 88.3%,

Specialties – 92.6%,

Secure Services and Offender Health – 75.99%

The number of shifts requested in September decreased by 1,260 compared to August.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

Oct-2023

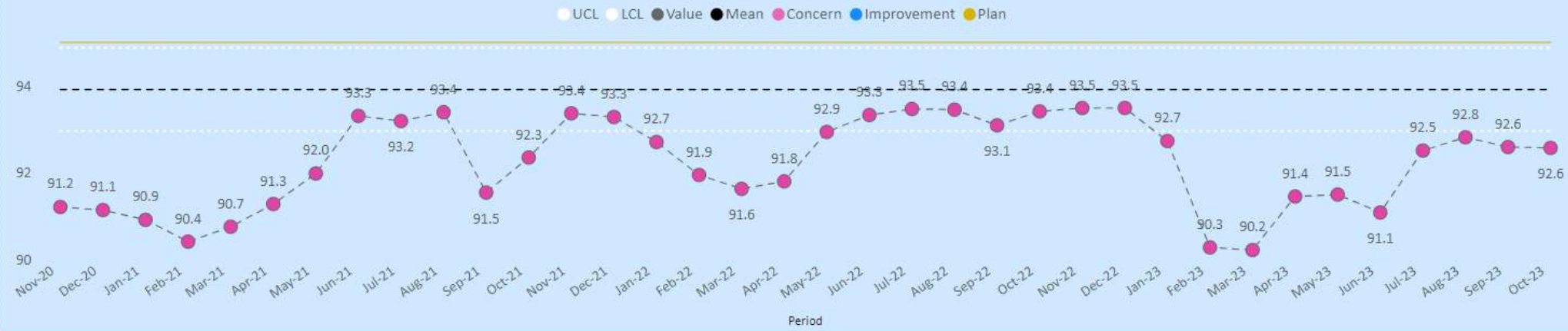
Question	Answers
A: What has happened?	The bank and agency fill rate increased from 85.3% in September to 88.6% in October. The bank fill rate remained relatively stable, as did the agency fill rate. The fill rate breakdown by division is as follows: ICCR – 92.8% (Sept was 88.9%); Specialties – 93.8% (Sept was 92.5%); Acute and Urgent Care – 88.6% (Sept was 87.2); and Secure Services and Offender Health – up significantly to 81.0% (Sept was 76.0%). However, the number of shifts requested in October decreased by 791 compared to September (17,871 from 18,662). Bank filled 66 more shifts in October than September, and agency filled 144 less shifts. The breakdown of shifts requested by division is as follows: ICCR – 2,873 (down from 3,244); Specialties – 2,951 (up from 2546); Secure Services and Offender Health – 5,362 (down from 5,819, which explains the 5% rise in fill rate); and Acute and Urgent Care – 5,145 (down from 5502).
B: Why has it happened?	17,871 temporary staffing shifts were requested in October. This is a decrease of 791 from 18,662 in September. 15,835 shifts were filled in October (14,465 of these were bank). Fill rate has seen a 3.3% increase. The main reasons for requested shifts in October were: Clinical Activity (6,438 shifts requested); Additional Work (3,749 shifts requested); Vacancies (2,840 shifts requested); Block booking (1,723 shifts requested) sickness (907), Staff Training (521), Annual leave (377), and other 1,316.
C: What are the implications and consequences?	There were higher fill rates resulting in more filled shifts by percentage, but overall, slightly less shifts filled in October than September, which has an implication on safer staffing levels and the Trust's ability to deliver high quality patient care. Having less staff also has an impact on workload and staff health and wellbeing – there appears to be a ceiling of available staff and shifts.
D: What are we doing about it?	Bank overall Fundamental Training continues to be an area of focus and be above 85% 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. Substantial work is being undertaken to ensure adequate availability of induction and averts placements for bank workers – working in conjunction with the trust's L&D department. Joint Projects between TSS and the Trust's Workforce Management Team / Bank staff Healthroster Management Team are being implemented in order to assist TSS Booking Co-ordinators and bank staff with increasing the number of shifts filled. TSS leadership's team held a recent meeting to look at longer term strategic projects and improvements for the TSS function in terms of processes, health and wellbeing, training, and support for TSS workers. TSS's Clinical and Pastoral wing will be visiting universities and colleges to promote BSMHFT as an employer of choice via the bank. In October 110 bank workers started with the trust.
E: What do we expect to happen?	With the significant work ongoing to reduce agency spend – particularly with HCA and Above Cap - we expect agency fill rates to decrease and bank fill rates to increase. However, it should be noted that with the winter season nearly upon us, the predicted rise in the number of requested shifts may further impact on the Trust's fill rates.
F: How will we know when we have addressed issues?	The overall bank rate increases and the agency rate decreases.

Fundamental Training

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	91.5%	91.1%	92.5%	92.8%	92.6%	92.6%
B: Acute and Urgent Care	89.9%	89.3%	91.4%	92.3%	92.5%	92.4%
C: ICCR	91.2%	90.9%	92.4%	93.1%	93.5%	92.9%
D: Secure Serv & Offender Health	92.9%	92.2%	93.5%	93.6%	93.0%	92.7%
E: Specialties	92.4%	91.2%	92.7%	93.4%	93.3%	93.3%
F: Corporate	90.5%	91.7%	92.1%	90.9%	89.6%	91.3%

Commentary

Substantive staff (Trust Target 95%, Commissioners Target 90%)
The Trust's overall compliance with Fundamental Training declined slightly from 92.6% in August 2023 to 92.4% in September 2023. Overall compliance of TSS staff has decreased from 89.4% last month to 85% this month. The Trust has, nevertheless, met the Commissioners' goal.
FT breakdown by division:

- Chief Executive Locality – 86.2%,
- Exec Director - Medical Locality – 86.6%,
- Exec Director - Nursing Locality – 92.6%,
- Exec Director – Operations
  - Acute and Urgent Care –92.6%,
  - ICCR – 93.4%,
  - Secure Services and Offender Health – 93.0%

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Oct-2023

Fundamental Training

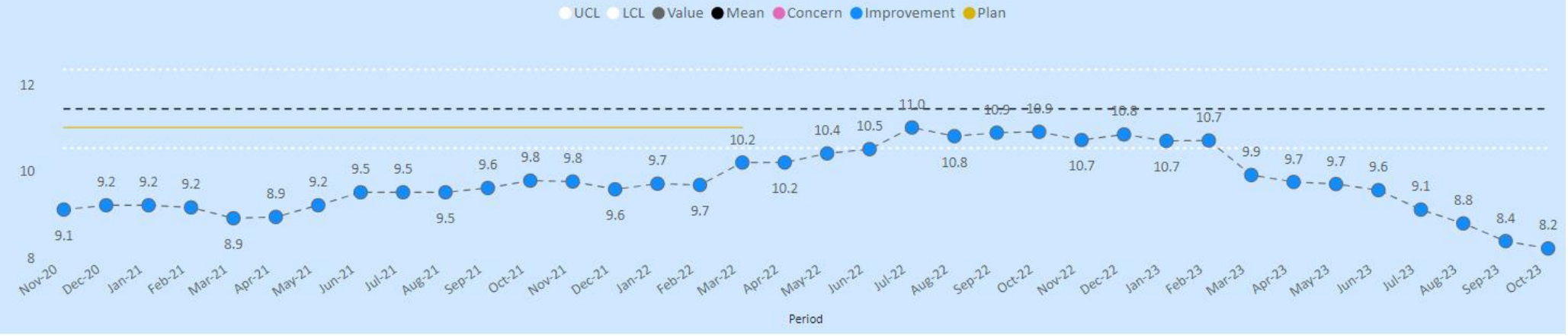
Question	Answers
A: What has happened?	Substantive Fundamental Training Compliance has remained the same from September into October at 92.6%. TSS Compliance has decreased to 85% from 87%. The trust has overall reached the Commissioners Target however we are below the Trust Target of 95% for substantive staff. All areas remain below the 95% trust target other than Exec Director - Resources.FT breakdown by division: • Chief Executive Locality – 70.8%, • Exec Director - Medical Locality – 90.6%, • Exec Director - Nursing Locality – 93.7%, • Exec Director – Operations o Acute and Urgent Care –92.4%, o ICCR – 92.8%, o Secure Services and Offender Health – 92.7% o Specialties – 93.3% • Exec Director - Resources Locality – 97.2%, • Exec Director - Strategy People and Partnerships Locality – 90.7%
B: Why has it happened?	Face to face and webinar courses have reduced in compliance as the trust recruited 201 employees in September and 153 in October which is significantly more than the average of 110. The DNA rates on courses is also above the 12% agreed buffer, operational pressures and sickness is cited as the main reasons for DNAs.
C: What are the implications and consequences?	Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
D: What are we doing about it?	• Recovery Plan is in place for Fundamental Subjects below 90% compliance which includes monthly trajectories. • Trajectories have been updated to take into account higher level of Recruitment • More spaces have been provided for CRAM to meet the influx of new starters • The Fundamental Training team are sending out extra reminders around upcoming training. • Businesses as usual process, to keep the compliance at the required percentages, L&D constantly chasing staff to fill the spaces. This is ongoing process that L&D team does. • Additional training provision is available for TSS staff to increase capacity so TSS workforce can have the skills to practice safely in clinical environment. • DNA emails are being sent to both employee and manager asking for what the reason for DNA is and asking employees to book on again as soon as possible.
E: What do we expect to happen?	We expect to meet 90% for Averts 1 Day and CRAM by the end of November. We expect ILS to reach 90% by March 2024. Currently it won't be possible for ELS to reach 90% as there is a lack of spaces available however the Trust is looking to procure more ELS spaces. We also expect the overall trust compliance will remain above 90%.
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight

Rolling 12m Turnover

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	9.7%	9.6%	9.1%	8.8%	8.4%	8.2%

Commentary

Turnover has decreased to 8.37% in September from 8.8% in August and is below the KPI of 11%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Rolling 12m Turnover

Oct-2023

Question	Answers
A: What has happened?	Turnover has reduced to 8.2% in October from 8.37% in September. In October, 16 colleagues left the organisation. In a rolling 12 months, 372 colleagues have left. For all service areas, the turnover rate is below the KPI target of 11%. However, when looking at staff groups, Psychology are still over the KPI at 11.7% and Talking Therapies at 13.2%. Of the 16 leavers, 3 left due to relocation and 3 retired. Two colleague left due to work/life balance. Three colleagues left with less than 1 year service with the Trust. 50% of the leavers in Ocotber were in nursing roles.
B: Why has it happened?	Turnover has seen a slow decline and is now significantly below the KPI level. The Trust has focussed work around flexible working opportunities for staff, improving the onboarding process for new starters, health and wellbeing initiaves and staff engagement strategies to all support decreased turnover. The Trust is also involved in the BSol Retention Group, focusing on a number of regional initatives such as flexible working, preceptotship, rostering etc.
C: What are the implications and consequences?	If turnover increases, there will be a further impact on staffing levels. For clinical areas, this will impact safe staffing and impact on staff morale.
D: What are we doing about it?	Continue to work on initiatives to support turnover such as flexible working. For flexible working, we are looking at the culture of teams around flexible working and enabling managers to support requests.
E: What do we expect to happen?	Continued reduction or stablised levels of turnover below KPI
F: How will we know when we have addressed issues?	Higher and safer levels of staffing across wards and teams

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	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	70.7%	72.9%	76.0%	76.9%	77.6%	78.9%
B: Acute and Urgent Care	55.6%	56.8%	63.2%	66.2%	67.2%	67.1%
C: ICCR	74.8%	80.3%	82.9%	84.4%	84.7%	85.1%
D: Secure Serv & Offender Health	79.0%	80.5%	83.0%	82.0%	82.5%	86.0%
E: Specialties	77.9%	78.1%	79.2%	78.5%	82.4%	82.7%
F: Corporate	61.1%	63.4%	67.4%	69.9%	67.6%	69.7%

Commentary

The trust's Appraisal compliance for September is 76.5% which is a 0.6% slight decline from August. The teams within the Trust that are below the compliance trajectory of 75% are: Acute and Urgent Care services at 65.3% (slightly decreased position from August), Exec Dir-Medical at 62.1% (slightly decreased position from August), Exec Dir-Nursing at 62.7% (slightly decreased position from August), New Care Models at 46.2% (improved position from August) and Exec Dir-Resources at 71.3% (improved position from August). However, the trust remains below the Trust target of 90% and commissioner's target of 85%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals

Oct-2023

Question	Answers
A: What has happened?	Insight report data (27 October) 79% . This is below the trajectory of 89.7% for October 2023. Compliance is below the 85% Commissioner target, but showing steady improvement from April 2023
B: Why has it happened?	The improvement in appraisal compliance has not been as rapid as expected. Issues with a managers having access to SMART cards has been flagged as a blocker to completing appraisals. There are also some issues with the technical aspects of ESR with individuals not "completing" their appraisals.
C: What are the implications and consequences?	On the ESR appraisals have been started but not completed, without the manager sign off the appraisal will be being reflected in ESR. Low appraisal rates can impact on staff morale, development and retention.
D: What are we doing about it?	L and D have a completion report and team managers are contacted and offered support to resolve any issues There is a task and finish group that meets regulary to review and address any emerging themes or barriers. Recovery plan- analysis of appraisal data weekly and any actions to support 'hot spot' areas (below 75%) identified From November 2023, additional support for operational areas has been offered to hot spot areas to include, VBA demonstration, course booking, ESR support, SMART card access. In addition, targeted clinics will be held with team managers of staff that have started but not completed. ESR team have confirmed that all smartcards for expired cards have been issued. QI project -The focus of the review is centred upon the improvement of quality of appraisal conversations. The exclusion list has been reviewed and revised and we are hopeful to see the realisation of this in compliance figures from November.
E: What do we expect to happen?	Compliance to return to historical levels of 85 % by end Q3
F: How will we know when we have addressed issues?	Appraisal compliance with reach and stabilise at 85% with 5% tolerance .

Staff Sickness

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	5.0%	4.3%	4.6%	5.4%	5.5%	6.0%
B: Acute and Urgent Care	6.2%	4.9%	3.9%	4.7%	5.0%	6.6%
C: ICCR	4.3%	3.9%	4.4%	5.0%	5.3%	6.2%
D: Secure Serv & Offender Health	6.2%	5.4%	5.4%	7.4%	6.9%	7.4%
E: Specialties	4.9%	4.6%	6.0%	6.2%	6.4%	6.3%
F: Corporate	3.1%	2.8%	3.1%	3.2%	3.8%	3.2%

Commentary

Sickness absence rates for the Trust has seen an increase to 5.5% which is the highest since June when the Trust saw the lowest levels of sickness absence which was 4.3%. This current increase is due to a combination of short term and long term absences. Short term sickness at 1.9 and long term sickness at 3.58

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

Acute and Urgent Care –5%

Corporate 3.8%,

ICCR – 5.3%,

Specialties – 6.4%,

Secure Services and Offender Health – 6.88%

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

Oct-2023

Question	Answers
A: What has happened?	Sickness absence rates for the Trust has seen an increase to 6% which is the highest since June 2023 when the Trust saw the lowest levels of sickness absence at 4.3%. This current increase is due to a combination of short term and long term absences. Short term sickness at 2.54% and long term sickness at 3.42% Overall sickness absence rates by division for October are as follows: Acute and Urgent Care –6.6% Corporate 3.2%, ICCR – 6.2%, Specialties – 6.3%, Secure Services and Offender Health – 7.4%
B: Why has it happened?	waiting for information
C: What are the implications and consequences?	High levels of sickness across wards and teams impact staffing levels and patient safety. There is also an impact on the morale of other staff, and there are financial implications for cover via bank/agency.
D: What are we doing about it?	HR clinics continue to run across divisions, supporting managers to manage sickness. The Health, Wellbeing and Attendance Policy will be launched in November. The focus of the policy is encouraging health and wellbeing and supporting staff even before they go off sick. This was communicated to staff and managers via Trust-wide comms at the end of October. Alongside the launch of the policy, the People team have launched the new training for sickness absence for line managers. Booking via ESR will start from end of November. There is also more work with our Occupational health Provider to explore other targeted intervention to support staff with anxiety ,stress and depression. The People team continues to promote other health and wellbeing offers to managers to support their staff, so that there are several offerings for support for staff with their health and Wellbeing. Following discussions at TCSE, a deep dive will commence into reasons for sickness for staff groups (nursing at a starting point).
E: What do we expect to happen?	As we move into the winter period, we do expect that we will see some rise in sickness absence rates due to seasonal colds and flu. Towards quarter 4 we would look to see improvement in rates towards the summer.
F: How will we know when we have addressed issues?	When the Trust hits the KPI target of 3.9%

Staff Vacancies

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	12.2%	12.2%	12.6%	12.4%	11.7%	11.0%
B: Acute and Urgent Care	13.4%	14.3%	15.3%	15.1%	15.1%	12.8%
C: ICCR	14.6%	12.2%	11.4%	10.7%	10.7%	11.2%
D: Secure Serv & Offender Health	14.7%	14.8%	14.7%	14.5%	14.3%	13.7%
E: Specialties	13.3%	14.9%	16.6%	18.1%	16.4%	15.7%
F: Corporate	1.4%	1.1%	0.8%	-0.6%	-2.3%	-2.7%

Commentary

The vacancy rate for September is not available yet

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Vacancies

Oct-2023

Question	Answers
A: What has happened?	The staff vacancy rate for October is at 11% a reduction from September which was 11.7%
B: Why has it happened?	waiting for information
C: What are the implications and consequences?	High vacancy rates can impact on patient care and cause low morale in teams. This can also cause diffculties in attracting bank workers to areas when they know they are short staffed.
D: What are we doing about it?	Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are being rolled out throughout the recruitment process to: -Ensure flexibility is promoted in internal advertisements and vacancy information. - Enhance training for hiring managers to equip them to discuss flexible working at interview. -Update recruitment processes and training to ensure that the drop down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created. -Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles. - Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs. -Start monitoring number of new joiners who are recruited flexibly and collate this centrally. BSMHFT's EDI Lead and The People Partner for Resourcing will be hosting a 2nd Listen Up Live programme to all trust wide members on the 21.11.2023, explaining again the Trust's newly updated Recruitment Panel Guidance, incorporating Equity Panel members and updated Visible Diversity policies. This followed 2 Inclusive Recruitment Sessions attended by Recruitment members with the Trust's EDI lead. The sessions concentrated on interview panels (and the recruitment process in general) maximising (visible) diversity and ensuring an even more equitable process, which has ensured that the Trust's Recruitment and Selection Training is more comprehensive and fully up to date with current guidance and legislation. The sessions explored in detail, how, at every step of the recruitment process, there is a need to refrain from the potential of unconscious bias. 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 trust wide BSMHFT recruitment fairs is being planned for November 29th, with another one around Easter 2024. This will incorporate every discipline and area of the trust for Qualified Healthcare Professionals at Highbury Hall, with a view to maximising the potential of success via strategic advertising and the fact that representatives and management for Nursing and AHP's will be involved.

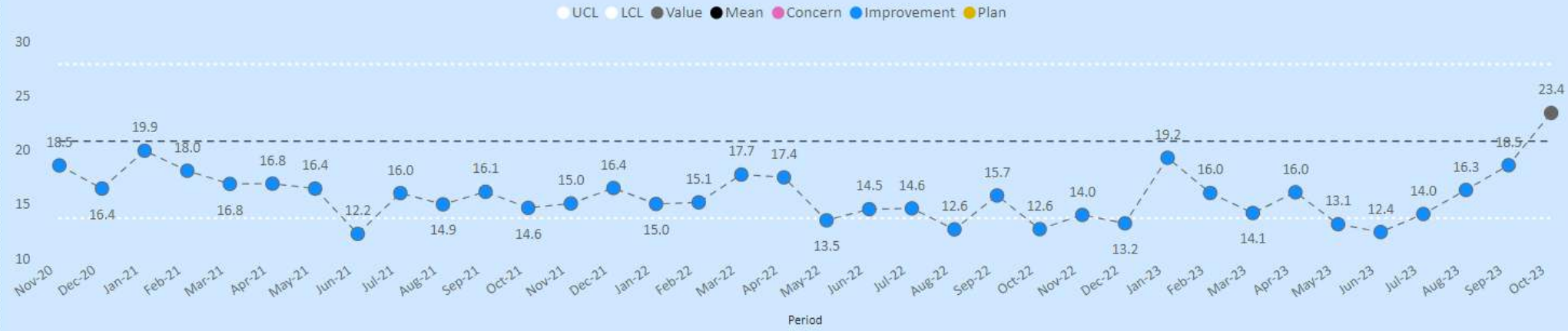
	A weekly vacancy control panel has been implemented, which is predominantly to ensure cost reduction and control measures are in place trust wide. A by-product of these discussions however is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place. The trust also hosted a stand at the University of Nottingham Nursing, Midwifery and Physiotherapy Careers Fair 2023 at the start of November with 25 potential candidates spoken to in detail about current available and future vacancies and the relevant pathways into the trust. 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 48 are active in the system. A second department wide Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling. The recruitment department will continue to work in conjunction with the workforce transformation project leads to facilitate long and short-term planning bearing fruition. The recruitment department, in conjunction with the trusts workforce transformation processes is working to understand and improve on the levels of vacancies that are current and advertised, compared to the trust actual vacancy rates. Currently, our time to hire from authorisation to start date is 87.41 days. This has reduced from 98 in September.
E: What do we expect to happen?	We expect the vacancy rate to reduce in line with the recruitment iniatives
F: How will we know when we have addressed issues?	Reached 3% target of reduction by March 2024.

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Incidents resulting in harm (patients)

Divisions

Statistical Process Control (SPC)



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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	13.1%	12.4%	14.0%	16.3%	18.5%	23.4%
B: Acute and Urgent Care	10.0%	12.9%	16.4%	14.6%	18.9%	24.6%
C: ICCR	16.7%	17.2%	21.4%	29.6%	28.3%	27.6%
D: Secure Serv & Offender Health	15.6%	9.8%	10.7%	14.9%	13.3%	18.8%
E: Specialties	15.9%	15.6%	14.8%	16.7%	25.6%	30.2%

Commentary

(Blank)

Monthly Agency

Divisions

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Statistical Process Control (SPC)

Commentary

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

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
A: All	£941k	£935k	£956k	£1,143k	£851k	£819k

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Monthly Agency

Oct-2023

Question	Answers
A: What has happened?	YTD agency expenditure remains well above NHSE ceiling of 3.7%, though September spend at £851k lowest since Apr-23
B: Why has it happened?	Level of medical staff expenditure (£2.8m), particularly in ICCR on key staff vacancies
C: What are the implications and consequences?	Breach of agency cap by BSMHFT will lead to increased oversight and controls from NHSE
D: What are we doing about it?	Instituting temporary staffing panel
E: What do we expect to happen?	Reduction in agency spend over time, depends on recruitment to key roles
F: How will we know when we have addressed issues?	When spending is less than 3-7% on a sustainable basis

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 15 November 2023

Performance metric trajectory updates

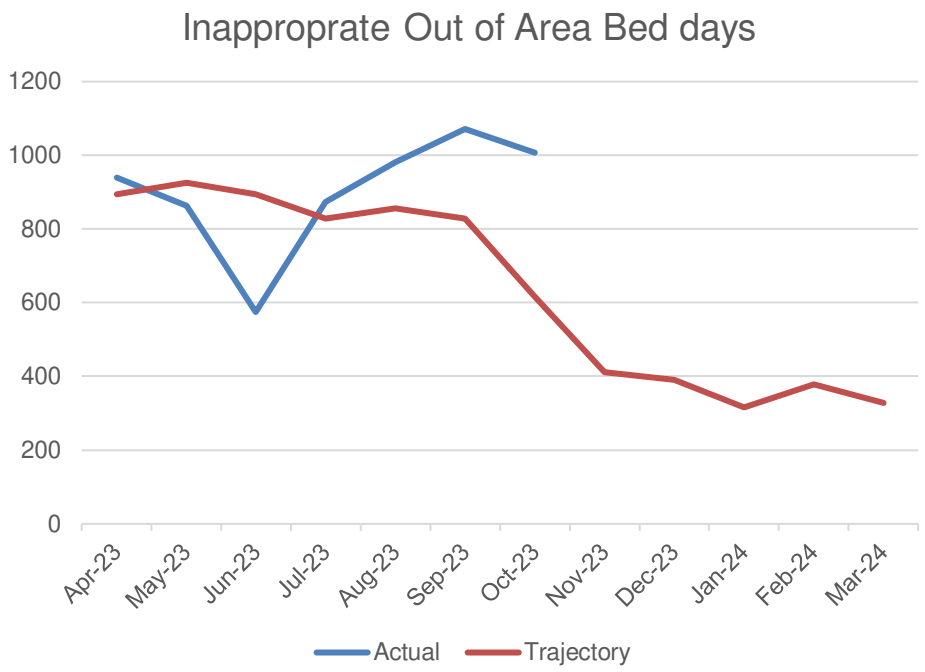
Trust Performance Metrics

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 most recently discussed at the Performance Delivery Group on the 2nd November 2023 with a focus on providing FPPC feedback from October's meeting to relevant leads. The commentaries on the IPD and below have been updated by the relevant Leads. 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



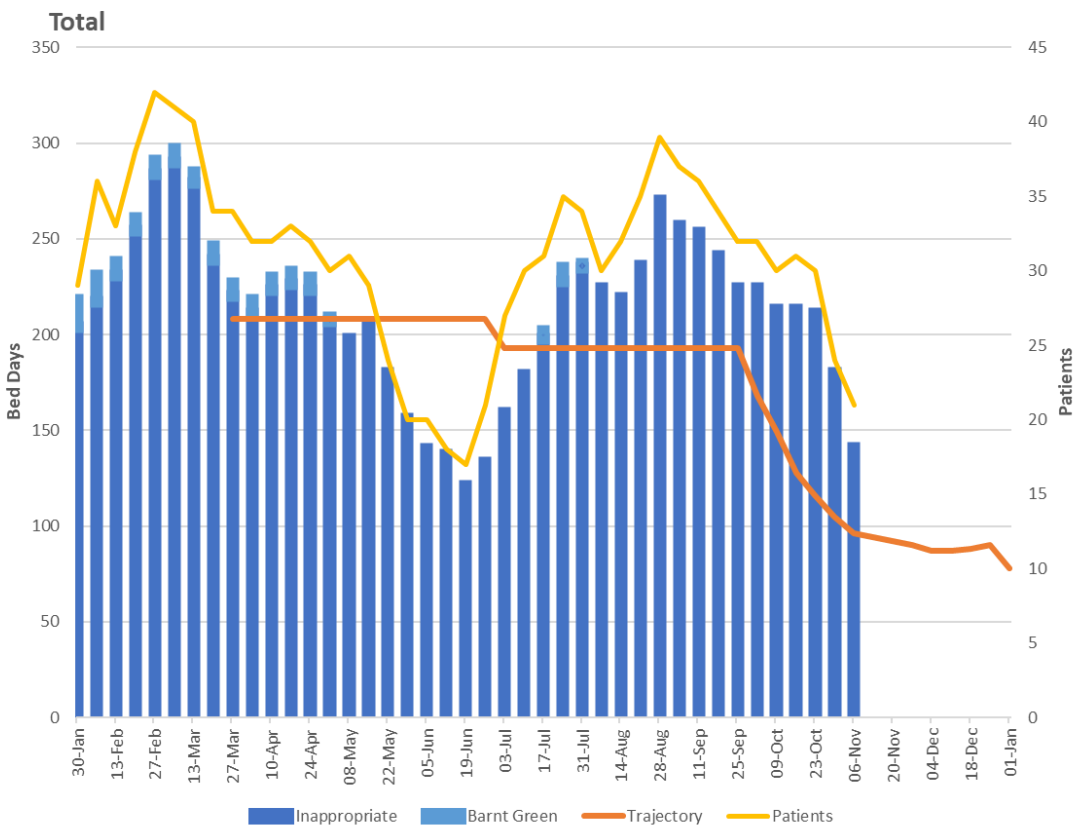
Inappropriate Out of Area trajectories have been agreed as part of the national planning round for 2023/24. The aim is to reach 328 bed days in March 2024.

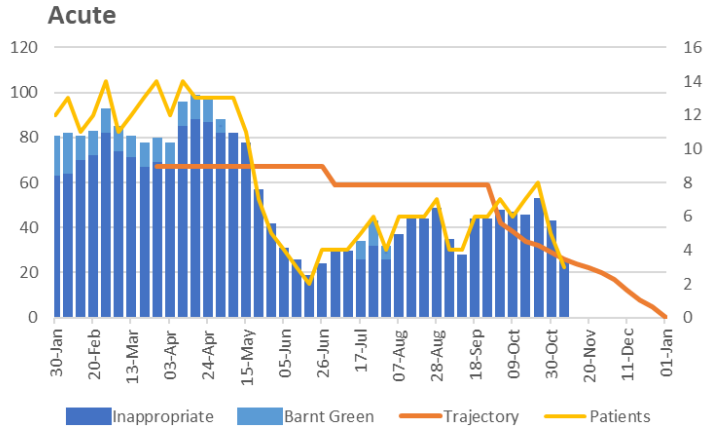
The action plan to transform the acute & urgent care pathway will focus on 4 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available and an update on progress is outlined below.

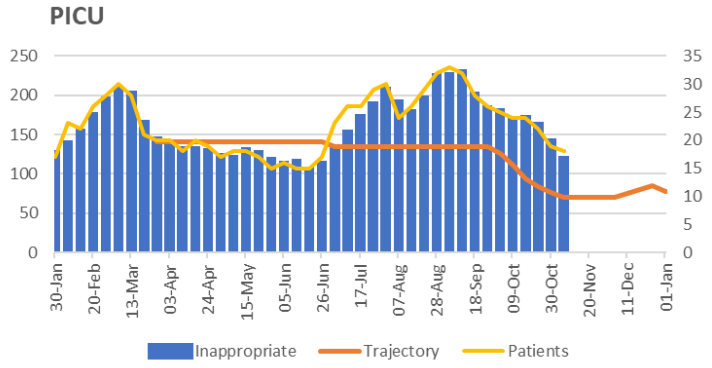
Current Progress:

Performance continues to fluctuate and remains above trajectory. However, Slide 4 highlights the weekly progress being achieved in reducing PICU inappropriate placements and acute bed usage reaching trajectory in November. A key pressure point is the impact of delayed transfers of care that are not within Trust control impacting on reducing available Trust capacity to support repatriation. As a result, a dedicated workstream has been established to focus on addressing system and partnership wide barriers. Slides 5, 6 & 7 outline progress in each of the above workstreams.

2. Inappropriate Out of Area Bed Usage - BSMHFT







- Sustained reduction in PICU bed usage has continued this week.
- Acute bed usage reduced this week, reaching a trajectory position.

Out of Area Productivity Plan

Current Progress:

Demand Management/Gatekeeping (RAG status Green)

- In hours gatekeeping process has been mapped and agreed at task and finish group and presented at OOA Steering Group for sign off. Discussed 'barriers to discharge' that would increase flow in locality's. Areas which have been identified are: Identified need for more respite beds (which are aligned with localities), Social Workers to be provided in a timely manner, consider alternative locations for people to wait for Social Care Assessments and better utilisation of day services. OOA Steering group agree to focus on respite beds to improve availability while the workstream reviews day service provision.
- Review HTT responsibilities and their establishment to identify ways of improvement – ongoing action.

Optimise capacity (RAG status Amber)

- Agreed during the OOA Steering Group in September for the workstream to be stood down and continue as business as usual with continual reporting of data from informatics on progress to OOA Steering Group.

Out of Area Productivity plan

Locality model development (RAG status Green)

- Positive traction in East, with bed waiting list reducing and repatriation to locality beds from other localities & OOA starting to take place. Data requirements have been confirmed with the informatics team and the locality model has begun in West Locality and AOT with meetings being held with the South and North Locality to prepare for roll out of the model. New bed management function being developed to support the locality model.

DTOC Workstream and length of stay (RAG status Red)

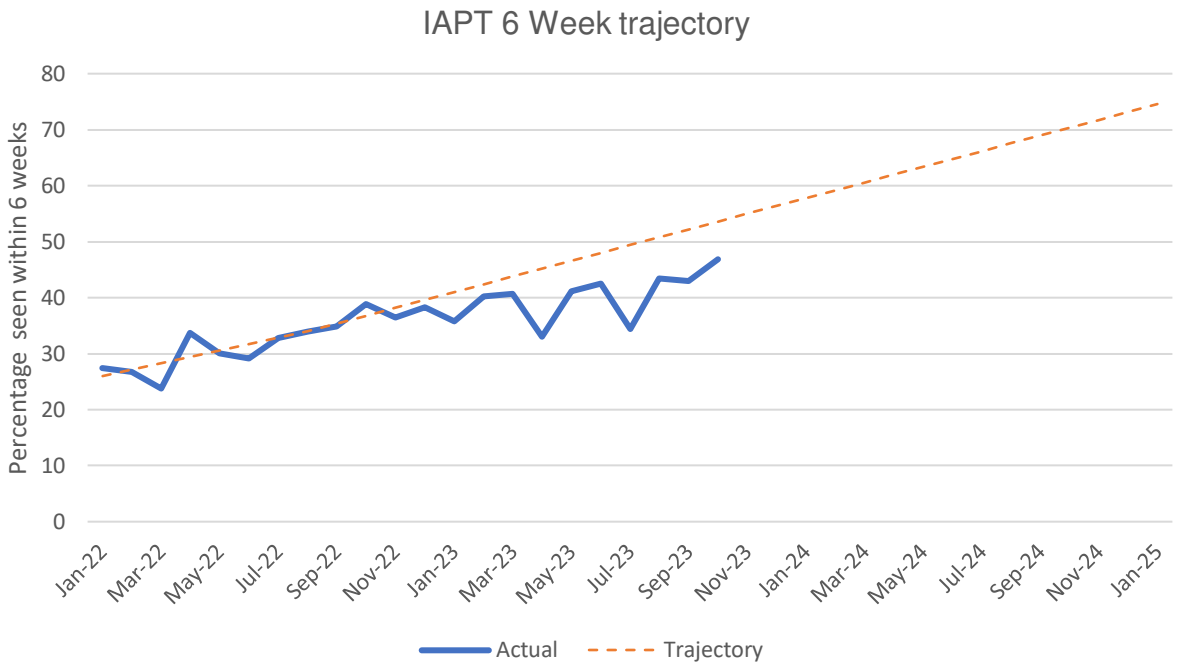
- Workstream to be stood down and continue as business as usual however due to the continual increase in delays of transfer of care DTOC, a dedicated workstream has been established to focus on system wide and partnership based challenges.

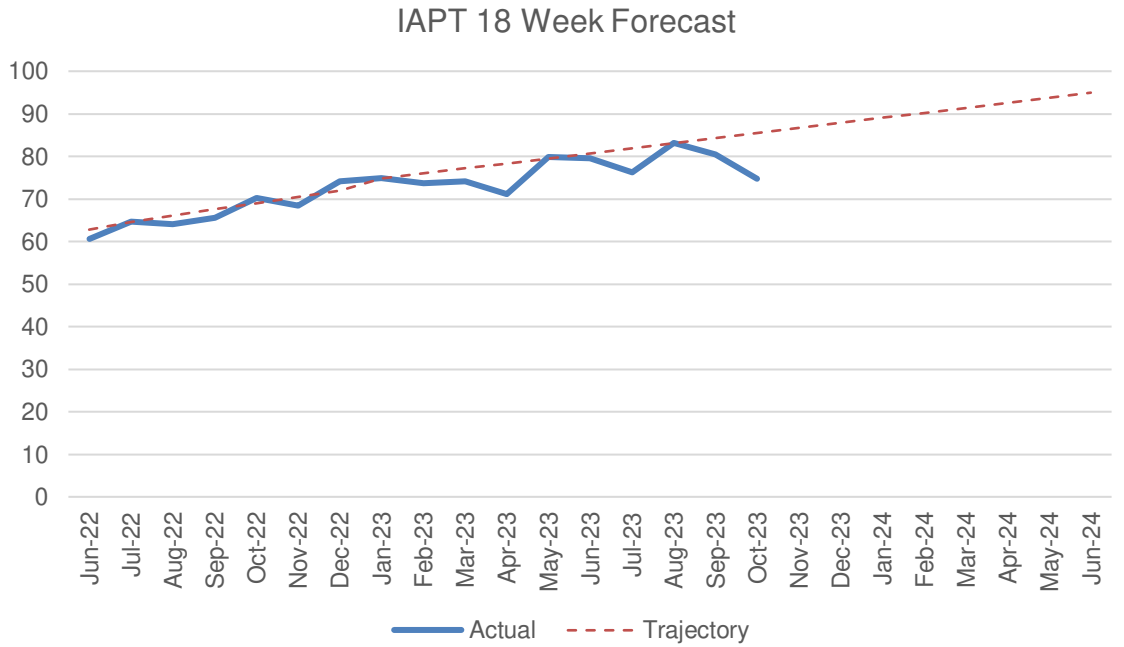
Length of Stay/ Clinical Oversight Group (RAG status Red)

- The Clinical Oversight Group is in the process of being established, in the interim, discussions have commenced in some wards by clinical leads to understand the challenges and barriers at a ward level that the oversight group can help to mitigate and progress.

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. October 2023 performance at 46.90% which has shown an increase but remains below trajectory.

Trajectory provided by Associate Director for Specialties

The revised trajectory is to reach the 95% target by end June 2024 based on staffing plans in place. October 2023 Performance at 74.87% below trajectory.

Talking Therapies – updated action agreed in July 2023 remains in place

The trajectory for 6 weeks is not due to be met until January 2025, but progress has been slower than anticipated. New staff have commenced in October, and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes it will take time for this to come through in the data.

A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across Bsol. 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.

The recruitment plan has progressed with, 8 PWP workers and 5 B7 qualified psychological therapists commencing in October. In addition, 8 PWP trainees and 7 Higher intensity trainees also commenced.

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 has been sourced through Xyla (a digital service) and letters being sent out to service users to see if they would like to be seen by the service.

Talking Therapies – action plan summary

2 new posts have been created in the service. The step 2 lead who commenced post, August 2023 will be instrumental in providing valuable oversight of step 2 interventions and aligning the pathway as well as promoting community engagement and networking with our Neighbourhood Mental Health Teams. The clinical development lead is also in post and will support the team to screen referrals and identify barriers to recovery planning and to develop existing relationships with neighbourhood mental health teams to enable further support. The role also has a focus on access and waiting list targets

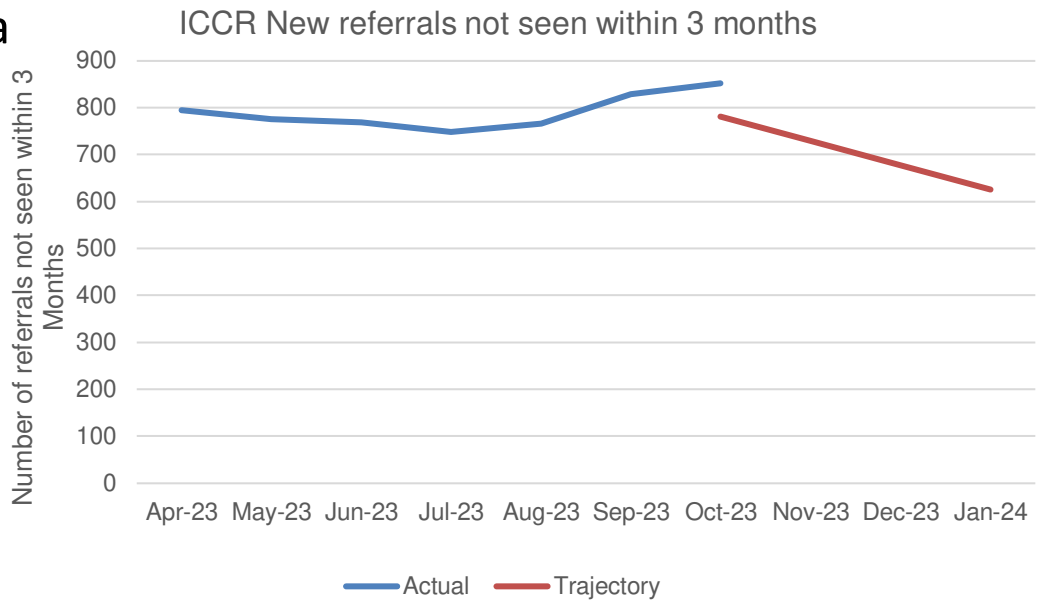
A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff.

Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate has been affected, falling to 42% in October and below the 50% national standard. The change in recording of activity has been applied to internal and external reporting.

BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project.

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 is to reduce the long waits. The revised trajectory is based on achieving a 20% reduction in the new referrals not seen within 3 months by the end of January 2024. October 2023 at 851



Actions:

Short Term: ICCR are currently reviewing all CMHT activity via our twice monthly waiting list & KPI oversight meeting. Clinical service managers review the detail of waits and take away actions for their teams.

These actions include a focus on DNA rates, cleansing the data, discharging or prioritising appointments for service users who need an appointment with community mental health services.
The new Neighbourhood mental health function (NMHT) are now our front door to CMHTs. The NMHTs have seen over 11'000 patients over the past 12 months since inception and the majority of those service users are seen within 2-4 weeks.

Note - ICCR Trajectory provided by Associate Director for ICCR.

New Referrals not seen within 3 months

ICCR action plan cont:

- All referrals are now first screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. We envisage over the next 12 months as the NMHTs grow that this will have a significant impact on reducing waits and capacity within CMHT.

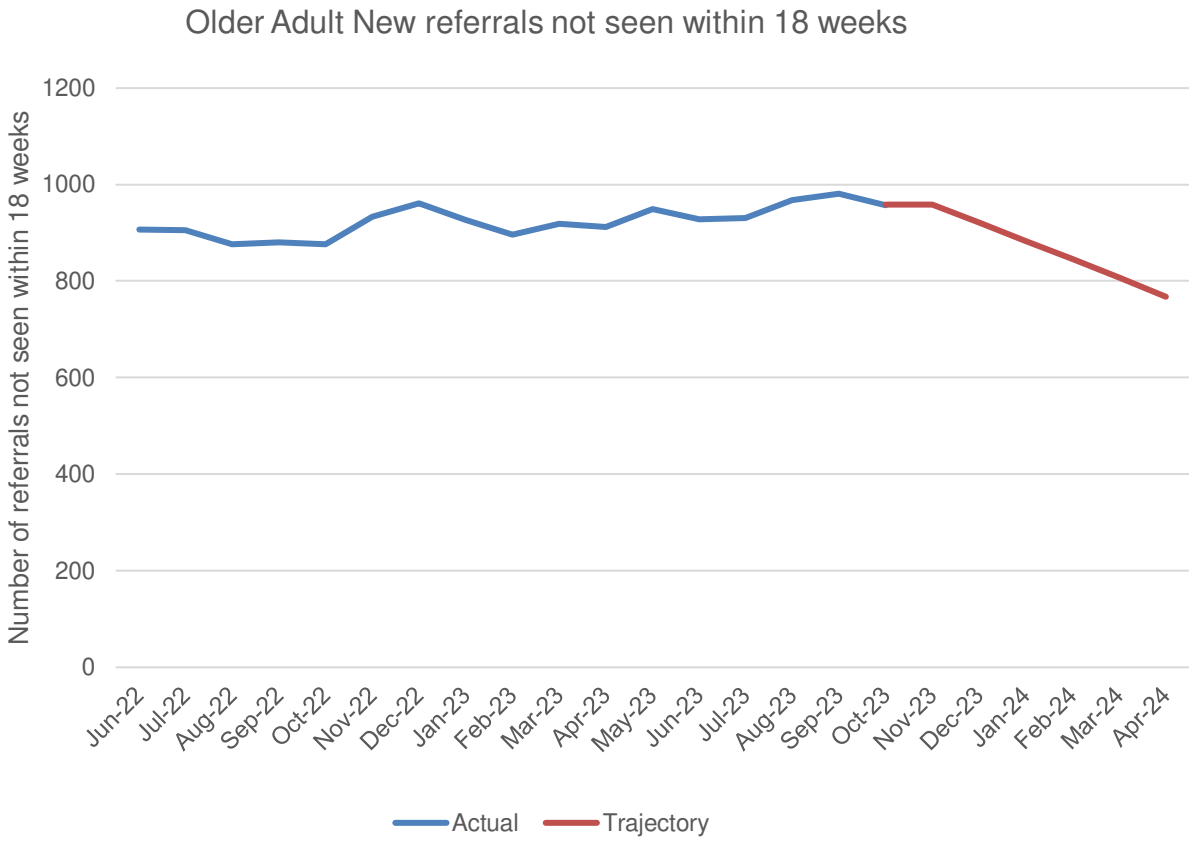
Medium Term:

- The 5 NMHTs are at varying levels of staffing and are working through recruitment plans ,it is hoped that they will be fully recruited to by May 2024.
- Engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHT to take on low level CMHT cases (we have noted in NMHT data that 70% of referrals to our NMHT function are for presentations of depression & anxiety who should be signposted to talking therapies as the correct service to meet the service users needs), reducing DNA rates for first appointments to 20% by May 2024, reduce numbers not seen over 3 months by 20% by end January 2024.

Longer term:

- To achieve capacity within CMHTs and to achieve a 4 week wait by end of 2024. By end of 2024 we will have complete coverage of all PCNs and will therefore have greater impact on our ability to manage referrals effectively

New Referrals not seen within 3 months- Older Adults



Due to immediate staffing pressures Older Adults did not initially have a trajectory set, but due to an improved staffing position they are now aiming to focus on the long waits and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024. October 2023 at 957 below the trajectory of 959.

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

New Referrals not seen within 3 months

Older adults CMHTs Action Plan: Deep Dive meeting on 2nd November - Focused on demand and capacity challenges and management actions within the CMHTs. Detail provided in Appendix IIb, Performance Framework Update.

Demand: Referrals and Caseloads on increasing trend, service having to hold onto those service users being prescribed anti dementia medication due to the inability to discharge these service users to GPs, patients with a stable serious Mental Illness (SMI) could also be discharged but no appropriate alternative service & GPs will not take on the long-term prescribing requirements.

Capacity: Staffing challenges in Solihull Older Adult CMHT beginning to ease with 8 new starters and 2 people awaiting start dates to join the service.

Recruitment: New Roles – multi-disciplinary based, ANP Role to be fully utilised in all hubs, ACP Role to be explored as a clinical developmental opportunity, career progression and of value to Service users, MHWB workers in post and more to train, Workforce transformation (skill mix, recruitment, retention, new roles), Health inequalities – older people under-represented in the workforce.

Retention: Manageable jobs - continue caseload reviews, explore more consistent models of capacity and demand in CMHTs looking at impact of new roles, Workforce skill mix, Leadership development.

Staff Engagement: Work on Pathways – improved Clarity re Clinical Offer and Team Purpose, Work on capacity and demand so manageable workload.

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

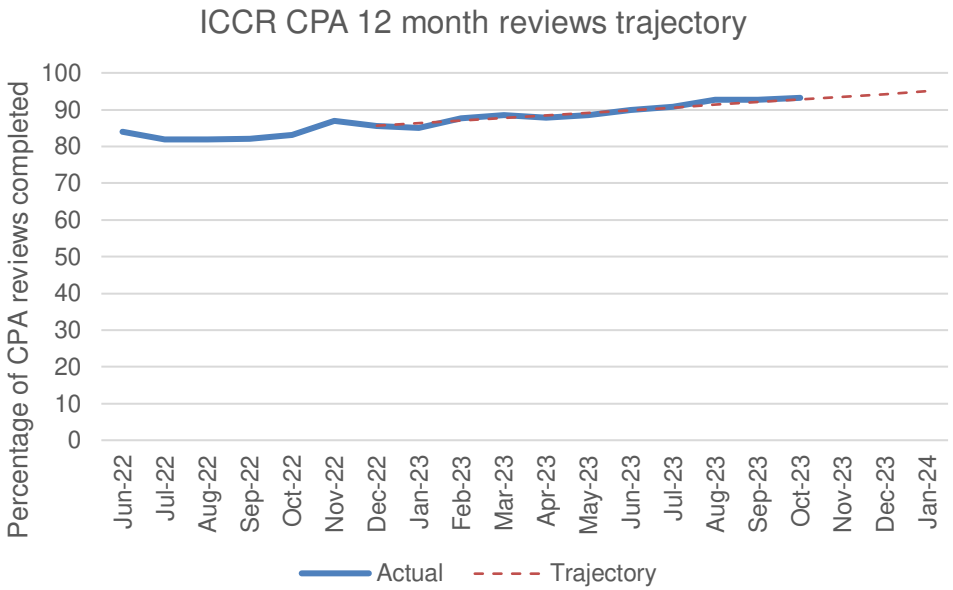
CPA 12-month reviews - ICCR

ICCR performance for October has seen a positive overall improvement at 95.1% and with adult CMHTs marginally below target at 93.3%.

There are a total of 78 reviews outstanding in October for adult CMHTs, which is the lowest number outstanding in the last 3 years. Performance varies between the CMHTs between 1-14 , the first time that all teams have under 15 reviews outstanding.

The division are holding twice monthly meetings with clinical service managers supported by the Information team to review the data for all CMHTs and identify actions to manage.

The trajectory has been reviewed and it is anticipated that adult CMHTS will reach 95% by January 2024. The number of CPA reviews due in the next couple of months have been shared with the service to allow them to start planning future CPA reviews.



Note - Trajectory position provided by Associate Directors for ICCR

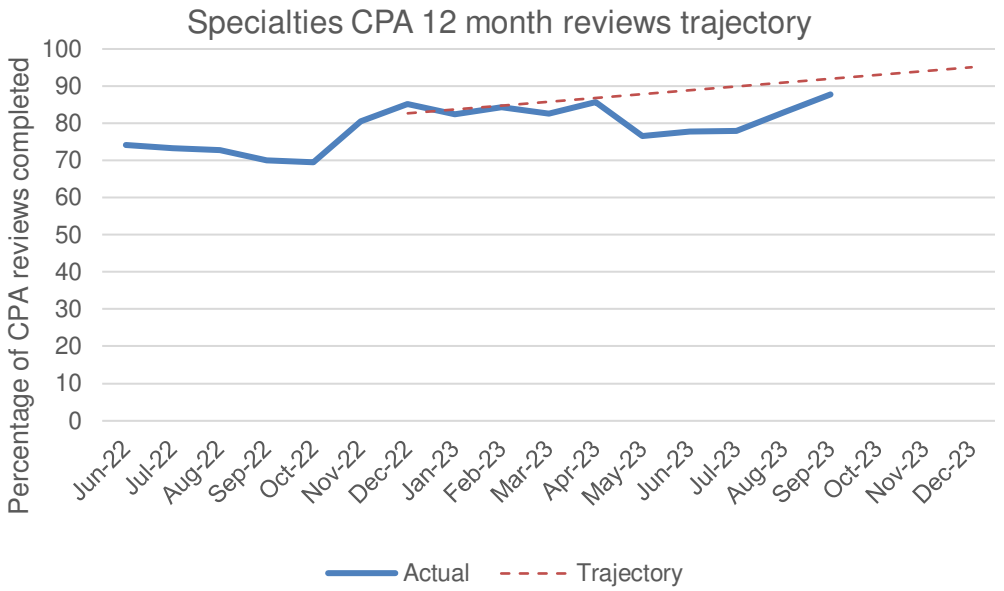
CPA 12 month reviews - Specialties

Specialties performance for October has seen a positive overall improvement at 94.6%, marginally below trajectory with older adult CMHTs at 94.7%

Older adults CMHTs – although the improvement trajectory to achieve 95% by the end of September 2023 has not been achieved, good progress has been made and there are now only 6 outstanding reviews. Agency staff to aid with vacancies have commenced and have taken over caseloads which has enabled them to undertake reviews in the last couple of months.

The trajectory has been reviewed and it is anticipated that adult CMHTS will reach 95% by January 2024.

The number of CPA reviews due in the next couple of months have been shared with the service to allow them to start planning future CPA reviews in order to maintain a level of 95%



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. We are now starting to ask services to undertake this as many of the service users are discharged to local trusts and using the shared care record allows staff to check whether they have been seen. Although the number of service users is small, the impact in percentage terms is high. The addition of FTB data to Rio now enables staff to see whether the patient has been seen, but a 3 day follow up form will need to be completed to capture this data.
- Late data entry within services is an ongoing factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD.

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 October 2023 at 83.78% - 6 of 24 service users were discharged to other trusts (including FTB) and 6 follow ups have been completed but awaiting data entry, once confirmed this will take the compliance level up to 88.44%.

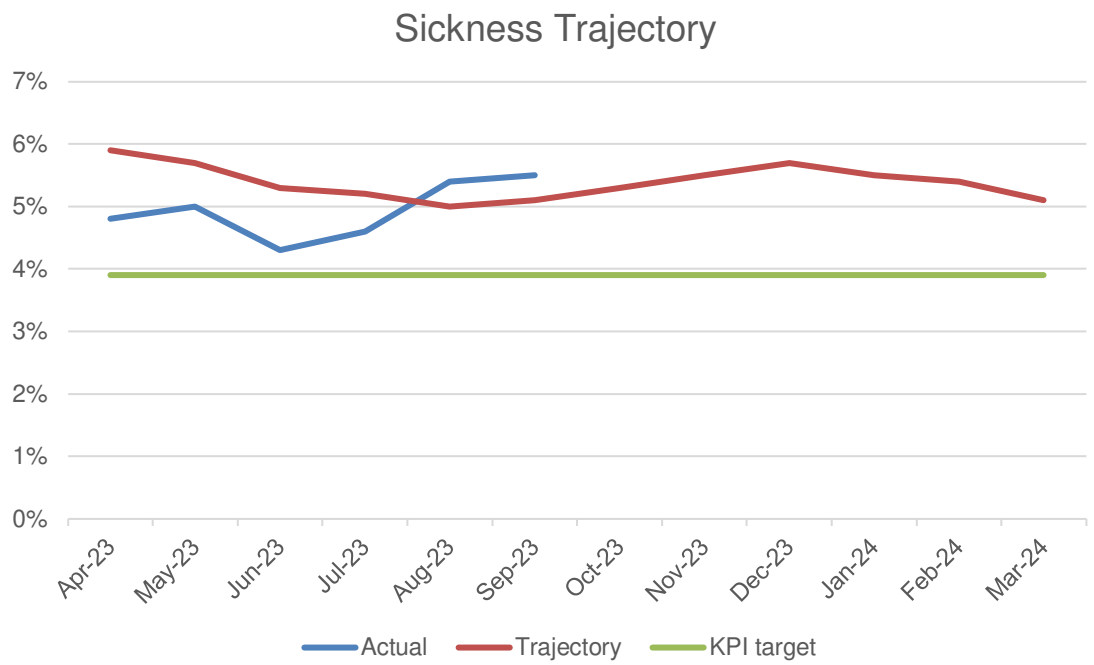
Note – Commentary above provided by the AD for Performance & Information

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories

The workforce trajectories commenced in April 2023

Sickness Absence



Sickness levels for October increased to 6% and above trajectory of 5.3%. In October there was a small decrease in long-term sickness to 3.42% and an increase in short-term sickness to 2.54%.

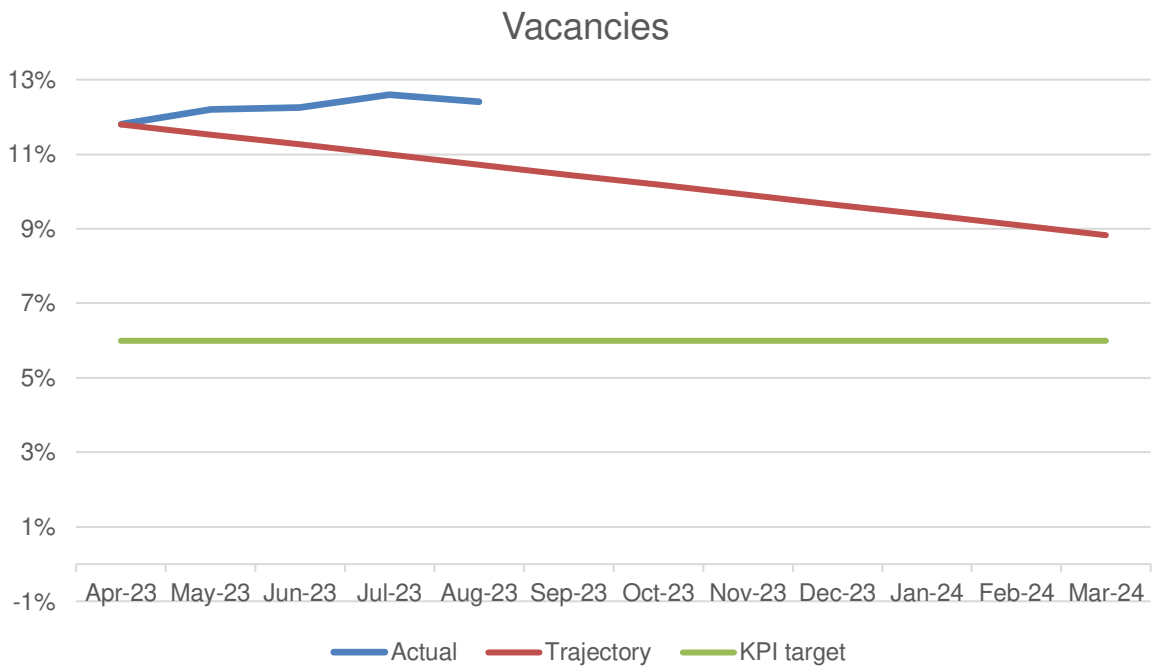
- HR clinics continue to run across divisions, supporting managers to manage sickness.
- The Health, Wellbeing and Attendance Policy will be launched in November. The focus of the policy is encouraging health and wellbeing and supporting staff even before they go off sick. This was communicated to staff and managers via Trust-wide comms at the end of October.
- Alongside the launch of the policy, the People team have launched the new training for sickness absence for line managers. Booking via ESR will start from end of November. There is also more work with our Occupational health Provider to explore other targeted intervention to support staff with anxiety ,stress and depression.

Note - Trajectory provided by People team

Sickness absence

- The People team continues to promote other health and wellbeing offers to managers to support their staff, so that there are several offerings for support. Deep dives are planned and will commence into reasons for sickness for staff groups (nursing at a starting point).

Vacancies



The HR lead has confirmed that the agreed target for 2023/24 is a 3% reduction in vacancies over the year, with a trajectory starting at 11.8% and moving to 8.8% by March 2024. The KPI target is 6%. October saw a small fall to 11%

Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are being rolled out throughout the recruitment process to:

-Ensure flexibility is promoted in internal advertisements and vacancy information.

- Enhance training for hiring managers to equip them to discuss flexible working at interview.

-Update recruitment processes and training to ensure that the drop-down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created.

Note - Trajectory provided by People team

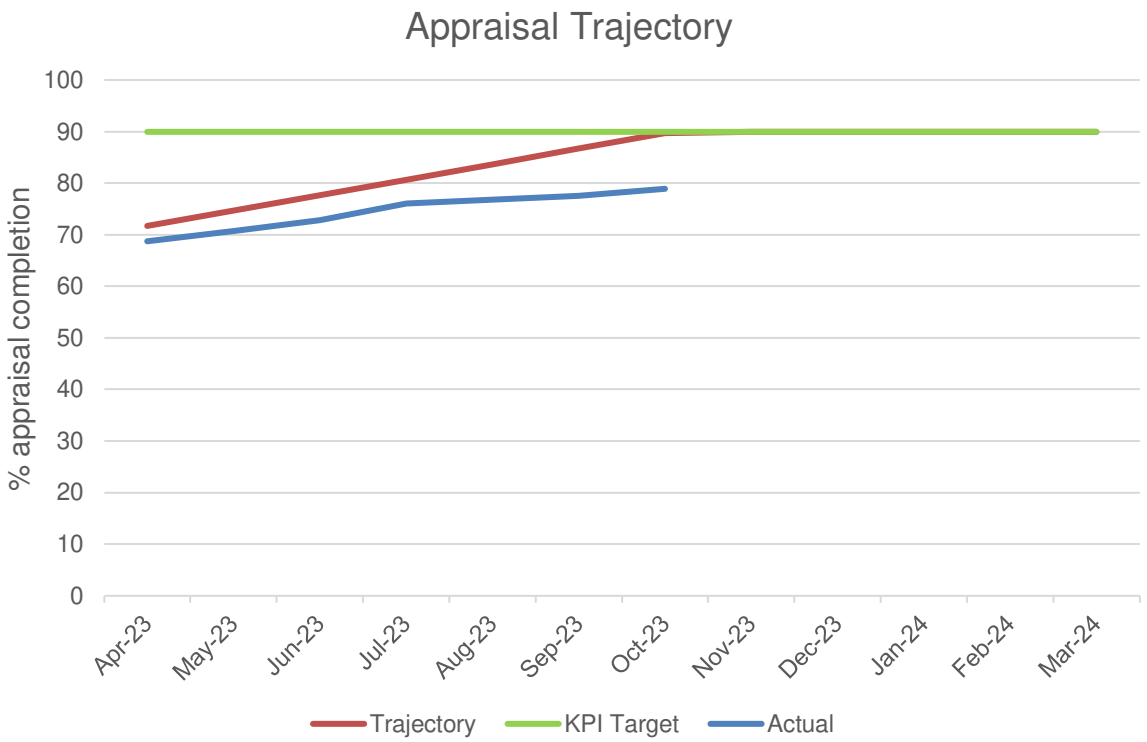
Vacancies

- Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles.
- Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs.
- Start monitoring number of new joiners who are recruited flexibly and collate this centrally.
- BSMHFT's EDI Lead and The People Partner for Resourcing will be hosting a 2nd Listen Up Live programme to all trust wide members on the 21.11.2023, explaining again the Trust's newly updated Recruitment Panel Guidance, incorporating Equity Panel members and updated Visible Diversity policies. This followed 2 Inclusive Recruitment Sessions attended by Recruitment members with the Trust's EDI lead. The sessions concentrated on interview panels (and the recruitment process in general) maximising (visible) diversity and ensuring an even more equitable process, which has ensured that the Trust's Recruitment and Selection Training is more comprehensive and fully up to date with current guidance and legislation. The sessions explored in detail, how, at every step of the recruitment process, there is a need to refrain from the potential of unconscious bias.
- 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 trust wide BSMHFT recruitment fairs is being planned for November 29th, with another one around Easter 2024. This will incorporate every discipline and area of the trust for Qualified Healthcare Professionals at Highbury Hall, with a view to maximising the potential of success via strategic advertising and the fact that representatives and management for Nursing and AHP’s will be involved.
- A weekly vacancy control panel has been implemented, which is predominantly to ensure cost reduction and control measures are in place trust wide. A by-product of these discussions however is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place.

Vacancies

- The trust also hosted a stand at the University of Nottingham Nursing, Midwifery and Physiotherapy Careers Fair 2023 at the start of November with 25 potential candidates spoken to in detail about current available and future vacancies and the relevant pathways into the trust.
- 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 48 are active in the system.
- A second department wide Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.
- The recruitment department will continue to work in conjunction with the workforce transformation project leads to facilitate long and short-term planning bearing fruition.
- The recruitment department, in conjunction with the trusts workforce transformation processes is working to understand and improve on the levels of vacancies that are current and advertised, compared to the trust actual vacancy rates.
- Currently, our time to hire from authorisation to start date is 87.41 days. This has reduced from 98 in September.

Appraisals



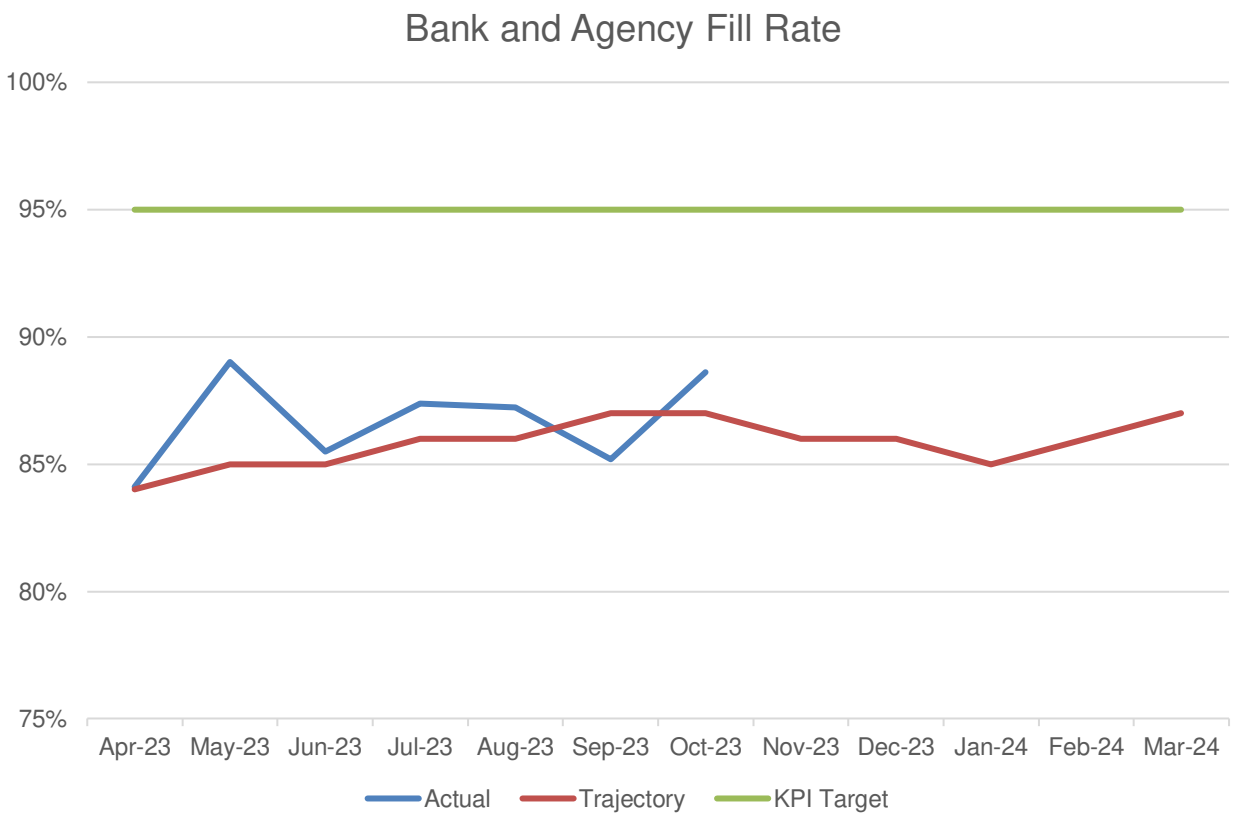
- Appraisals at 78.9% and remain below the trajectory of 89.7% for October 2023.
- The improvement in appraisal compliance has not been as rapid as expected. Issues with managers having access to SMART cards has been flagged as a blocker to completing appraisals. There are also some issues with the technical aspects of ESR with individuals not "completing" their appraisals.
- L & D have a completion report and team managers are contacted and offered support to resolve any issues
- There is a task and finish group that meets regularly to review and address any emerging themes or barriers.
- Recovery plan- analysis of appraisal data weekly and any actions to support 'hot spot' areas (below 75%) identified

Note - Trajectory provided by People team

Appraisals

- From November 2023, additional support for operational areas has been offered to hot spot areas to include, VBA demonstration, course booking, ESR support, SMART card access. In addition, targeted clinics will be held with team managers of staff that have started appraisals but not completed.
- ESR team have confirmed that all smartcards for expired cards have been issued.
- QI project -The focus of the review is centred upon the improvement of quality of appraisal conversations.
- The exclusion list has been reviewed and revised and we are hopeful to see the realisation of this in compliance figures from November.

Bank and Agency fill rate



Note - Trajectory provided by People team

Bank and agency fill rate at 88.6% and above the trajectory of 87% for October 2023.

A detailed agency reduction programme is in progress working in conjunction with ICB policies and restrictions. Two areas of renewed focus are the expediating of the TSS bank worker to substantive process and the reduced reliance on block bookings. Other initiatives to be considered include Finance, HR and AD sign-off being required for all future RMN agency block bookings (currently 80% of all expenditure via TSS is block bookings). Currently all HCA agency requests, and above cap block bookings require Exec approval. Meetings have taken place with NHS Professionals as a source of providing temporary staff as a (cheaper) alternative to agency utilisation.

Bank and Agency fill rate

Direct Engagement for Agency workers is being discussed at senior levels of the trust and demonstrations are being planned by potential providers, with the aim of meeting potential ICB and NHSE requirements. Direct Engagement can have a significant effect on fill rates and also have significant, tangible cost saving implications.

In October 110 bank workers started with the trust, helping to alleviate the need for agency.

Note - Trajectory provided by People team

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Sustainability

Monthly Agency costs

- There has been a decrease in agency spend from c. £851K in September to c. £819K in October. In October 110 bank workers started with the trust, alleviating the need for agency staff.
- A detailed agency reduction options appraisal has been submitted to senior management in order for its proposals to be incorporated in conjunction with impending ICB policies and restrictions (An Agency Staff Diagnostic Toolkit was completed and passed on to B/Sol ICB in January to assist and aid with the reduction of agency spend). Two areas of renewed focus (within TSS's agency reduction proposals) are the expediating and streamlining of the TSS bank and agency worker to substantive process and the reduced reliance on block bookings. Other proposals include Finance, HR and AD sign-off being required for all future agency block bookings (currently 80% of all expenditure via TSS is block bookings). Meetings are also being arranged with NHSProfessionals as a source of providing temporary staff as a cost effective alternative to agency utilisation.
- Direct Engagement for Agency workers is being discussed at senior levels of the trust with the aim of meeting potential ICB and NHSE requirements. During 2022 a presentation from 247 Allocate demonstrated how Direct Engagement can have a significant effect on fill rates and also have significant, tangible cost saving implications.
- A temporary staffing panel is being introduced

Appendix II Performance Management framework

Performance Delivery Group meeting on 2nd November 2023

The agenda for the meeting focused on the following areas:

i) Feedback from the Trust Board FPPC meeting in October was provided to the Group with a reiteration to update metric commentaries in line with improvement action plans being implemented on a monthly basis outlining actions achieved or being undertaken. It was also highlighted that we currently report on 7 day follow up with a 95% compliance standard but that this qualitative standard has been updated to achieving a minimum of 80% of service users being followed up within 3 days. An update on Trust compliance levels was shared together with a reiteration of timely and accurate data entry. FPPC is asked to note that this financial year to date, the 80% standard has been consistently achieved.

ii) Out of Area Productivity Plan – Urgent & Acute Care service - The Clnical Nurse Manager and the Operational Manager for Acute and Urgent care gave an update and the slides shared are attached (appendix IIa).

Within the plan there are four workstreams and updated actions were outlined:

1. **Demand Management and gatekeeping**
   - The in hours gatekeeping process has been signed off and the out of hours gatekeeping process has been drafted for consultation and agreement.
   - East Locality has started piloting the gatekeeping process and locality model which has led to a positive increase in levels of gatekeeping by Home Treatment Teams.

2. **Reducing Length of stay (LOS) and Delayed Transfers Of Care (DTOC)**
   - A DTOC task and finish group has been established and will be chaired by the Senior Mental Health Commissioner to focus on 'system wide' issues and actions to mitigate and reduce.
   - A clinical oversight group is being established led by the Medical Director which will review patients length of stay and conduct deep dives to identify actions to reduce and support discharge planning.

3. **Optimising Capacity**
   - Noted that there has been a reduction in the PICU inappropriate OOA area bed days over the last month.
   - Maximising the use of contracted beds to avoid spot purchase.
   - Bed waiting list has been reduced via the work on gatekeeping and locality model working.

4. **Locality Model**
   - Principles of the locality model and associated bed management function are being developed.
   - Locality model rolled out in East in September and in West and AOT in mid October. The rollout for North and South is due mid November and there are engagement sessions with clinical teams to take this forward.
   - Early data for East locality has shown a reduction in the bed waiting list and no out of area admissions being made.

iii) Highlighted that the CQC relationship meeting had taken place and the CQC had requested benchmarking data which has been sent to them. They are looking at Adult and Older adult CMHTS and Adult and Older Adult inpatient services and have asked for a further update on how we are using the data and any actions we are taking as a result for the next meeting in December.

iv) The Performance Management framework relaunch for the Performance Delivery Group (PDG) and the Service Area Deep dives is planned for further discussion at an Executive Team meeting.

Service Area Deep Dive Meetings – Update

1. Introduction

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

Since the October 2023 FPPC meeting, the following service area deep dives have taken place:

- Secure and Offender Health deep dive on 20th October 2023.
- Specialties deep dive on 2nd November 2023

2. Secure and Offender health Deep dive – 20th October 2023

The Associate Director (AD) for Secure and Offender Health Care services focused the discussion on HR and staffing issues.

- HR KPIs:

- Sickness levels have been on a reducing trend and the current level is mainly driven by Long Term Sickness (LTS). HR clinics are being arranged to support managers to help address the issues and take the cases forward.
- High use of bank and agency due to the level of observations, which are attracting extra packages of care. It was noted that there are high levels of qualified nurse vacancies, but progress in recruitment is being made and new staff in the process of joining. The safer staffing review has also recommended an increase in the numbers of HCA's and costings for this have now been completed and will be submitted for consideration.
  It was noted that resignations received due to work-life balance will be reviewed by HR and managers to further understand and learn from these.

- Appraisal rates have been on a gradually improving trend and are currently being maintained at 82%. However, it was noted that the move to ESR for appraisal and regular management supervision has placed a burden on staff and it was highlighted that this remains an area of impact to manage with managers. The Executive Director of Finance confirmed that a Workforce Systems & Processes Group is to be established to manage future process changes and operational/clinical representation will be sought.

3. Specialties Deep Dive – 2nd November 2023

The Associate Director (AD) for Specialties and the Clinical Director (CD) for Specialties

(Dementia and Frailty) focused the discussion on the demand and capacity challenges being faced by Older Adult CMHTs. The presentation shared by the service leads is attached as appendix IIb.

Demand

They outlined that following COVID referrals have shown an increasing trend and caseloads have started to increase in the last 6 months. An ongoing pressure on caseload relates to holding onto those service users being prescribed anti dementia medication due to the inability to discharge these service users as GPs are unwilling to take over the prescribing responsibilities. It was recognised that discussion on this issue continue to be taken forward with the Head Pharmacist and primary care leads but to date has been difficult to progress.

The review periods for anti dementia prescribing have been moved from 6 months to 12 months following a review to allow increased capacity for appointments.

The other group of patients who could be discharged are those with a stable serious Mental Illness (SMI) but there is either no appropriate alternative service to discharge them to or the GP will not take on the long term prescribing requirements, with many of these service users being in care homes.

It was highlighted that Birmingham seems to be an outlier in both the above approaches. It was recognised that discussion on these issues are continuing to be taken forward by the Head Pharmacist and primary care leads but to date has been difficult to progress.

It was noted that a review of the service users experiencing long waits has identified that the majority of these patients are in care homes and who have started treatment but as the clinical contact has been with care home staff only, these remain on the waiting list as this currently requires a direct contact with the service user. This deep dive provided assurance that the majority of service users needs have been reviewed. Of those waiting 52+ weeks, 64 of 84 service users in care homes and 22 in their own home are receiving treatment and also have the support of carers/family.

It was noted that there had been good progress on maintain annual CPA reviews with the number of exceptions reducing.

Capacity

Staffing has been an ongoing challenge over the last year particularly in Solihull Older Adult CMHT but this is beginning to ease with 8 new starters and 2 people awaiting start dates to join the service.

To address some of the demand and capacity issues the following actions are being taken:

Recruitment

- New Roles – multi-disciplinary based
- ANP Role to be fully utilised in all hubs.
- ACP Role to be explored as a clinical developmental opportunity, career progression and of value to Service users.

- MHWB workers in post and more to train
- Workforce transformation lead (help with skill mixing, recruitment, retention, new roles)
- Health inequalities – older people under-represented in the workforce.

Retention

- Manageable jobs
    - Continue caseload deep dives within MDT to understand the issues to develop mitigation actions with the teams.
    - Explore more consistent models of capacity and demand in CMHTs looking at impact of new roles.
- Workforce skill mix
- Leadership development
    - Team Managers – many are new to these posts.

Staff Engagement

- Work on Pathways – improved Clarity re Clinical Offer and Team Purpose
- Work on capacity and demand so manageable workload.

Support Required from:

- Workforce transformation lead
- ACP Lead
- Business plan support – for new roles
- People team

Birmingham and Solihull Mental Health NHS Foundation Trust

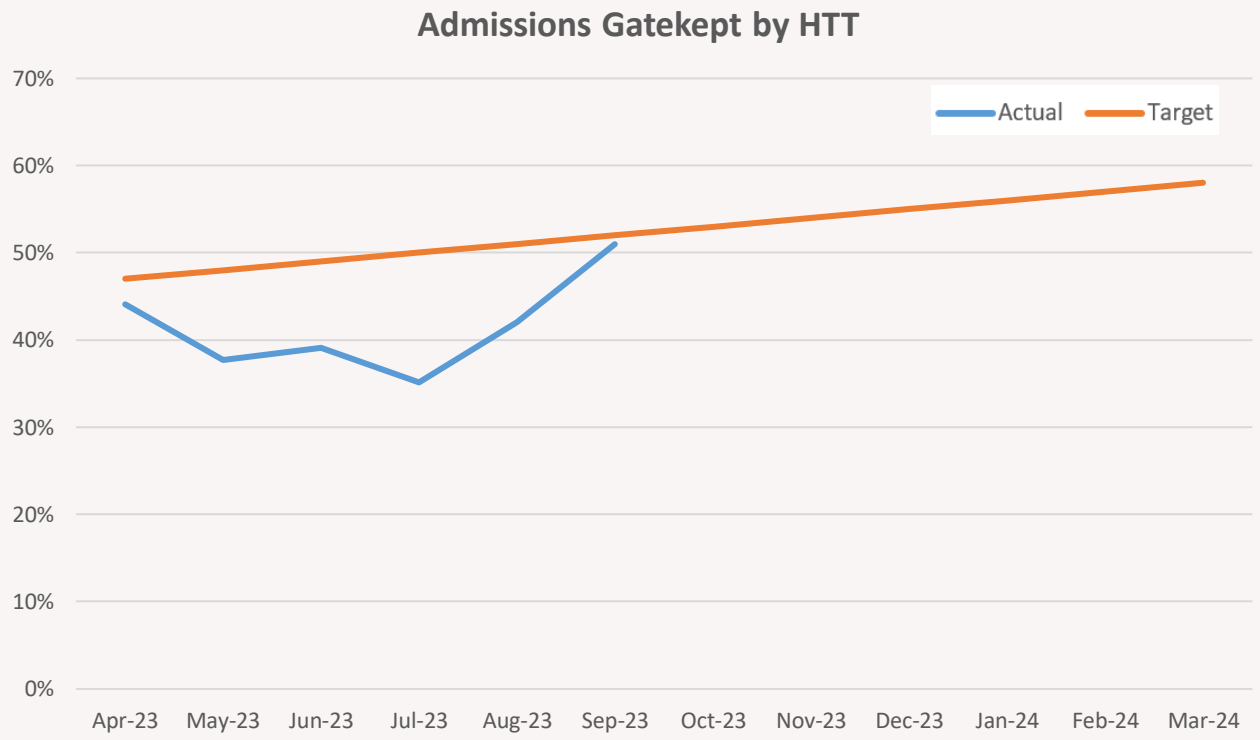
OOA Productivity Plan
PDG Nov 2023

Updates on 4 key areas outlined in the OOA Productivity Plan

Demand Management & Gatekeeping

Develop a roadmap to regain a managed referral process for inpatient beds across gatekeeping teams that is both consistent and appropriate for the service user, in-hours and out-of-hours.

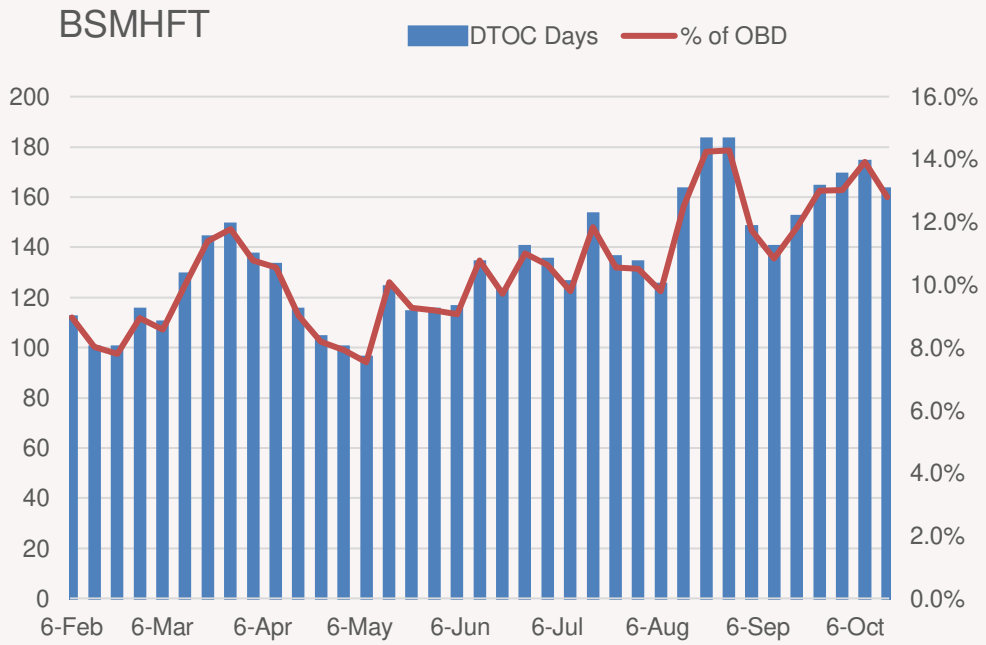
- Continued engagement with colleagues in Acute Trust to ensure flow of patients from A&E.
  - Twice daily Silver system calls, with options to increase
  - Verbal recognition received from ICB about positive changes in mental health patient flow from A&E
- Meetings with WMAS and WMP to enable direct access to PDU, preventing A&E attendance.
- In hours Gatekeeping process awaiting final sign off and communication to wider workforce.
- Out of hours Gatekeeping process in first draft – engagement & consultation to start w/c 06.11.23
- Increase in proportion of admissions gatekept by. HTT from 35% (July '23) to 51% (Sept '23). Associated with work from East as an early adopter of Locality Model & Gatekeeping.



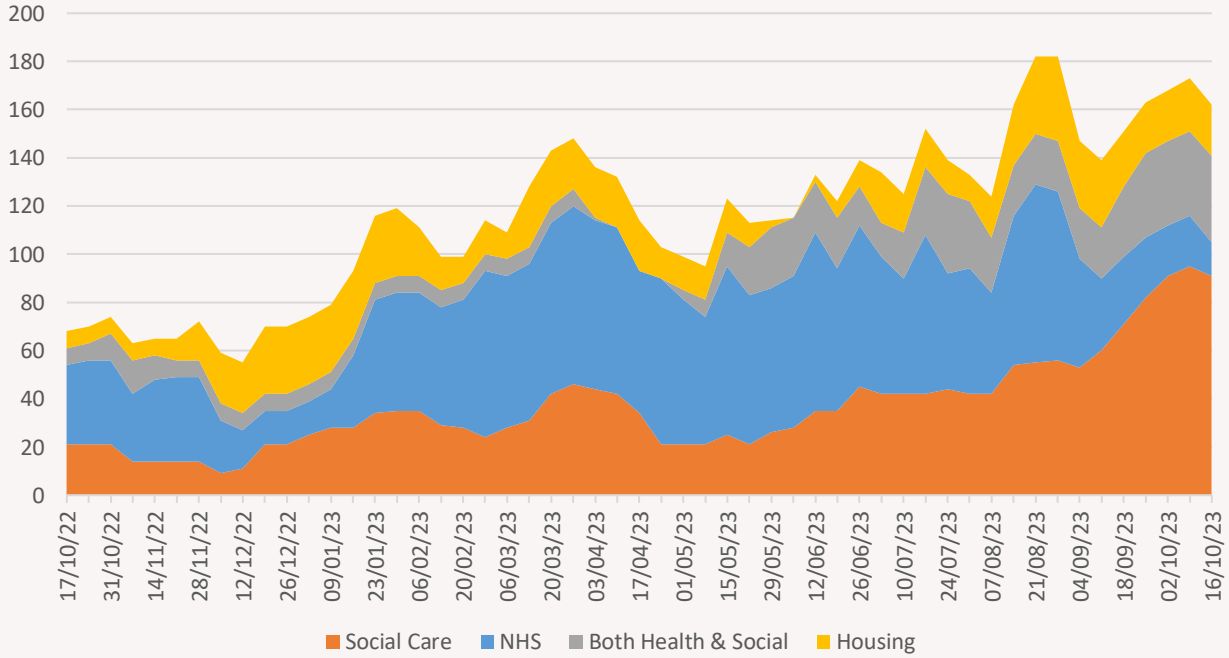
Reducing LOS & DTOCS

Reducing DTOCs and LOS for wards which is currently identified as being higher than average in benchmarking.

- 'Reducing LOS & DTOCs' Task & Finish Group to commence & to be chaired by Rob Devlin. Meeting to outline agenda, stakeholders & TOR on 02.11.23
- Fabida organising Clinical Oversight Group which will challenge LOS and conduct deep dives into DTOCs



Marked reduction in number of DTOC bed days attributed to NHS since Sept '23. Corresponding increase in number of DTOC bed days attributed to social care.



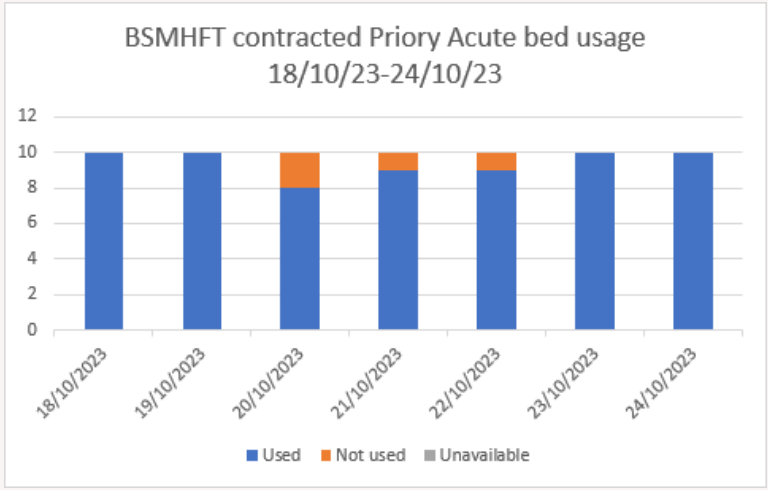
Optimising Capacity

Optimising capacity to reduce OOA placements. Includes reviewing crisis services and block contracts.

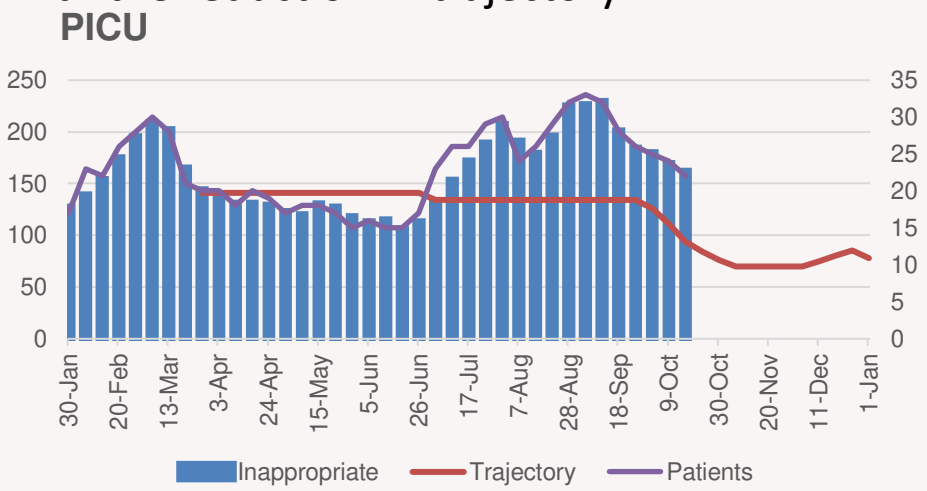
Reduction in inappropriate OOA Bed Days:

	02/10/23	16/10/23
Inappropriate OOA Bed Days (Acute & PICU)	224	201
Inappropriate OOA Bed Days (Acute)	46	41
Inappropriate OOA Bed Days (PICU)	178	160

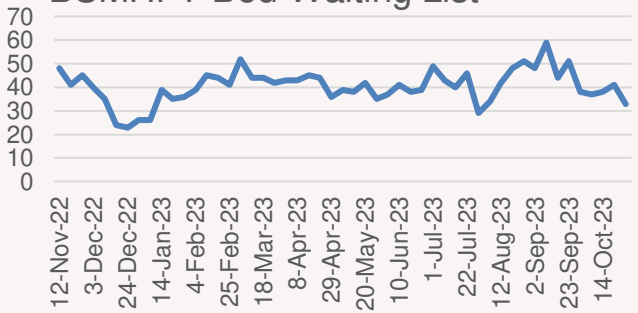
Utilisation of contracted Priory beds:

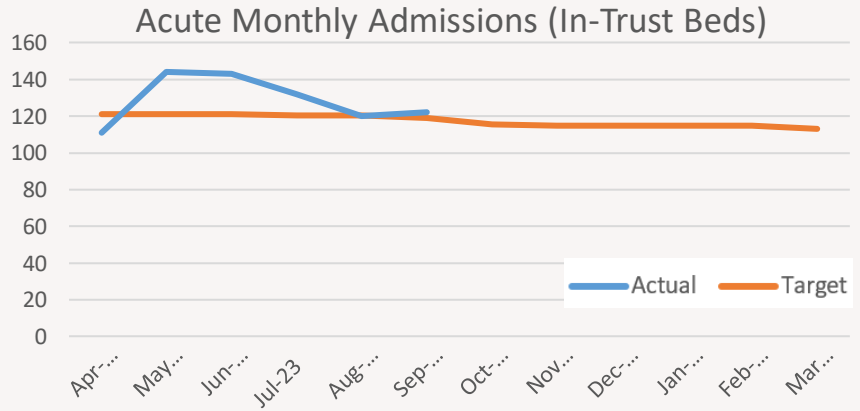


OOA PICU bed usage is on a downward trend in line with the reduction in trajectory.



Reduction in admissions/month, in line with trajectory:



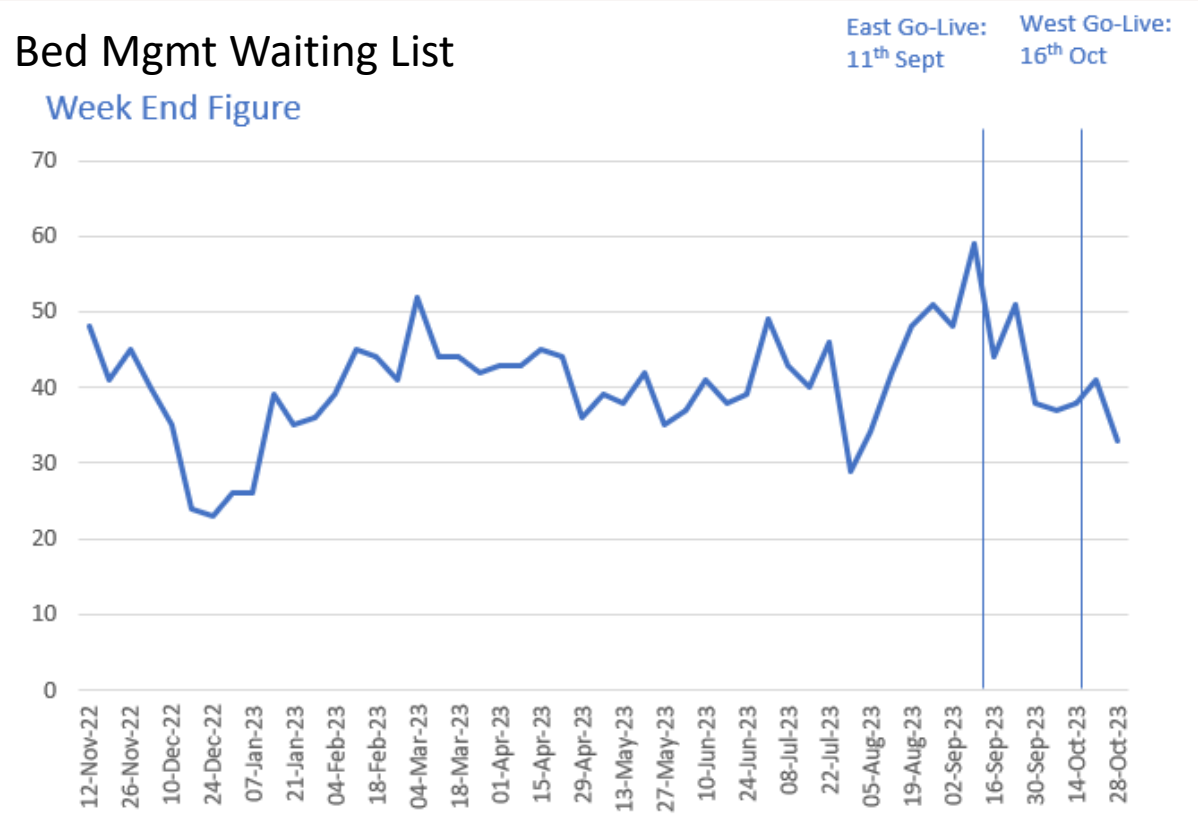


Locality Model

Birmingham and Solihull Mental Health NHS Foundation Trust

Improving the current processes and procedures to ensure the locality model helps support reduction of out of area.

- Principles of Locality model & associated bed management function outlined.
- Rolled out in East on 11.09.23
- Rolled out in West & AOT on 16.10.23.
- Roll out for North & South mid-November. Further engagement with these localities organised for w/c 06.11.23



Since East roll out:

- Bed waiting list: from >10 to 0
- OAA – >10 pts in acute to 3pts
- 37 patients gatekept
- 20 admissions to locality beds
- 14 admissions avoided
- 0 out of area acute admissions
- Step down plans for OOA PICU and appropriate acute OOA

Further updates

- To confirm metrics being used for each T&F Group in meeting on 02.11.23. Engagement has been sort from operational and clinical colleagues to ensure metrics are supporting the narrative.
- Meeting held 01.11.23 to look at reporting template from T&F Groups to OOA Steering group and then other forums (incl. PDG). Subsequent meeting arranged 06.11.23 to develop reporting template for sign off via OOA Steering Group.
- Meeting arranged 06.11.23 with Tim Hamilton to ensure appropriate Comms support to manage change. Information Briefing session for all staff provisionally booked 16.01.24.

Birmingham and Solihull Mental Health NHS Foundation Trust

Secure Care and Offender Health

Workforce Deep Dive

October 2023 (August 2023 Data)

Vacancy Rate

Top 5 teams with highest vacancy rate:

Team	Head count	%
436 Inplace Team	1	87.1%
436 Probation Contract Team	3	59.7%
436 Womens Blended Service Team	4	55.6%
436 Forensic HILL Psychology Team	1	54.5%
436 Forensic HILL Occupational Therapy Team	1	50.0%

Locality & Section	Sum of Budget MPE	Sum of Actual MPE	Sum of Variance	Vacancy Rate
436 Secure Services and Offender Health Locality	**1127.74**	**957.40**	**170.34**	**15.1%**
436 FCAMHS Section	119.98	91.51	28.47	23.7%
436 Forensic Outreach Service Section	96.85	69.99	26.86	27.7%
436 Offender Health Section	85.33	68.36	16.97	19.9%
436 Secure Male - Tamarind Section	295.12	270.47	24.65	8.4%
436 Secure Service Male - Reaside & Hillis Lodge Section	316.46	279.61	36.85	11.6%
436 Secure Services Male - Liaison and Diversion Section	28.60	26.03	2.57	9.0%
436 Secure Services Womens Section	185.40	151.44	33.96	18.3%

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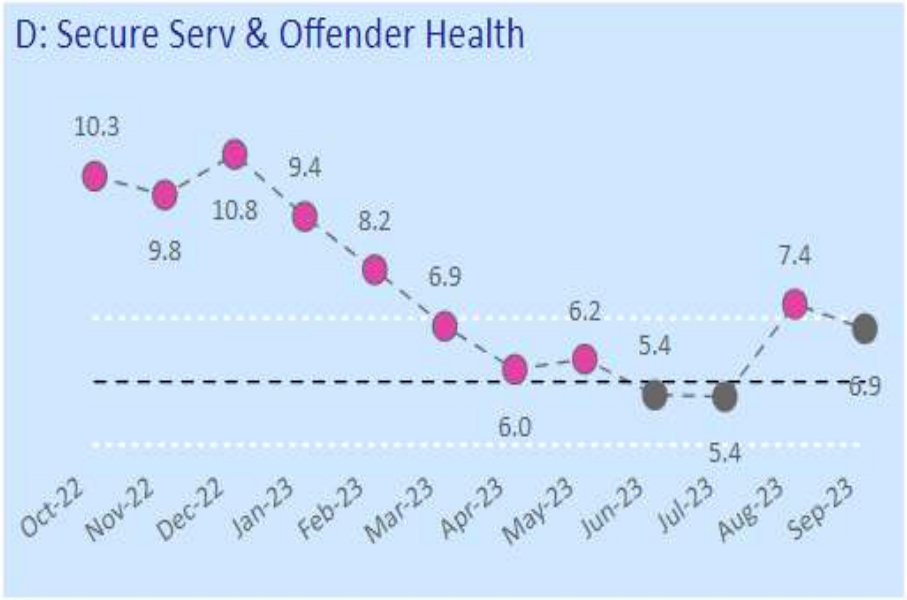
Sickness Absence Rate



Top 5 teams with highest sickness rate:

Team	Head count	%
436 Forensic REAS Swift Team	30	30.75%
436 Forensic ARDN Reception Team	11	28.57%
436 Forensic REAS Kennett Team	26	18.91%
436 Tamarind Occupational Therapy Team	14	16.85%
436 Foston Hall Prison Contract Team	7	15.24%

Locality	Headcount	FTE	FTE Days Available	ST FTE Days Lost	LT FTE Days Lost	Total FTE days Lost	ST Sick %	LT Sick %	Total Sick %
436 Secure Services and Offender Health Locality	**1022**	**953.08**	**29545.53**	**863.58**	**1319.92**	**2183.49**	**2.92%**	**4.47%**	**7.39%**
436 FCAMHS Section	96	91.19	2826.79	68.21	62.00	130.21	2.41%	2.19%	4.61%
436 Forensic Outreach Service Section	72	68.99	2138.59	25.00	62.00	87.00	1.17%	2.90%	4.07%
436 Offender Health Section	73	68.36	2119.08	77.60	92.00	169.60	3.66%	4.34%	8.00%
436 Secure Male - Tamarind Section	282	268.47	8322.71	201.85	213.80	415.65	2.43%	2.57%	4.99%
436 Secure Service Male - Reaside & Hillis Lodge Section	307	278.61	8636.80	360.23	545.64	905.87	4.17%	6.32%	10.49%
436 Secure Services Male - Liaison and Diversion Section	28	26.03	806.83	15.00	31.00	46.00	1.86%	3.84%	5.70%
436 Secure Services Womens Section	164	151.44	4694.75	115.68	313.48	429.15	2.46%	6.68%	9.14%

Bank/Agency Rate

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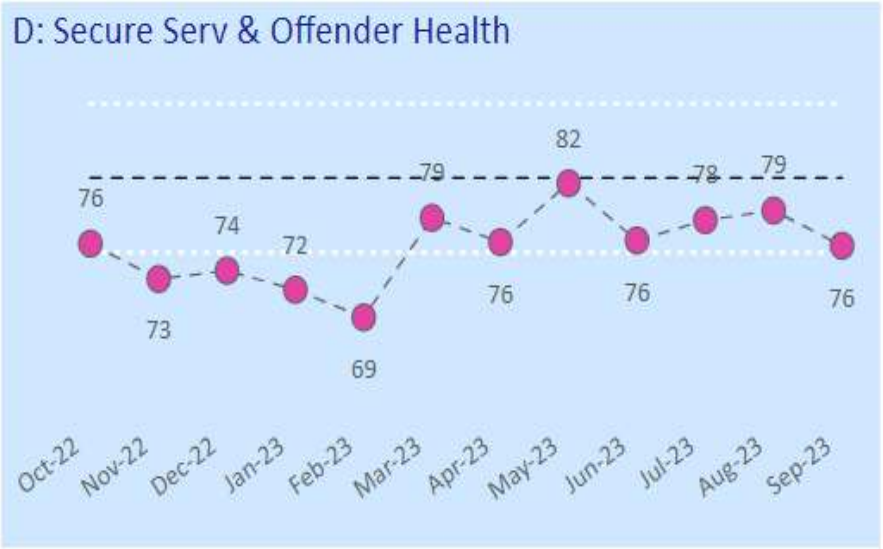


Top 5 teams with highest requested TSS shifts:

Team	Req. shifts	Fill rate
436 FCAMHS Pacific Ward Team	863	79.0%
436 CAMHS Low Secure Team	462	72.3%
436 Forensic ARDN Citrine Ward Team	456	79.8%
436 Tamarind Sycamore Team	401	89.3%
436 Forensic REAS Severn Team	399	70.9%

Locality & Section	Total requested Shifts	Bank Filled	Agency Filled	Total Filled	Bank Filled Rate	Agency Filled Rate	Total Filled Rate
436 Secure Services and Offender Health Locality	**5966**	**4366**	**360**	**4726**	**73.2%**	**6.0%**	**79.2%**
436 FCAMHS Section	1356	881	165	1046	65.0%	12.2%	77.1%
436 Forensic Outreach Service Section	58	12	46	58	20.7%	79.3%	100.0%
436 Offender Health Section	152	79	68	147	52.0%	44.7%	96.7%
436 Secure Male - Tamarind Section	1334	1147	0	1147	86.0%	0.0%	86.0%
436 Secure Service Male - Reaside & Hillis Lodge Section	1981	1484	2	1486	74.9%	0.1%	75.0%
436 Secure Services Male - Liaison and Diversion Section	28	28	0	28	100.0%	0.0%	100.0%
436 Secure Services Womens Section	1057	735	79	814	69.5%	7.5%	77.0%

Turnover/Leavers Rate

Top 5 teams with highest turnover:

Team	Head count	%
436 Inplace Team	1	100.0%
436 Foston Hall Prison Contract Team	7	71.4%
436 Forensic ARDN Psychology Team	3	33.3%
436 SCC Prison Community Service Team	12	33.3%
436 IIRMS Project Team	9	33.3%*

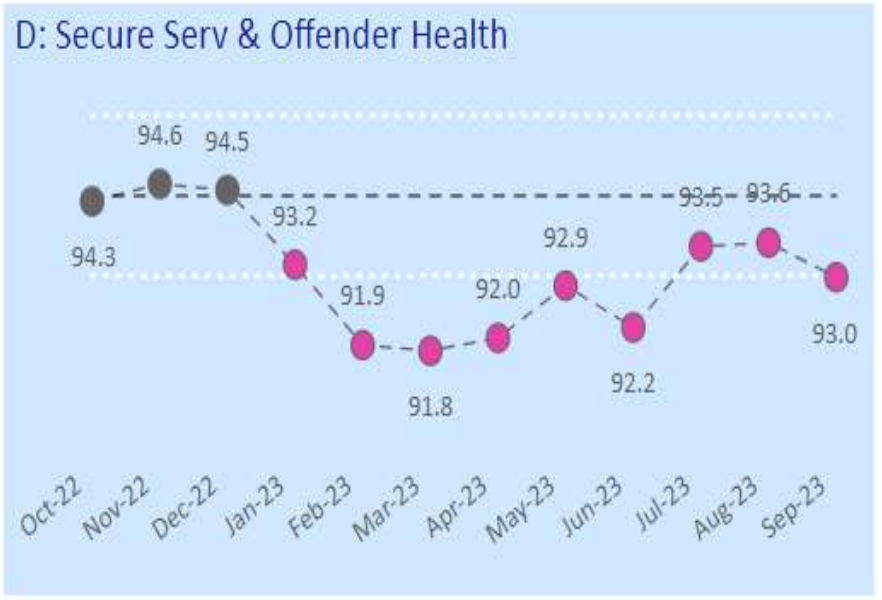
*436 Forensic ARDN W Nurse Management Team also at 33.3%

Top 5 reasons for leaving in rolling 12 months:

Reason	Qty
Voluntary Resignation - Other/Not Known	26
Voluntary Resignation - Relocation	15
Voluntary Resignation - To undertake further education or training	13
Voluntary Resignation - Work Life Balance	9
Retirement Age	8

Locality & Section	Headcount	FTE	Leavers	Turnover %	In Month Leavers
436 Secure Services and Offender Health Locality	**1022**	**953.08**	**88**	**8.61%**	**2**
436 FCAMHS Section	96	91.19	6	6.25%	0
436 Forensic Outreach Service Section	72	68.99	8	11.11%	0
436 Offender Health Section	73	68.36	9	12.33%	0
436 Secure Male - Tamarind Section	282	268.47	9	3.19%	1
436 Secure Service Male - Reaside & Hillis Lodge Section	307	278.61	30	9.77%	0
436 Secure Services Male - Liaison and Diversion Section	28	26.03	4	14.29%	0
436 Secure Services Womens Section	164	151.44	22	13.41%	1

Fundamental Training Rate



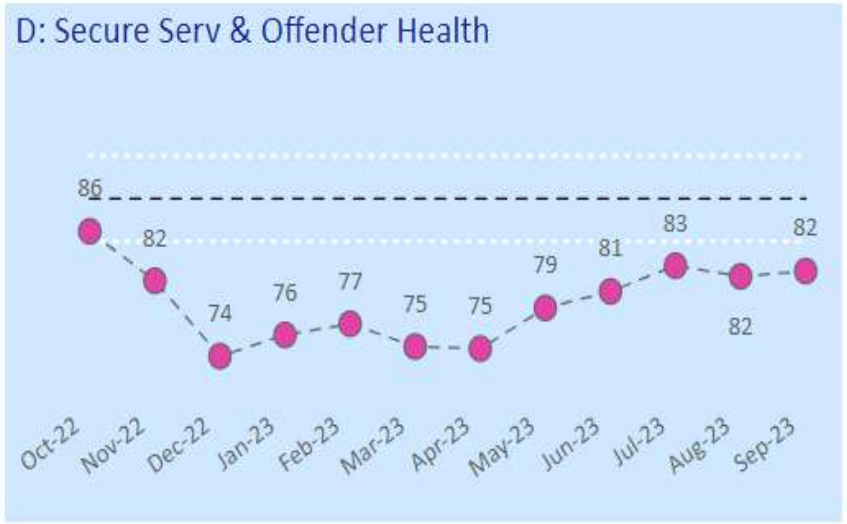
Top 5 teams with lowest FT rate:

Team	Head count	%
436 Tamarind Senior Medics Team	6	50.0%
436 Forensic REAS Junior Medics Other Team	4	61.8%
436 Forensic Womens Junior Medics Team	2	67.9%
436 Forensic ARDN Senior Medics Team	5	71.3%
436 Forensic REAS Senior Medics Team	8	72.4%

Row Labels	APPROACHING EXPIRY	APPROACHING EXPIRY BUT BOOKED (After Expiry)	APPROACHING EXPIRY BUT BOOKED (Before Expiry)	CURRENT	CURRENT AND BOOKED (Before Expiry)	Grace period	Grace period and booked)	NOT COMPLETED	BOOKED	EXPIRED	EXPIRED BUT BOOKED	Grand Total	
Secure Services and Offender Health Locality	**904**	**15**	**51**	**16087**	**383**	**16**	**1**	**529**	**95**	**667**	**79**	**18827**	**92.7%**
FCAMHS Section	94	1	7	1460	36	1	1	39	8	56	10	1713	93.4%
Forensic Outreach Service Section	80		2	1008	1			44	5	69	4	1213	89.9%
Offender Health Section	73	1	2	1068	3			42	3	19	5	1216	94.3%
Secure Male - Tamarind Section	199	4	14	4710	149	6		138	33	148	22	5423	93.7%
Secure Service Male - Reaside & Hillis Lodge Section	280	6	16	4935	144	4		158	24	254	26	5847	92.1%
Secure Services Male - Liaison and Diversion Section	30		2	417		1		13	2	12	3	480	93.8%
Secure Services Womens Section	148	3	8	2489	50	4		95	20	109	9	2935	92.1%

Appraisal Rate

Birmingham and Solihull Mental Health NHS Foundation Trust



Top 5 teams with lowest appraisal rate:

Team	Head count	%
436 FCAMHS Management Team	3	0.0%
436 Forensic REAS Admin & Central Team	13	45.5%
436 Forensic ARDN Senior Medics Team	5	50.0%
436 Forensic ARDN W Occupational Therapy Team	10	50.0%
436 Tamarind Psychology Team	15	50.0%*
*436 Forensic ARDN Management Team also at 50.0%		

Row Labels	APPROACHING EXPIRY	APPROACHING EXPIRY BUT BOOKED (Before Expiry)	CURRENT	Grace period	NOT COMPLETED	EXPIRED	Grand Total	Compliency%
Secure Services and Offender Health Locality	**117**		**535**	**4**	**12**	**127**	**795**	**82.5%**
FCAMHS Section	7		57		1	6	71	90.1%
Forensic Outreach Service Section	13		33	1		9	56	83.9%
Offender Health Section	10		43			4	57	93.0%
Secure Male - Tamarind Section	34		170	2	4	21	231	89.2%
Secure Service Male - Reaside & Hillis Lodge Section	31		144		5	63	243	72.0%
Secure Services Male - Liaison and Diversion Section	2		15			3	20	85.0%
Secure Services Womens Section	20		73	1	2	21	117	80.3%

Locality	Team	H/C	FTE	Budget WTE	Sick %	ST Sick %	LT Sick %	RTWC	Bank Fill Rate %	Agency Fill Rate %	Total Bank & Agency Fill Rate %	Turnover %	Vacancy %	Appraisals %	FT %
SCC & OH	**436 Secure Services and Offender Health Locality**	**1022**	**953.08**	**1127.74**	**7.39%**	**2.92%**	**4.47%**	**78.2%**	**73.2%**	**6.0%**	**79.2%**	**8.6%**	**15.1%**	**82.5%**	**92.7%**
SCC & OH	436 CAMHS Low Secure Team	25	23.90	32.20	10.93%	2.56%	8.37%	85.7%	68.2%	4.1%	72.3%	4.0%	25.8%	100.0%	96.1%
SCC & OH	436 FCAMHS Management Team	3	3.00	1.95	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-53.8%	0.0%	96.8%
SCC & OH	436 FCAMHS Pacific Ward Team	43	40.30	56.23	3.62%	3.62%	0.00%	50.0%	64.7%	14.4%	79.0%	4.7%	28.3%	91.2%	95.2%
SCC & OH	436 FIRST St Andrews Team	10	10.00	12.50	0.00%	0.00%	0.00%	-	-	-	-	0.0%	20.0%	75.0%	79.8%
SCC & OH	436 Forensic ARDN C Admin & Central Team	2	2.00	2.00	0.00%	0.00%	0.00%	-	0.0%	95.7%	95.7%	0.0%	0.0%	100.0%	100.0%
SCC & OH	436 Forensic ARDN CAMHS Youthfirst Team	1	1.00	1.00	-	-	-	-	-	-	-	0.0%	0.0%	-	91.7%
SCC & OH	436 Forensic ARDN Citrine Ward Team	27	24.05	31.65	11.67%	7.51%	4.16%	83.3%	72.1%	7.7%	79.8%	3.7%	24.0%	84.2%	90.5%
SCC & OH	436 Forensic ARDN Coral Ward Team	26	24.67	32.14	10.60%	0.65%	9.95%	33.3%	56.3%	13.5%	69.7%	11.5%	23.3%	81.0%	97.6%
SCC & OH	436 Forensic ARDN Management Team	4	4.00	1.33	0.00%	0.00%	0.00%	-	100.0%	0.0%	100.0%	0.0%	-200.8%	50.0%	73.1%
SCC & OH	436 Forensic ARDN Occupational Therapy Team	5	4.84	6.00	0.67%	0.67%	0.00%	0.0%	100.0%	0.0%	100.0%	20.0%	19.3%	80.0%	96.7%
SCC & OH	436 Forensic ARDN Psychology Team	3	2.55	3.60	-	-	-	-	-	-	-	33.3%	29.3%	100.0%	94.3%
SCC & OH	436 Forensic ARDN Reception Team	11	10.50	12.00	28.57%	0.00%	28.57%	-	96.2%	0.0%	96.2%	18.2%	12.5%	75.0%	97.2%
SCC & OH	436 Forensic ARDN Risk Management	3	3.00	4.00	0.00%	0.00%	0.00%	-	100.0%	0.0%	100.0%	0.0%	25.0%	100.0%	97.2%
SCC & OH	436 Forensic ARDN Senior Medics Team	5	4.70	4.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-17.5%	50.0%	71.3%
SCC & OH	436 Forensic ARDN Tourmaline Ward Team	25	21.19	26.91	14.42%	4.61%	9.81%	100.0%	73.8%	0.0%	73.8%	8.0%	21.3%	66.7%	88.2%
SCC & OH	436 Forensic ARDN W Admin & Central Team	6	5.23	7.25	0.00%	0.00%	0.00%	-	-	-	-	16.7%	27.8%	75.0%	97.9%
SCC & OH	436 Forensic ARDN W Nurse Management Team	3	2.80	3.00	0.00%	0.00%	0.00%	-	-	-	-	33.3%	6.7%	100.0%	100.0%
SCC & OH	436 Forensic ARDN W Occupational Therapy Team	10	9.80	8.33	0.00%	0.00%	0.00%	-	100.0%	0.0%	100.0%	0.0%	-17.6%	50.0%	91.8%
SCC & OH	436 Forensic ARDN W Psychology Team	14	13.21	7.40	4.15%	4.15%	0.00%	100.0%	-	-	-	14.3%	-78.5%	100.0%	90.8%
SCC & OH	436 Forensic ARDN W Senior Medics Team	3	2.90	2.80	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-3.6%	-	89.4%
SCC & OH	436 Forensic CAMHS Community Team	9	8.90	13.00	0.36%	0.36%	0.00%	0.0%	-	-	-	11.1%	29.1%	100.0%	85.9%
SCC & OH	436 Forensic HILL Nursing Centres Team	28	23.77	26.45	2.34%	0.54%	1.79%	100.0%	96.0%	0.0%	96.0%	7.1%	10.1%	59.3%	94.8%
SCC & OH	436 Forensic HILL Occupational Therapy Team	1	1.00	2.00	-	-	-	-	-	-	-	0.0%	50.0%	-	-
SCC & OH	436 Forensic HILL Psychology Team	1	1.00	2.20	0.00%	0.00%	0.00%	-	-	-	-	0.0%	54.5%	100.0%	100.0%
SCC & OH	436 Forensic HILL Senior Medics Team	1	1.00	1.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	0.0%	-	90.9%
SCC & OH	436 Forensic REAS Admin & Central Team	13	11.45	14.82	0.00%	0.00%	0.00%	-	100.0%	0.0%	100.0%	30.8%	22.8%	45.5%	93.6%
SCC & OH	436 Forensic REAS Avon Team	27	24.74	31.53	11.92%	3.71%	8.21%	100.0%	76.7%	0.0%	76.7%	0.0%	18.4%	100.0%	89.6%
SCC & OH	436 Forensic REAS Blythe Team	26	23.83	27.65	12.96%	2.17%	10.79%	0.0%	68.6%	0.0%	68.6%	7.7%	13.8%	59.1%	93.3%
SCC & OH	436 Forensic REAS Dove Team	24	21.83	23.16	8.95%	2.95%	6.00%	50.0%	74.1%	0.0%	74.1%	4.2%	5.7%	63.2%	94.8%
SCC & OH	436 Forensic REAS Junior Medics Other Team	4	3.21	3.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-7.1%	-	61.8%
SCC & OH	436 Forensic REAS Kennett Team	26	23.35	22.94	18.91%	6.48%	12.43%	87.5%	75.4%	0.0%	75.4%	11.5%	-1.8%	59.1%	90.1%
SCC & OH	436 Forensic REAS Liaison Diversion Team	28	26.03	28.60	5.70%	1.86%	3.84%	75.0%	100.0%	0.0%	100.0%	14.3%	9.0%	85.0%	93.8%

Locality	Team	H/C	FTE	Budget WTE	Sick %	ST Sick %	LT Sick %	RTWC	Bank Fill Rate %	Agency Fill Rate %	Total Bank & Agency Fill Rate %	Turnover %	Vacancy %	Appraisals %	FT %
SCC & OH	436 Forensic REAS Management Team	11	10.60	11.33	3.04%	3.04%	0.00%	-	100.0%	0.0%	100.0%	9.1%	6.4%	87.5%	73.5%
SCC & OH	436 Forensic REAS Occupational Therapy Team	10	10.00	14.33	1.94%	1.94%	0.00%	100.0%	-	-	-	20.0%	30.2%	83.3%	95.1%
SCC & OH	436 Forensic REAS Pharmacy Team	10	8.70	11.70	8.90%	5.93%	2.97%	100.0%	100.0%	0.0%	100.0%	10.0%	25.6%	100.0%	95.5%
SCC & OH	436 Forensic REAS Psychology Team	16	15.20	12.90	0.42%	0.42%	0.00%	100.0%	-	-	-	31.3%	-17.8%	72.7%	98.5%
SCC & OH	436 Forensic REAS Reception Team	17	15.89	15.00	0.20%	0.20%	0.00%	0.0%	97.8%	0.0%	97.8%	5.9%	-6.0%	73.3%	90.4%
SCC & OH	436 Forensic REAS Senior Medics Team	8	7.80	7.33	10.26%	0.00%	10.26%	-	0.0%	100.0%	100.0%	0.0%	-6.4%	-	72.4%
SCC & OH	436 Forensic REAS Severn Team	32	30.46	43.75	9.64%	6.35%	3.28%	87.5%	70.9%	0.0%	70.9%	9.4%	30.4%	67.9%	92.4%
SCC & OH	436 Forensic REAS Shop Team	1	0.56	0.40	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-40.0%	100.0%	100.0%
SCC & OH	436 Forensic REAS Swift Team	30	27.13	24.17	30.75%	16.04%	14.72%	62.5%	69.2%	0.0%	69.2%	6.7%	-12.2%	83.3%	93.7%
SCC & OH	436 Forensic REAS Trent Team	21	17.07	20.80	10.49%	2.83%	7.66%	100.0%	75.3%	0.0%	75.3%	14.3%	17.9%	78.9%	97.2%
SCC & OH	436 Forensic Womens Junior Medics Team	2	2.00	3.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	33.3%	100.0%	67.9%
SCC & OH	436 Forensics Reachout First Team	62	58.99	57.95	4.76%	1.37%	3.39%	100.0%	11.5%	88.5%	100.0%	12.9%	-3.5%	85.4%	91.7%
SCC & OH	436 Foston Hall Prison Contract Team	7	5.80	8.25	15.24%	1.33%	13.90%	100.0%	-	-	-	71.4%	29.7%	100.0%	87.3%
SCC & OH	436 IIRMS Project Team	9	9.00	8.60	1.79%	1.79%	0.00%	100.0%	-	-	-	33.3%	-4.7%	100.0%	98.6%
SCC & OH	436 Inplace Team	1	1.00	7.76	0.00%	0.00%	0.00%	-	-	-	-	100.0%	87.1%	-	94.1%
SCC & OH	436 Prevent Team	6	6.00	5.40	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-11.1%	83.3%	93.8%
SCC & OH	436 Probation Contract Team	3	2.69	6.68	0.00%	0.00%	0.00%	-	-	-	-	0.0%	59.7%	100.0%	96.2%
SCC & OH	436 SCC Prison Admin Team	10	8.88	9.50	4.00%	4.00%	0.00%	0.0%	100.0%	0.0%	100.0%	30.0%	6.5%	57.1%	87.0%
SCC & OH	436 SCC Prison Community Service Team	12	11.17	11.00	10.97%	2.31%	8.66%	100.0%	37.0%	63.0%	100.0%	33.3%	-1.6%	100.0%	98.0%
SCC & OH	436 SCC Prison IDTS Team	20	19.40	28.20	9.41%	4.26%	5.15%	100.0%	72.6%	21.4%	94.0%	0.0%	31.2%	93.8%	90.7%
SCC & OH	436 SCC Prison Management Team	5	5.00	6.20	0.00%	0.00%	0.00%	-	-	-	-	0.0%	19.4%	100.0%	91.8%
SCC & OH	436 SCC Prison Pharmacy Team	18	16.28	15.60	7.33%	1.19%	6.14%	100.0%	-	-	-	5.6%	-4.4%	100.0%	97.1%
SCC & OH	436 SCC Prison Ward 2 Team	8	7.63	11.10	11.42%	11.42%	0.00%	100.0%	13.2%	86.8%	100.0%	12.5%	31.3%	100.0%	98.8%
SCC & OH	436 Tamarind Acacia Team	26	24.46	25.93	6.68%	2.59%	4.09%	87.5%	80.6%	0.0%	80.6%	3.8%	5.7%	91.7%	97.2%
SCC & OH	436 Tamarind Admin Team	12	11.60	11.75	0.00%	0.00%	0.00%	-	100.0%	0.0%	100.0%	8.3%	1.3%	70.0%	97.2%
SCC & OH	436 Tamarind Cedar Team	26	24.03	25.01	13.99%	3.22%	10.77%	80.0%	82.8%	0.0%	82.8%	11.5%	-0.1%	87.0%	96.0%
SCC & OH	436 Tamarind Hibiscus Team	27	26.25	28.60	4.30%	0.49%	3.81%	100.0%	85.8%	0.0%	85.8%	0.0%	8.2%	91.7%	96.8%
SCC & OH	436 Tamarind Junior Medics Team	7	7.00	3.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-166.7%	-	74.8%
SCC & OH	436 Tamarind Laurel Team	30	28.31	39.60	0.30%	0.00%	0.30%	0.0%	85.7%	0.0%	85.7%	0.0%	28.5%	96.4%	93.4%
SCC & OH	436 Tamarind Lobelia Team	24	22.29	26.93	1.88%	1.88%	0.00%	100.0%	79.9%	0.0%	79.9%	0.0%	17.2%	100.0%	96.6%
SCC & OH	436 Tamarind Management Team	1	1.00	1.87	0.00%	0.00%	0.00%	-	-	-	-	0.0%	46.5%	100.0%	100.0%
SCC & OH	436 Tamarind Myrtle Team	30	28.61	30.58	0.11%	0.11%	0.00%	100.0%	90.6%	0.0%	90.6%	0.0%	6.4%	91.7%	94.6%
SCC & OH	436 Tamarind Nurse Management Team	7	7.00	9.00	0.00%	0.00%	0.00%	-	-	-	-	0.0%	22.2%	83.3%	96.9%

Locality	Team	H/C	FTE	Budget WTE	Sick %	ST Sick %	LT Sick %	RTWC	Bank Fill Rate %	Agency Fill Rate %	Total Bank & Agency Fill Rate %	Turnover %	Vacancy %	Appraisals %	FT %
SCC & OH	436 Tamarind Occupational Therapy Team	14	13.40	15.90	16.85%	9.39%	7.46%	100.0%	-	-	-	21.4%	15.7%	60.0%	95.3%
SCC & OH	436 Tamarind Psychology Team	15	13.71	13.45	0.00%	0.00%	0.00%	-	-	-	-	0.0%	-1.9%	50.0%	91.9%
SCC & OH	436 Tamarind Reception Team	10	9.67	11.00	10.68%	10.68%	0.00%	100.0%	100.0%	0.0%	100.0%	0.0%	12.1%	100.0%	99.2%
SCC & OH	436 Tamarind Risk & Security Team	4	4.00	3.00	-	-	-	-	60.0%	0.0%	60.0%	0.0%	-33.3%	100.0%	100.0%
SCC & OH	436 Tamarind Senior Medics Team	6	6.00	6.50	0.00%	0.00%	0.00%	-	-	-	-	0.0%	7.7%	-	50.0%
SCC & OH	436 Tamarind Sycamore Team	43	41.15	43.00	8.01%	5.03%	2.98%	100.0%	89.3%	0.0%	89.3%	2.3%	4.3%	97.2%	93.7%
SCC & OH	436 Womens Blended Service Team	4	3.60	8.10	-	-	-	-	100.0%	0.0%	100.0%	25.0%	55.6%	100.0%	89.0%

Service Area hot spots

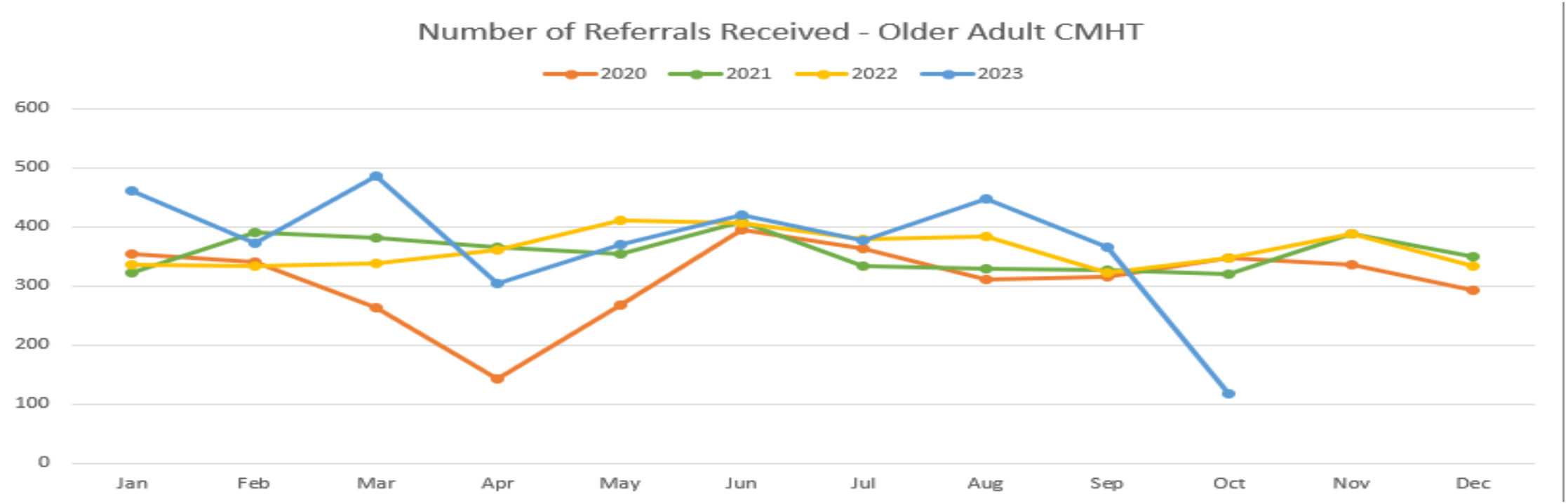
- **Inplace Team** – has appeared under top 5 for: turnover and vacancy
- **Forensic ARDN Senior Medics Team**– has appeared under top 5 for: appraisal and fundamental training
- **Foston Hall Prison Contract Team**– has appeared under top 5 for: sickness and turnover

Dementia and Frailty CMHT Deep Dive

2/11/23

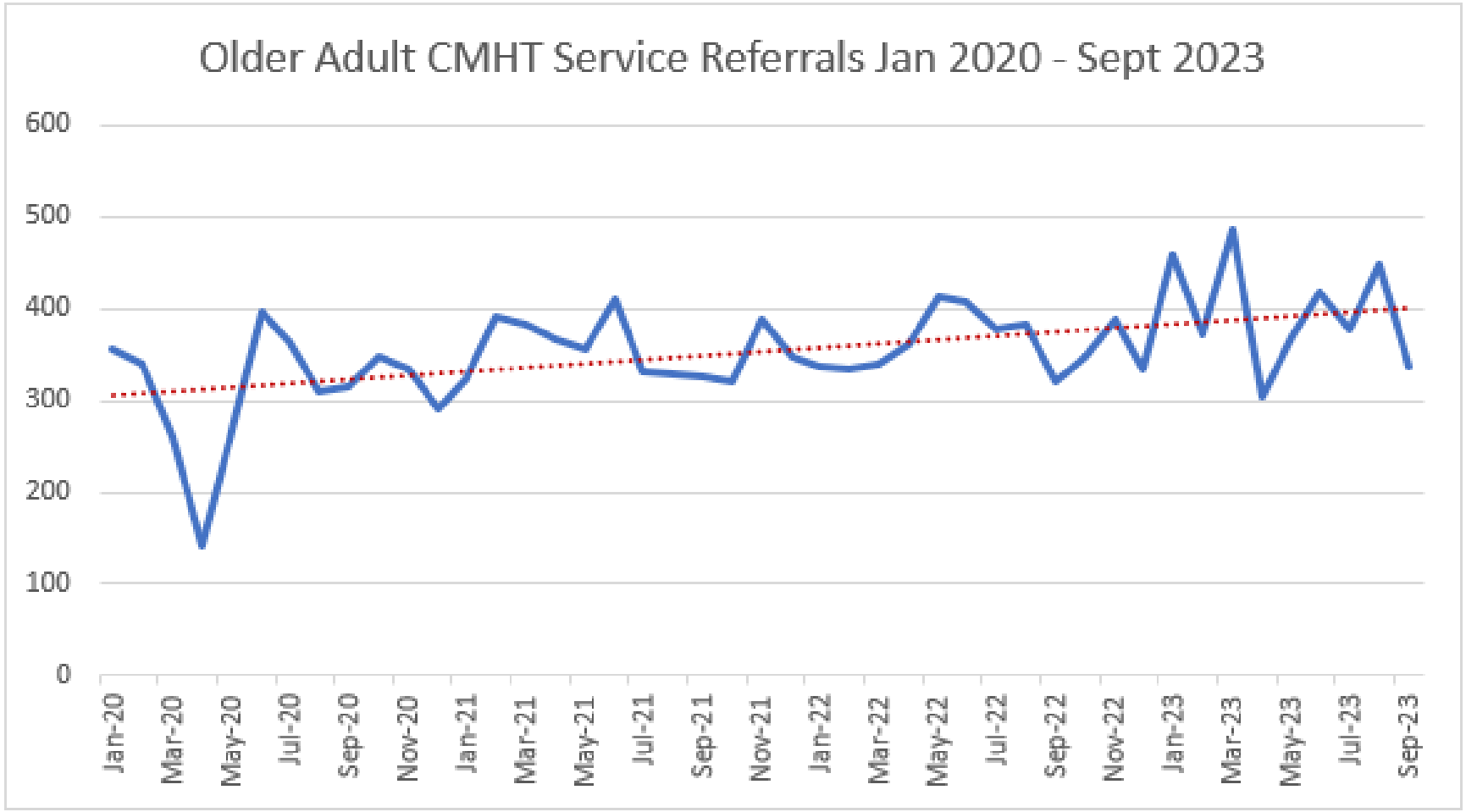
Referrals received 2020-2023

Activity



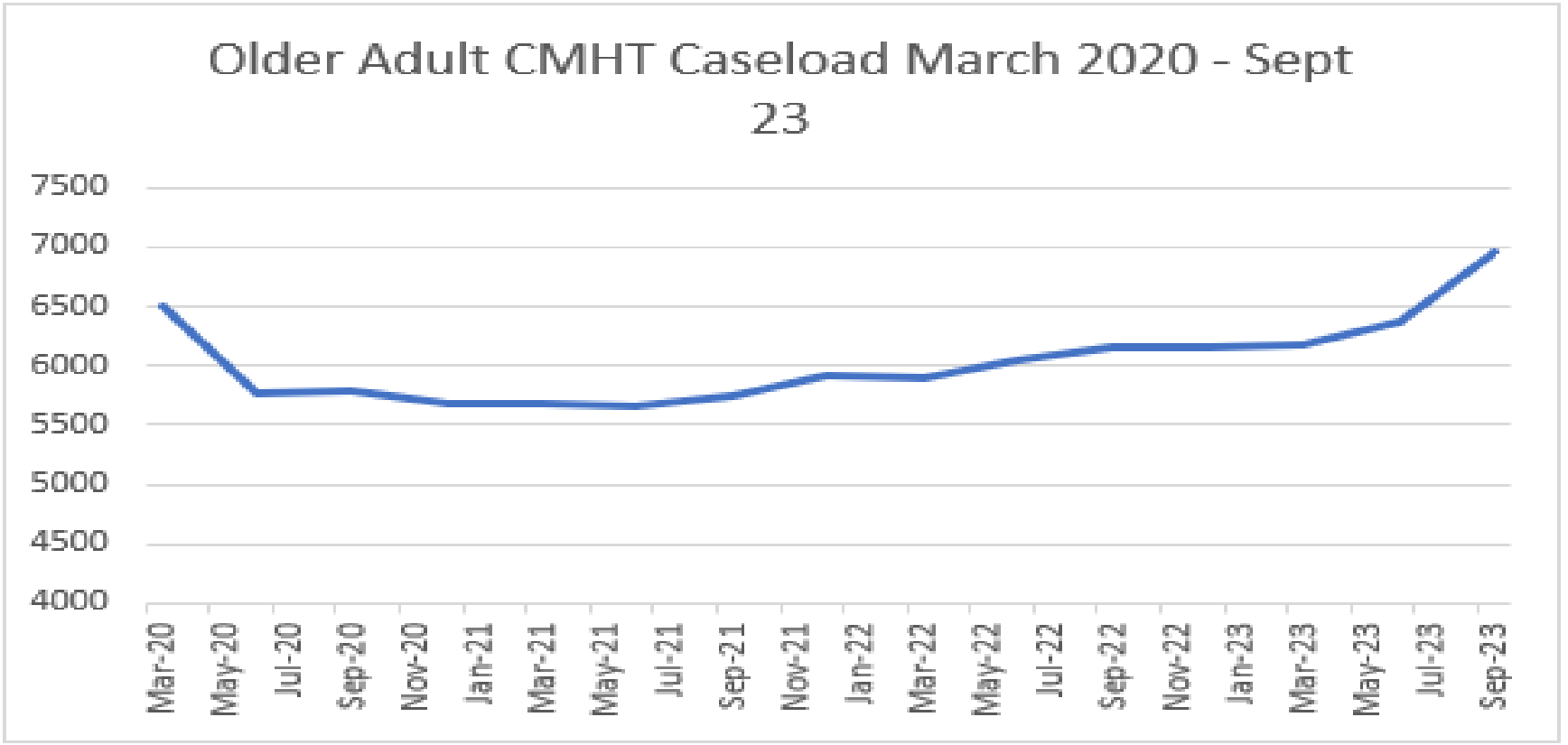
Referral Trend 2020-2023

Demand



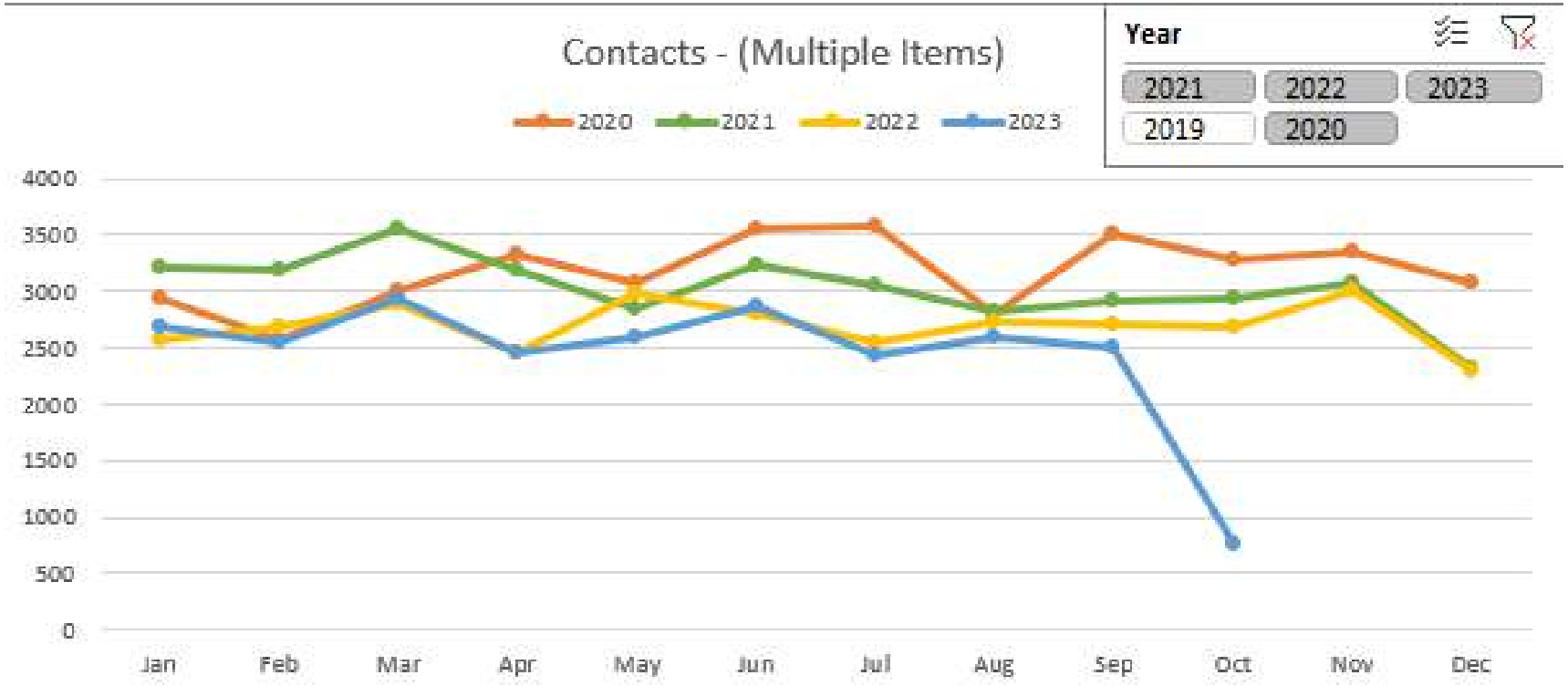
Caseload trend

Demand



Contacts 2020-2023

Demand



Current Older adults CMHT waiting times and referral pattern

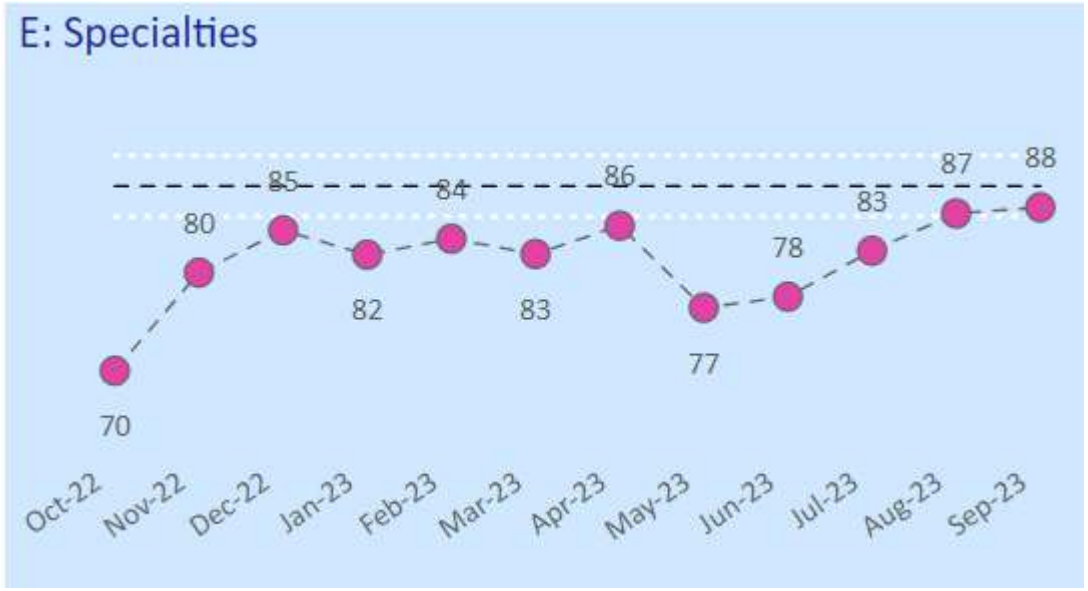
Service	Team	0-1 Wks	1-2 Wks	2-3 Wks	3-6 Wks	6-10 Wks	10-14 Wks	14-18 Wks	18-26 Wks	26-52 Wks	52+ Wks	Total
Older Adult CMHT	**Service Total:**	**65**	**85**	**62**	**148**	**108**	**50**	**57**	**70**	**90**	**84**	**819**
	MHSOP East HUB	14	13	7	25	19	7	8	14	15	15	**137**
	MHSOP North HUB	17	22	25	51	32	13	7	5	10	6	**188**
	MHSOP Solihull HUB	11	19	11	26	31	21	21	33	35	11	**219**
	MHSOP South HUB	12	12	7	13	16	3	9	3	13	21	**109**
	MHSOP West HUB	11	19	12	33	10	6	12	15	17	31	**166**

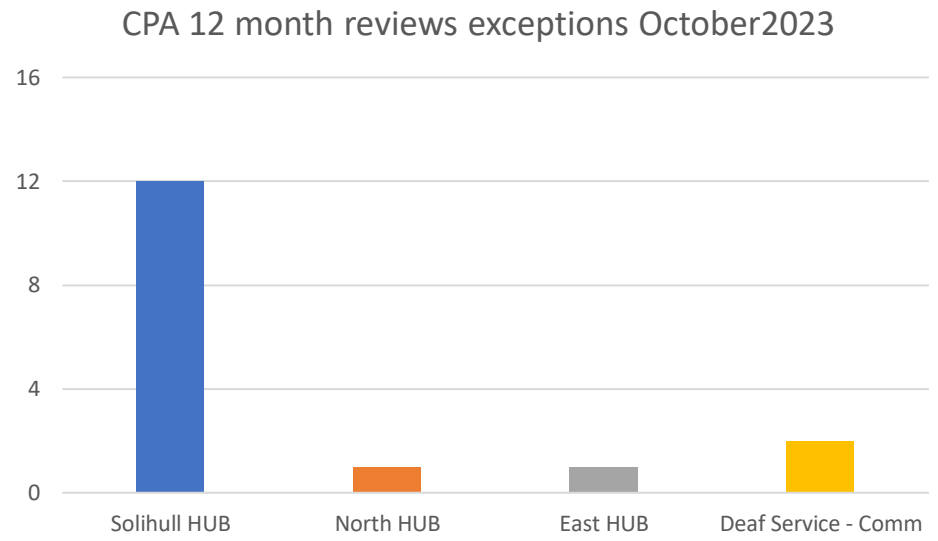
Waiting times Note: A number of older adults have commenced treatment but as the majority are in care homes, contact has been with the staff in the care home due to Covid-19 impact, and as a result, there are a cohort of service users who have not come off the waiting list as the requirement is for the contact to be with the service user rather than a third party.

The number waiting has decreased by 17 in the last 2 months

C29: CPA Reviews in 12 months

Demand





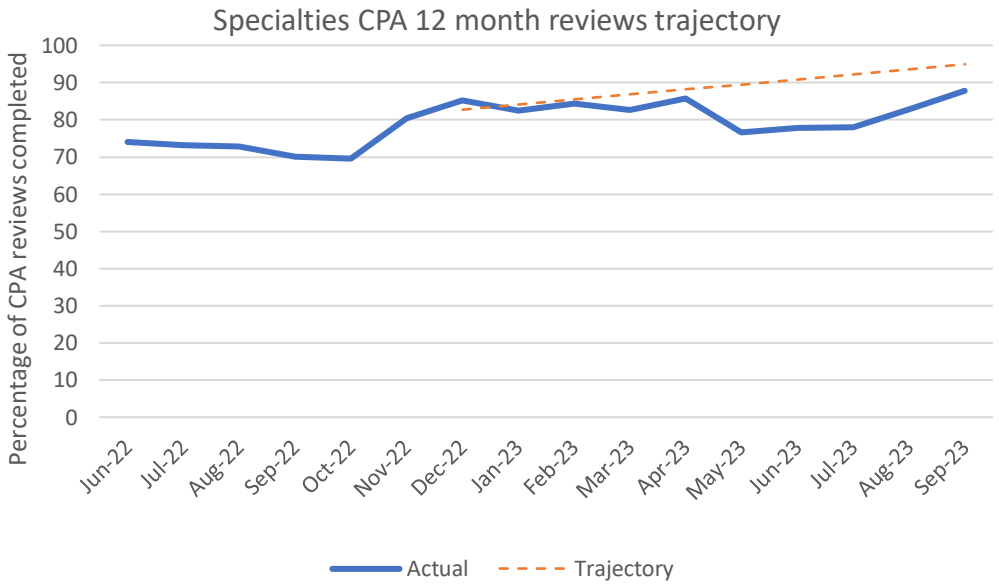
September Performance 87.8% - 18 exceptions

October – 14 exceptions as of 20th October 2023 currently 89.2% - improving performance
12 in Solihull Hub.

compassionate inclusive committed

C29: CPA Reviews in 12 months

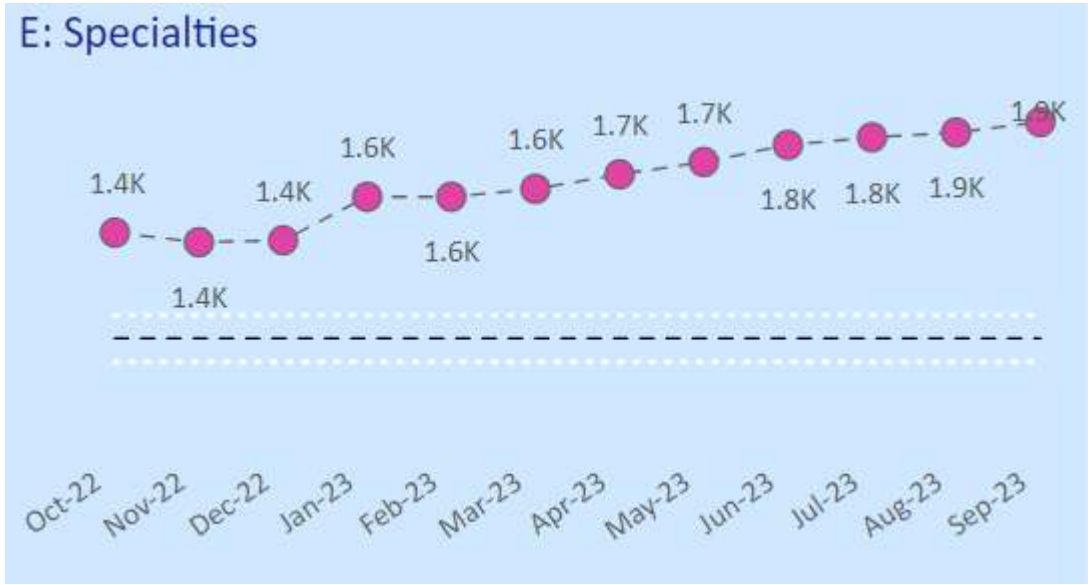
Demand



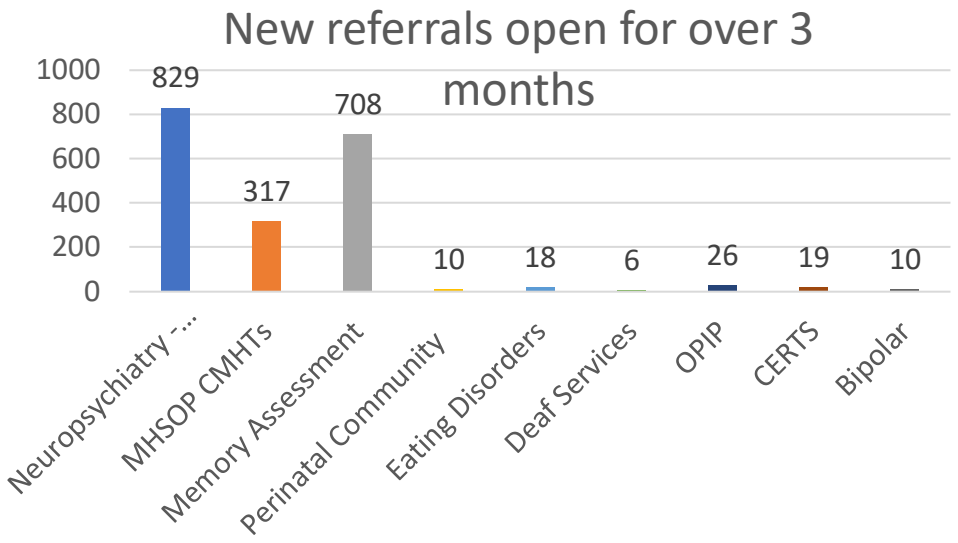
Trajectory and performance submitted to Trust FPPC in September 2023. Currently under trajectory at 87.9%.

COM03: Referrals >3 mths with no contact

Demand



Number of exceptions in October 2023 (1,943)



There were 1,898 exceptions in September 2023.

Appointment data

First Appointments – Medical staff - April 2023 – September 2023

Service / Team / Profession	Planned Appts	Attended	% Attended Planned Appts	Mean Duration Planned Attended (Mins)	DNA	DNA Rate for Planned Appts	Patient Canc	Trust Canc	Unoutcomed
MHSOP CMHT	823	540	66%	55	128	19%	86	59	10
MHSOP East HUB	222	148	67%	51	44	23%	22	5	3
MHSOP North HUB	75	46	61%	49	15	25%	9	5	0
MHSOP Solihull HUB	241	178	74%	58	37	17%	15	9	2
MHSOP South HUB	194	112	58%	62	21	16%	27	34	0
MHSOP West HUB	91	56	62%	47	11	16%	13	6	5

First Appointment – Nursing staff - April 2023 – September 2023

Service / Team / Profession	Planned Appts	Attended	% Attended Planned Appts	Mean Duration Planned Attended (Mins)	DNA	DNA Rate for Planned Appts	Patient Canc	Trust Canc	Unoutcomed
MHSOP CMHT	1102	780	71%	70	183	19%	75	41	23
MHSOP East HUB	88	67	76%	51	14	17%	4	2	1
MHSOP North HUB	473	325	69%	56	79	20%	49	20	0
MHSOP Solihull HUB	154	109	71%	74	17	13%	2	4	22
MHSOP Solihull HUB Nurse Led Review	2	1	50%	30	0	0%	1	0	0
MHSOP South HUB	136	92	68%	73	30	25%	9	5	0
MHSOP West HUB	249	186	75%	98	43	19%	10	10	0

CMHT Workforce

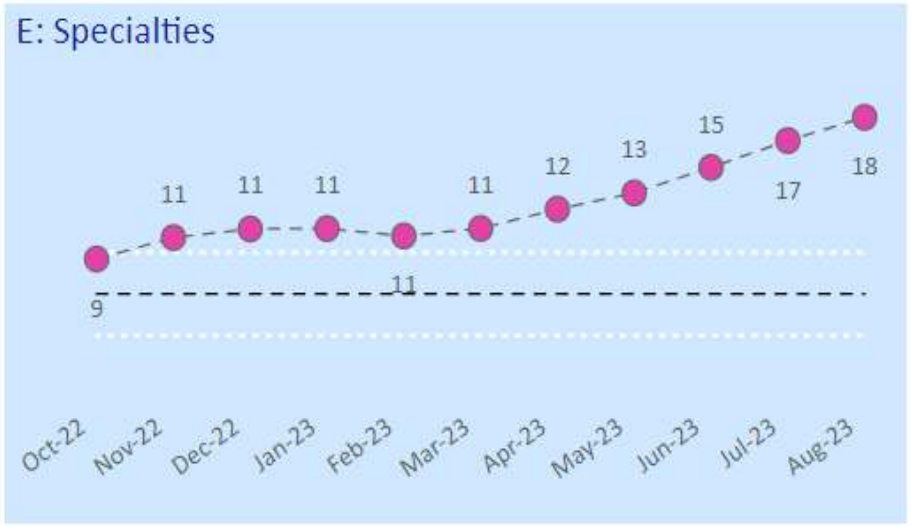
Capacity

Workforce data of concern

- Vacancy
- Sickness
- Retention

Vacancy Rate

Capacity



Top 5 teams with highest vacancy rate:

Team	Head count	%
436 M&B Solihull Team	8	72.5%
436 Barberry Chamomile M&B Community Team	3	64.5%
436 OA People Psychology Team	3	63.9%
436 Healthy Minds Central Birmingham Team	21	55.4%
436 Healthy Minds South Birmingham Team	24	54.2%

Locality & Area	Sum of Budget MPE	Sum of Actual MPE	Sum of Variance	Vacancy Rate
436 PCDS Locality	**895.54**	**719.92**	**175.62**	**19.6%**
436 Birmingham Healthy Minds Area	204.05	113.00	91.05	44.6%
436 Meriden Area	9.59	8.04	1.55	16.2%
436 Older People Area	365.68	324.69	40.99	11.2%
436 Other Primary Care & Dementia Service Area	14.20	9.20	5.00	35.2%
436 PCDS Psychotherapy Area	9.68	8.80	0.88	9.1%
436 Specialties Area	272.74	238.51	34.23	12.6%
436 Veterans Service Area	19.60	17.69	1.91	9.7%

Turnover/Leavers Rate

Capacity

Top 5 teams with highest turnover:		
Team	Head count	%
436 OA People Psychology Team	3	66.7%
436 OA Solihull HUB Team	14	42.9%
436 Veterans HIS Service Team	5	40.0%
436 Barberry CILANTRO EDS Community Team	8	37.5%
436 Spec. Barberry Jasmine Deaf Community Team	6	33.3%*
436 Spec. Barberry Jasmine Deaf Senior Medics Team also at 33.3%		

Top 5 reasons for leaving in rolling 12 months:	
Reason	Qty
Retirement Age	20
Voluntary Resignation - Other/Not Known	18
Voluntary Resignation - Promotion	10
Voluntary Resignation - Relocation	8
Voluntary Resignation - Work Life Balance	8

Locality & Area	Headcount	FTE	Leavers	Turnover %	In Month Leavers
436 PCDS Locality	792	714.81	78	9.85%	6
436 Birmingham Healthy Minds Area	126	112.20	18	14.29%	0
436 Meriden Area	10	8.04	1	10.00%	0
436 Older People Area	357	324.29	33	9.24%	3
436 Other Primary Care & Dementia Service Area	10	9.20	0	0.00%	0
436 PCDS Psychotherapy Area	11	8.40	1	9.09%	0
436 Specialties Area	258	235.60	19	7.36%	3
436 Veterans Service Area	20	17.09	3	15.00%	0

Sickness Absence Rate

Capacity

Top 5 teams with highest sickness rate:

Team	Head count	%
436 Neurology Medics Team	9	25.71%
436 OA Care Home Liaison Team	10	21.54%
436 Barberry CILANTRO EDS Inpatients Team	17	18.94%
436 OA Solihull HUB Team	14	15.81%
436 M&B Solihull Team	8	14.75%

Locality	Headcount	FTE	FTE Days Available	ST FTE Days Lost	LT FTE Days Lost	Total FTE days Lost	ST Sick %	LT Sick %	Total Sick %
436 PCDS Locality	**792**	**714.81**	**22159.23**	**448.31**	**988.48**	**1436.79**	**2.02%**	**4.46%**	**6.48%**
436 Birmingham Healthy Minds Area	126	112.20	3478.08	93.92	114.42	208.34	2.70%	3.29%	5.99%
436 Meriden Area	10	8.04	249.10	0.00	0.00	0.00	0.00%	0.00%	0.00%
436 Older People Area	357	324.29	10053.00	172.99	606.43	779.41	1.72%	6.03%	7.75%
436 Other Primary Care & Dementia Service Area	10	9.20	285.20	0.00	0.00	0.00	0.00%	0.00%	0.00%
436 PCDS Psychotherapy Area	11	8.40	260.40	0.00	0.00	0.00	0.00%	0.00%	0.00%
436 Specialties Area	258	235.60	7303.56	179.40	267.63	447.03	2.46%	3.66%	6.12%
436 Veterans Service Area	20	17.09	529.89	2.00	0.00	2.00	0.38%	0.00%	0.38%

Key D&F CMHT indicators

Capacity

OA CMHTs	H/C	FTE	Budget wte	Sick%	Agency Fill rate%	Turnover %	Vacancy %	Appraisal %	F Training %
South Hub	17	15.1	13.41	0	n/a	15.8	-12.6	86.7	96.1
North Hub	19	15.87	15.47	7.012	n/a	15.8	-2.6	53.3	92.3
Solihull Hub	14	11.41	15.1	15.81	100	42.9	24.4	70	94.9
West Hub	11	10.23	12	7.57	98.2	18.2	14.8	75	94
East Hub	18	14.16	16.1	0.46	n/a	0	12	94.1	98.1
Total	79	66.77	72.08	6.1704	99.1	18.54	7.2	75.82	95.08
West Medics	17	16.7	18.93	11.2	100	5.9	11.8	100	78.7

Work to impact on this

Capacity

Recruitment

- Recruitment Fairs
- **Workforce transformation**
    - Skill mix
    - Role development
    - Advanced practice
    - Specialist doctors

- Retention
- WRES and Staff Survey actions – appraisals
- Reducing sickness and burnout through Engagement and Joy at Work

Plan - Recruitment

Capacity

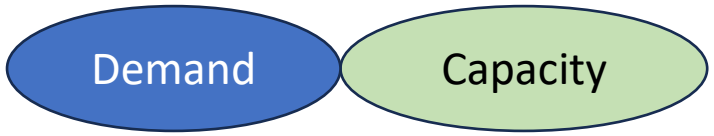
- **New Roles – multi-disciplinary**
  - **ANP Role to be fully utilised in all hubs**
  - **ACP Role to be explored a clinical developmental opportunity, career progression and value to SU.**
  - **MHWB workers in post and more to train**
- Workforce transformation lead (help with skill mixing, recruitment, retention, new roles)
- Interviews scheduled for ACP Lead
- National maturity matrix from HEE
- Health inequalities – older people are under-represented in all aspects of mh care and the workforce– **we need all corporate services to be aware of unconscious bias about the importance of this work.**

Plan - Retention

Capacity

- Manageable jobs
  - Continue caseload deep dives within mdt to improve key KPIs
  - Explore more consistent models of capacity and demand in CMHTs looking at impact of new roles
- Workforce skill mix
  - New Specialist doctors posts to reduce overspend on medical vacancies
  - New ACP roles
  - Development of ANP roles
- CPD specific to role – Frailty, Dementia, Suicide prevention etc
- Leadership development
  - Team Managers
  - New Roles and CPD opportunities

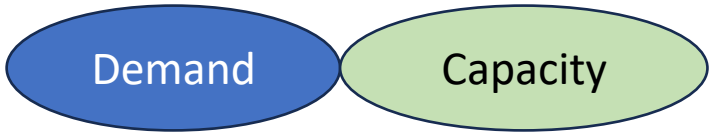
Plan -Engagement



Engagement *is a work-related state denoted by positive emotional attachment to work and is composed of:* ***vigour*** *(described as high levels of mental fortitude and energy during work),* ***dedication*** *(a sense of significance and enthusiasm for work),* ***absorption*** *(maintaining full concentration in work)*

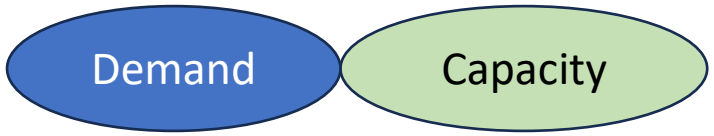
- Staff Engagement
  - Work on Pathways – improved Clarity re Clinical Offer and Team Purpose
  - Work on capacity and demand so manageable workload.
  - Webinar to managers and key leads

Plan & Expected Impacts



- Continue caseload deep dives within mdt to improve key KPIs
- Explore more consistent models of capacity and demand in CMHTs looking at impact of new roles
- Workforce skill mix
  - New Specialist doctors posts to reduce overspend on medical vacancies
  - New ACP roles
  - Development of ANP roles
- Recruit, Retain and Engage

Support required



- Workforce transformation lead
- ACP Lead
- Business plan support – for new roles
  - Specialist doctors
- HR
  - Wellbeing & Engagement webinar
  - Sickness
  - Retention
  - HR recruitment
- Understanding ageing as a health inequality
- Understanding complexity of place based care for older adult services

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Board of Directors**		
Agenda item	**14**		
Paper title	**TRUST FIVE YEAR STRATEGY: MID-YEAR UPDATE REPORT**		
Date	6 December 2023		
Author (s)	Louise Butler Business Development and Partnerships Manager		
Executive sponsor	Patrick Nyarumbu Executive Director of Strategy, People and Partnerships		
Executive sign-off	☒ Yes	☐ No	(Tick as appropriate)

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

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

Executive summary & Recommendations:

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

- Clinical Services
- People
- Quality
- Sustainability

Each year we agree goals for each strategic priority. The goals for 2023/24 (year 3 of our strategy) were taken through Committees and Board at the beginning of the financial year and progress on these goals is reported quarterly to the relevant committees.

As agreed by Trust Board, a prioritisation exercise was carried out on the Trust goals and goals prioritised as level 1 are reported to Trust Board twice yearly. This is the first of those reports for the 2023/24 goals.

For 2023/24, across our four strategic priorities we have 98 goals in total, of which 39 are prioritised as level 1. The report contains narrative about our achievement against the milestone plans for each of these goals, including a rating of red, amber or green which reflects the status of the goal against the set milestones and indicates if it is where we expected it to be at the mid-year point.

In addition, we are currently developing a framework to measure the impact of the strategy. This will articulate where we want to be at the end of the five years and measure whether we are doing the right things to get there, how far we have got on that journey, and how we will know that we've succeeded. The framework will be further developed and tested over the next few months, ensuring alignment to other key pieces of work such as the Quality Management System and the Integrated Performance Dashboard. Once in place, we will review our reporting to incorporate the impact of the strategy as well as progress updates on the goals.

The purpose of this report is to provide:

Part A - an update on level 1 and 2 goals for the Clinical Services strategic priority at the end of Quarter 2 of 2023/24 for assurance about how we are delivering the strategy.
Part B – an update on the work we are doing on measuring the impact of the strategy.

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

The Trust Board is asked to:

1. **NOTE** the contents of this report.
2. **GAIN ASSURANCE** that good progress has been made in Quarter 2 and that plans are in place where goals are not on track against milestones.
3. **GAIN ASSURANCE** that there is a clear staged approach and timeline for developing a framework for measuring the impact of the Trust Strategy.

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

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

Previous consideration of report by: (If applicable)

Detailed quarterly reports relating to each strategic priority were taken to the relevant Board sub-committees on 23 August 2023 for Quarter 1 and 22 November 2023 for Quarter 2 as follows:

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

This Board report was reviewed by the Executive Team on 27 November 2023.

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

CLINICAL SERVICES: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.

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

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

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

Financial Implications *(detail any financial implications)*

Any goals with financial implications have costed plans/budgets.

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

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

Equality impact assessments:

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

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

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

The updates in this report have been compiled by engagement with each service/ corporate area by the Strategy and Business Development Team, including through attendance where appropriate at local meetings as well as a range of conversations and contact with goal owners. In addition, we are working with the Trust lead for service user participation and experience to align the strategy with the working groups that will fall under the new HOPE (Health, Opportunities, Participation and Experience) Strategy to ensure ongoing input from Experts by Experience.

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

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

Defining levels of assurance:

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

Our Trust Five Year Strategy

2023/24 Goals – mid-year update

Trust Board
6 December 2023

compassionate inclusive committed

1. Purpose of this report

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

Each year we agree goals for each strategic priority. The goals for 2023/24 were approved by Committees and Board at the beginning of the financial year and we report on them quarterly to Committees and bi-annually to Board.

We are currently developing a framework to measure the impact of the strategy. This will articulate where we want to be at the end of the five years and measure whether we are doing the right things to get there, how far we have got on that journey, and how we will know that we've succeeded. The framework will be further developed and tested over the next few months and once in place, we will review our reporting to incorporate the impact of the strategy as well as progress updates on the goals.

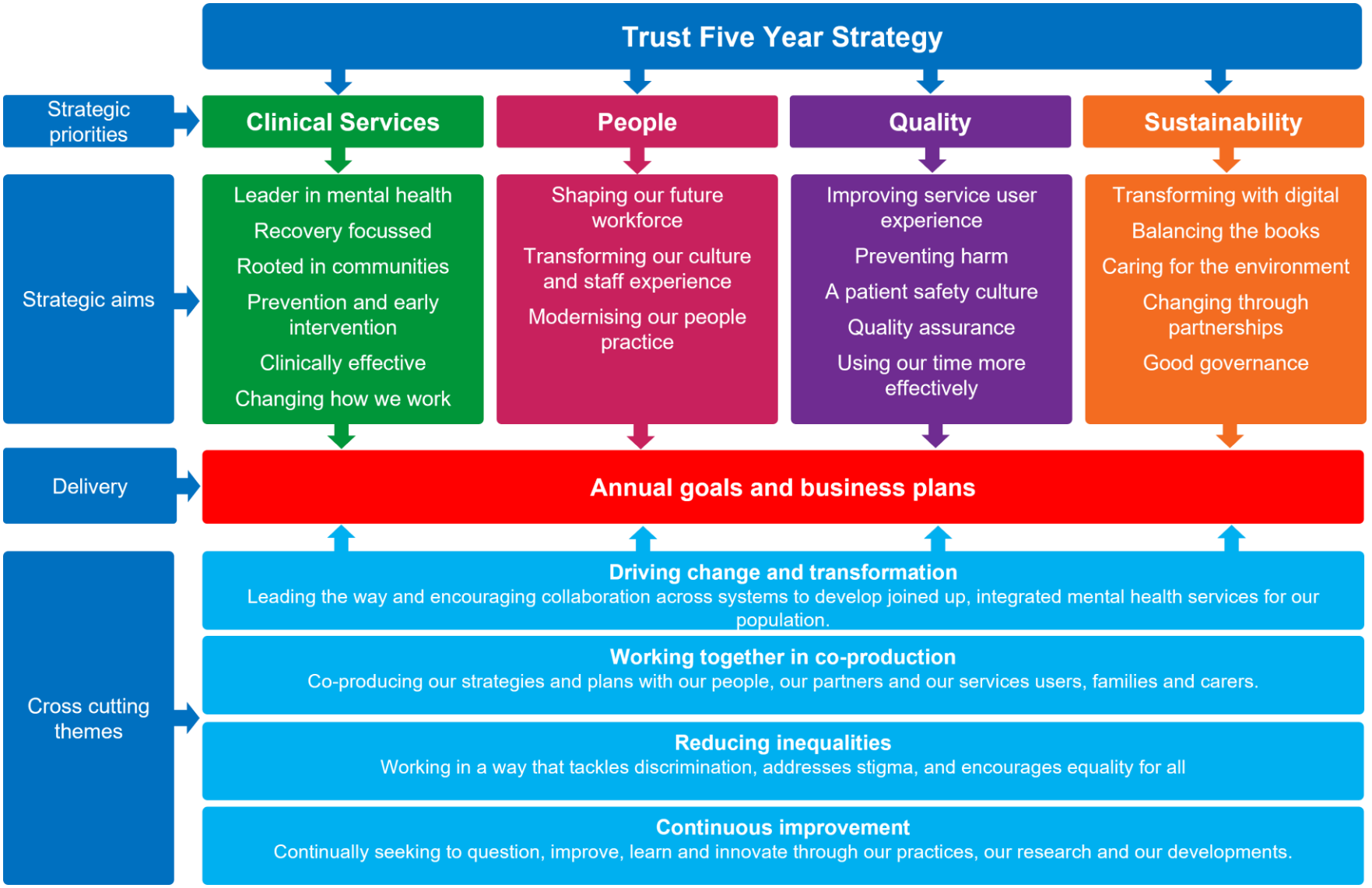
The purpose of this report is to:
Part A: Provide an update on 2023/24 goals as at the end of Quarter 2 for assurance about how we are delivering the strategy.
Part B: Provide an update on the work we are doing on measuring the impact of the strategy.

Detailed quarterly reports relating to each strategic priority have been taken to the relevant Board sub-committees in August and November as follows:

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

2. Our Trust Strategy

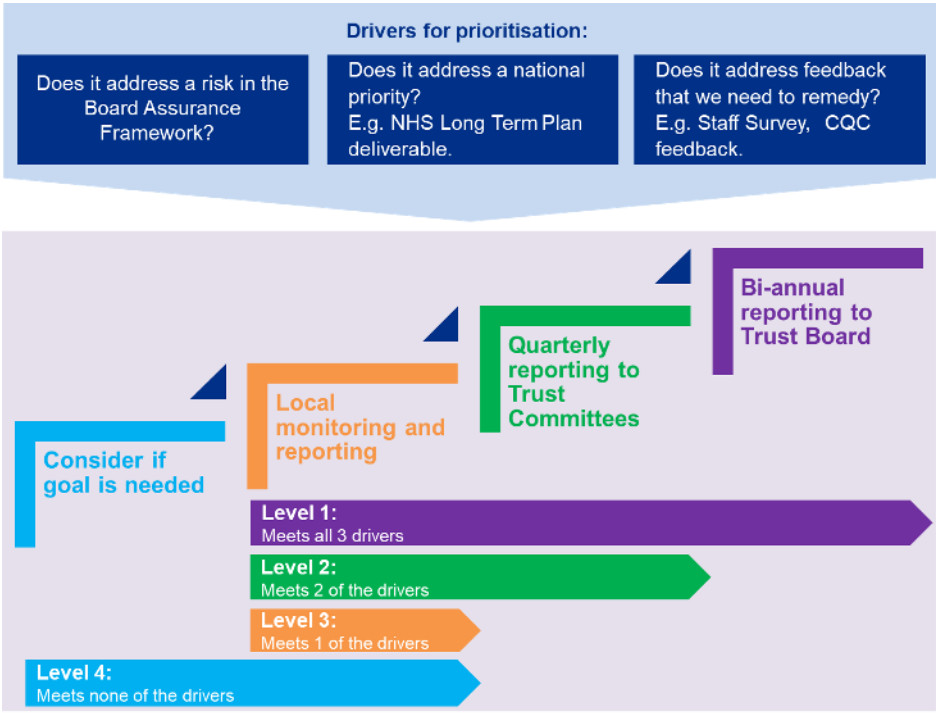
Birmingham and Solihull Mental Health NHS Foundation Trust



compassionate inclusive committed

3. Prioritisation of goals

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



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

Part A:
2023/24 mid-year review

4. Level 1 goals for 2023/24

* Inequalities goals highlighted in blue text
** *Following a review this goal was removed at the end of Q1 as it was deemed to be business as usual*

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

Clinical Services (11 goals)

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

Recovery focussed
- Family and carer pathway – review and refresh

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

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

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

Quality (12 goals)

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

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

Patient safety culture
- Review of organisation's safety culture

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

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

People (9 goals)

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

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

Modernising our people practice
- Developing digital solutions

Sustainability (8 goals)

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

Balancing the books
- Implement framework for transformational change.

Caring for the environment
- Implement the Green Plan

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

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

5. Trust goals: an overview at end of Q2

Birmingham and Solihull Mental Health NHS Foundation Trust

Each year we set annual goals which underpin our strategic priorities and their aims. These align to the ambitions of what we want the future to look like as set out in our strategy. The annual goals have quarterly milestones which are regularly monitored and RAG rated throughout the year. The RAG ratings reflect the progress of each goal against the milestones set for them, e.g. a 'Green' RAG rating tells us that the goal is on track and progressing as we expected at the end of Quarter 2.

RAG definitions:
Red = not started / seriously behind / major issues
Amber = partially met / moderate issues
Green = fully met / fully on track / minor issues

Once our Impact Framework is fully developed, we will be able to triangulate performance against milestones with performance against key performance metrics and qualitative measures, to assess whether we are where we intend to be at this point in the five year strategy in terms of positive impact on service users, carers and staff.

There are **98 Trust goals in total** for 2023/24, which is year 3 of our strategy. There are **39 goals prioritised as Level 1** and reported in detail to Trust Board in this report. A summary of the overall status at the end of Quarter 1 and Quarter 2 is shown below.

Strategic aim		Red		Amber		Green	
	Q2 Total	Q1	Q2	Q1	Q2	Q1	Q2
Clinical Services	11	1	3	6	4	4	4
People	9	0	0	6	3	3	6
Quality	11	3	1	1	3	8	7
Sustainability	8	0	1	6	3	2	4
Total	39	4	5	19	13	17	21
		10%	13%	47%	33%	43%	54%

6. Overview at end of Q2 (continued)

It is encouraging that **87% of the level 1 priority goals are rated 'Green' or 'Amber'** which means they are where we expected them to be in relation to their milestone plans or have moderate issues impacting delivery that are being addressed to bring them on track.

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

★ Green goals – some highlights ★

More integration between Trust services and avoiding silo working. **On track ✓**	Working in partnership with local communities to reduce racial inequalities. **On track ✓**	Transforming community services across the BSOL footprint. **On track ✓**	Work to support the development of a Just Culture. **On track ✓**	Reviewing and updating the comprehensive health and wellbeing offer. **On track ✓**	Progress on delivering our workforce plan. **On track ✓**
Recruitment and training of EBE Patient Safety Partners. **On track ✓**	Developing and embedding 'Think Family' principles. **On track ✓**	Development of a Quality Management System. **On track ✓**	Digital Strategy completed following extensive clinical engagement. **On track ✓**	All but two providers fully on the Shared Care Record. **On track ✓**	Review of Trust risk management arrangements going to plan. **On track ✓**

7. Overview at end of Q2 (continued)

⚠ Red goals ⚠

Five level 1 priority goals were rated 'Red' (13%) at the end of quarter 2 which means they are not where we wanted them to be in relation to their milestone plans. These are shown below:

Strategic priority	Goal	vs Q1 rating
Clinical services	*Reaside re-provision,* which was not successful in being awarded Department of Health and Social Care (DHSC) funding.	↔
Clinical services	*Highcroft redevelopment,* which although also unsuccessful in securing DHSC funding there is an alternative programme for a 30-bed unit, which has been hampered in quarter 2 by capacity and engagement challenges.	↓
Clinical services	*Birmingham Healthy Minds workforce and waiting times*, where while there has been some progress around recruitment, trajectories are not seeing the impact of this.	↓
Quality	*Complete Expert by Experience (EBE) observer project,* which has been impacted by delays in the job matching process.	↔
Sustainability	*To implement the framework for transformational change*, where work is ongoing but the framework is not yet developed.	↓

We are closely monitoring areas where although progress has been made and they are currently rated as amber, we are not achieving performance trajectories, and recovery plans developed with system partners are in place.

The following level 1 priority goals **moved from 'Red' to 'Amber'** during the quarter, both in the **Quality** strategic priority:

- *Using data to understand health inequalities in relation to incidents.*
- *Review of the organisation's safety culture.*

8. Strategic priority: Clinical services

Goal: Engage on and scope potential for more integration between Trust services to avoid silo working and fragmentation of care.

Leader in mental health

Key achievements:

- ✓ Senior leaders group formed for this piece of work and met several times to develop and scope the approach.
- ✓ Presented to Senior Leaders Forum.
- ✓ Planning undertaken and invites sent out for first dynamic space workshop, including relevant executive and associate directors, heads of professions, matrons, clinical nurse managers/clinical service managers, patient reps.
- ✓ Successful workshop held on 17 October with c50 attendees.

Focus areas for Q3 and Q4:

- Identify key priorities from the workshop.
- Plan second workshop for team and ward managers alongside Experts by Experience.
- Develop a timed project plan.

Risks and issues:

- Capacity for leaders and teams to engage and participate in this work.

Goal: Implementation of divisional health inequalities plans, following data with dignity sessions held in 2022/23, to ensure services are built on reducing inequalities data.

Leader in mental health

Key achievements:

- ✓ All divisions are developing a tailored approach to health inequalities, using the data available to them.
- ✓ Associate Director of Equality Diversity and Inclusion and Organisational Development supported senior teams around how to identify their priorities and what data is available to them.
- ✓ A range of specific health inequalities work is being undertaken at service level, e.g. in perinatal services, CMHTs, community transformation programme, Talking Therapies.

Focus areas for Q3 and Q4:

- Divisions to build on the above to implement divisional health inequalities plans.

Risks and issues:

- Ownership and accountability at divisional level for developing and implementing plans.

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

Recovery focussed

Key achievements:

- ✓ Review undertaken of where this work sits within the organisation.
- ✓ Review undertaken of progress to date and of the governance structure relating to the pathway.
- ✓ A new structure for the pathway was presented and supported at Trust Clinical Governance Committee and Operational Management Team.

Focus areas for Q3 and Q4:

- Move forward with the new structure.
- Continue of the refresh of the pathway and engagement with services around this.

Risks and issues:

- Risk of further delay and impact on family and carer strategy refresh.

9. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Continue to progress our detailed and wide-ranging plan to transform community services across all geographical areas within the BSOL footprint, across young people, adult and older adult services. Areas of focus include:

- Personality disorder
- Eating disorders
- Psychosis
- Rehabilitation
- 18-25
- Older adults

Rooted in communities

Key achievements:

Remains on track with highlights including:

- ✓ Roll out of Dialog+ and training which was positively received.
- ✓ Caseload validation at varying stages of completion and work ongoing on Insight to enable viewing of caseload data in one place.
- ✓ Physical health connector roles recruited and physical health check campaign launched.
- ✓ Managing Emotions programme pilot for personality disorder under way.
- ✓ Bipolar and Psychosis Transformation project group established to enhance the pathway.
- ✓ Agreement on enhanced Recovery College pilot with Neighbourhood Mental Health Teams.
- ✓ Peer support pilot in older adult service.
- ✓ Funding for the Solihull 18-25 project confirmed.
- ✓ Experts by Experience involved in a wide range of work across the programme.

Focus areas for Q3 and Q4:

- Recovery College pilot implementation.
- Evaluation and of Managing Emotions pilot.
- Monitoring and evaluation of peer support pilot in older adults.
- Link with wider trust to plan links with wider roll out of Dialog+.
- 18-25 roles - currently looking at Health Trainer, Youth Worker and STR worker.
- Complete stratification across adult Community Mental Health Teams (CMHTs).
- Evaluation and post go live review.

Risks and issues:

- Recruitment challenges to ensure delivery against plans.
- Delays to physical health connectors commencing in some practices due to queries regarding information sharing arrangements.
- Engagement with Primary Care Networks (PCNs) and GPs re future roles
  to ensure equity of care.

10. Strategic priority: Clinical services

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

Rooted in communities

Key achievements:

- ✓ Weekly Out of Area (OOA) Steering group meetings continue.
- ✓ Action plan developed focussing on 5 key workstreams: Locality Model, Demand Management/Gatekeeping, Length of Stay (Clinical Oversight Group, Delayed Transfer of Care and Optimising Capacity.
- ✓ Grant Thornton support ended in June 2023 and Programme Management Office (PMO) now supporting.
- ✓ A project initiation document (PID) drafted for submission to Strategy and Transformation Management Board.
- ✓ Engagement across all parts of the pathway.
- ✓ Listen Up Live held on this topic in August and was well received.
- ✓ Meeting with the communications lead to discuss engagement and a coordinated approach within workstreams.
- ✓ Locality model pilot commenced in the East.

Focus areas for Q3 and Q4:

- Submit PID to Strategy and Transformation Management Board in November for approval.
- Roll out locality model.
- Out of hours process to be discussed and a preferred option agreed for recommendation.
- Review Home Treatment responsibilities and establishment within the demand workstream to identify improvements.
- Sign off bed management function within the locality model.
- Agree process for management of FTB admissions to beds.
- Produce Standard Operating Procedures (SOPs) for new processes.
- Develop and implement Communications and engagement plan.
- Delayed Transfer of Care (DTOC) workstream to agree approach and timeline.

Risks and issues:

- There is progress on inappropriate OOA beds against trajectory however we are not currently meeting the agreed target trajectory for DTOC.
- Impact of not meeting the OOA trajectory including external scrutiny.

11. Strategic priority: Clinical services

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

Rooted in communities

Key achievements:

- ✓ Continuing work on PCREF response and next steps with community collaborative consisting of five community organisations.
- ✓ Community engagement function has moved into the provider collaborative which is an opportunity to ensure representation across the commissioning space.
- ✓ We were part of the national launch of the PCREF.

Focus areas for Q3 and Q4:

- Work with Catalyst 4 Change and the Association of Jamaican Nationals on a focused view of our complaints process, specifically around the experience of Black Caribbean service users.
- Internal organisational roll out of PCREF.

Risks and issues:

- None identified.

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

Prevention and early intervention

Key achievements:

- ✓ Scoping work on crisis alternatives with commissioners.
- ✓ Crisis pathways workshop held with partners (police, ambulance service and local authorities) to revisit roles, responsibilities and expectations.
- ✓ Strategic focus is currently on developing a locality model.
- ✓ Demand and capacity review to scope potential locality level respite beds.
- ✓ Place of Safety capacity has been increased from two rooms to three.
- ✓ We have increased access criteria for Psychiatric Decisions Unit (PDU), allowing West Midlands Ambulance Service direct access and introduction of a 24 hour 'Call before you Convey' pathway.
- ✓ Further integrated working on developments with CMHT colleagues, improving Psychiatric Liaison admissions (and avoidance) processes.
- ✓ Improved joint working with Forward Thinking Birmingham, e.g. where their patients are accessing PDU services.

Focus areas for Q3 and Q4:

- Continue work on developing a locality model.

Risks and issues:

- New Clinical Service Manager is seconded. Uncertainty over longer term for this role.
- Gatekeeping and locality model will take time to fully establish and the change will not be immediate.
- PDU capacity may not be sufficient.
- Staffing numbers are an ongoing risk with challenges around getting appropriate cover.

12. Strategic priority: Clinical services

Goal: Expand and support the Birmingham Healthy Minds workforce and improve waiting times to meet national trajectories by April 2025.

Prevention and early intervention

Key achievements:

- ✓ System workforce plan developed to further build on current use of training places to replenish/expand future capacity.
- ✓ Band 8a clinical development lead recruited to support the team to screen referrals and identify barriers to recovery planning and develop relationships with neighbourhood mental health teams.
- ✓ Band 7 Step 2 lead also now in post.
- ✓ Step 3 waiting list decision making group commenced on 31 July and will report quarterly from November; anecdotally this is reducing the number of people on the waiting list.
- ✓ Transfer of 150 service users to Xyla digital service for assessment and treatment completed and service now being offered to those on the waiting list who meet the criteria.
- ✓ Bespoke continuing professional development (CPD) training package purchased to support recruitment and retention.

Focus areas for Q3 and Q4:

- Continued recruitment and new staff to commence in post.
- Two Band 6 counsellors starting in February will offer a counselling for depression course, which is a non-CBT modality.
- Quality improvement (QI) project to develop and test change ideas.

Risks and issues:

- Impact of not meeting the trajectory and national/local scrutiny.
- Recruitment and retention challenges remain
- It takes time for newly qualified recruits to build up caseloads and experience, and therefore impact the waiting list.

Goal: Continue to deliver transformation plans for children and young people in Solihull.

Prevention and early intervention

Key achievements:

- ✓ Transition worker role fully embedded in the service and developing links across the various pathways.
- ✓ Pathways into CMHTs are working well.
- ✓ M-power service - to enable enhanced hospital avoidance for learning disability and autism - fully recruited to and regular multi-disciplinary team (MDT) is in place.
- ✓ Dialog+ training delivered and care plans started.
- ✓ Dialog+ is fully utilised within Solihull Early Intervention.
- ✓ Localised report is under construction around FREED (early intervention in eating disorders) needs.

Focus areas for Q3 and Q4:

- Further roll out end embedding of Dialog+.
- Work around reporting and requirements from the Integrated Care Board (ICB).

Risks and issues:

- Recruitment and retention is a challenge.
- There are no Children and Young People (CYP) ARRs workers for Solihull.
- Development of pathway between Solar and the PCNs is on hold due to their currently being no CYP worker.

13. Strategic priority: Clinical services

Goal: Progress with the developments for Highcroft redevelopment.

Changing how we work

Key achievements:

- ✓ Following notification from the Department of Health and Social Care in May that Highcroft was not selected for funding from the New Hospitals Programme, we began actively looking at alternative options/schemes.
- ✓ A number of alternative funding and building options based on have been reviewed and costed in an attempt to bring the overall capital cost down to below £100m
- ✓ Commenced design of an 'interim' option of a modular build creating a 30 bed unit
- ✓ Site visits arranged for clinical colleagues to visit recently completed modular build health schemes.
- ✓ Project meetings established to prioritise the model of care, capacity planning and staffing model.
- ✓ Workstreams identified and meetings for all workstreams and leads assigned. Sign-off responsibilities for those also confirmed.
- ✓ Requests for information circulated to relevant workstream leads.
- ✓ Key message document and letter to the local MP developed as part of the communications and engagement strategy.
- ✓ Initial programme timeline completed and forwarded to the ICB with indicative timelines for completion.

Focus areas for Q3 and Q4:

- Obtain sign-off for the model of care and demand and capacity work from the clinical lead and/or clinical reference group.
- Agree and sign-off the staffing model so that affordability can be determined.

Risks and issues:

- Attendance for some key stakeholders at meetings has been sporadic.
- In terms of the 'interim' option this has reverted to 'red' status due to capacity and engagement challenges.
- As a result of delays the business case will be completed at the end of March 2024 rather than January 2024 as planned.

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

Changing how we work

Update for Q2:

- No further update following notification from the Department of Health and Social Care in May that Reaside was not selected for funding from the New Hospitals Programme.

Focus areas for Q3 and Q4:

- Next steps to be confirmed.
- The project plan will be re-baselined if/when a decision is made to proceed with the Outline Business Case.

Risks and issues:

- Availability of funding.

14. Strategic priority: People

Goal: Deliver our workforce plan through:

- Increasing workforce supply to address workforce gaps across the organisation.
- Progressing the retention activities and improve our turnover rate.
- Support delivery of service specific recruitment and retention plans.
- Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.

Shaping our future workforce

Key achievements:

- ✓ ICS Mental Health Recruitment Fair held in May attracted 1500+ attendees. BSMHFT offered 17 nurses posts and created a mailing list of 800+ individuals interested in HCA roles.
- ✓ Divisions continue to report on progress through Shaping our Future Workforce sub-committee, however there is still an issue regarding the number of RMNs available across the region and nationally.
- ✓ Workforce initiatives group established to look at issues relating to staffing and developing a business case to support the Grow Your Own RMN capacity initiative.
- ✓ A full onboarding review undertaken including access to fundamental training and proposals are being developed for Executive Team discussion and approval.
- ✓ A Temporary Staffing Solutions (TSS) pilot project is in its infancy looking at how we can allow staff who are not AVERTS trained to work on wards in a safe manner having undertaken e-learning.

Focus areas for Q3 and Q4:

- Evaluate impact of operational workforce plans as well as international nursing and medical recruitment.
- Confirm proposals following onboarding review and submit to the Executive Team.
- Progress the TSS pilot.
- Review all activity based on positive action priorities.

Risks and issues:

- Lack of engagement with operational leaders to influence how the workforce is developed.
- Lack of resource to provide AVERTS training
- Lack of engagement with wards to pilot non-AVERTS trained colleagues working on wards.

Goal: 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

Shaping our future workforce

Key achievements:

- ✓ The Enough is Enough process has been reviewed and being rebranded to Values In Practice that will be re-launched in the coming months.
- ✓ Mediation process flow chart, role description and accredited training has been arranged for a dedicated bank of mediators.

Focus areas for Q3 and Q4:

- Roll out programmes.
- Launch Values in Practice process.

Risks and issues: Lack of local and corporate engagement/ ownership.

15. Strategic priority: People

Goal: Continue to embed staff engagement programme to ensure that Flexible Working is routinely promoted throughout the year using data and multiple channels

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Flexible working options continue to be promoted throughout the Trust; reporting is via Electronic Staff Record (ESR) however this is not as consistent as it could be.
- ✓ Available channels of communication mapped alongside gap analysis of opportunities that would add value.
- ✓ A full engagement plan and interventions has been developed within the Organisational Development (OD) function and socialised in several committees.
- ✓ Reporting mechanisms and governance developed.

Focus areas for Q3 and Q4:

- Promotion of how to record flexible working on ESR.
- Roll out engagement plan

Risks and issues:

- Lack of local engagement and ownership.

Goal: Develop and Implement a clear and regular engagement plan that seeks to Improve overall engagement scores to NHS Annual Staff Survey - measures of success via recommendations of a great place to work and receive care.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Associate and Clinical Directors engaged to identify baseline targets and co-produce improvement targets.
- ✓ Roadmap and engagement plan developed and socialised in a number of committees.
- ✓ Engagement lead is undertaking site visits to colleagues to discuss the importance of completing the staff survey.

Focus areas for Q3 and Q4:

- Roll out engagement plan.

Risks and issues:

- Lack of local engagement and ownership.

Goal: 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.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Board development session discussed Positive Action and the need for a clear transparent narrative as well as offer.
- ✓ Model Employer data being refreshed and timelines for Flourish reviewed.

Focus areas for Q3 and Q4:

- Test out and deliver the Flourish products
- Develop central portal on the Learning Zone.

Risks and issues:

- There has been a delay in delivery of some of the Flourish products due to capacity within the OD team, however capacity has recently improved in the team so key workstreams are due to be delivered over the next couple of months.
- Lack of local engagement and ownership

16. Strategic priority: People

Goal: Demonstrating improvement in the key areas Identified within the 2022 NHS staff survey which require improvement. Discrimination, recognition, health and wellbeing and Inclusion.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Integrated OD and EDI taking on a collective behaviours lens for supporting behavioural improvements and taking on a more holistic view to culture change.
- ✓ Interventions are supporting HR processes in the informal space.
- ✓ Interventions into teams are being focussed on supporting improvements around bullying and harassment, as dictated via the staff survey results 2022.
- ✓ Anti-racist campaign in next phase with roadshows being finalised.
- ✓ Ownership and delivery further reinforced via OD engagement plan which was approved by People Committee.

Focus areas for Q3 and Q4:

- Roll out plan.
- Implementation of the national wellbeing conversations for teams and individuals.

Risks and issues:

- Lack of local engagement and ownership, low OD resource.

Goal: Continually review and update the comprehensive and inclusive health and wellbeing offer (including cost of living) that meets the needs of our diverse workforce.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Outcomes from the 2022/23 survey reviewed and discussed and identified issue with how the vast array of offers are being communicated.
- ✓ A new health and wellbeing newsletter has been created, this will be a hard copy publication that will be distributed to all Trust sites and available at induction to ensure we are reaching those colleagues who do not have access to electronic communications.
- ✓ Recruitment for health and wellbeing champions is under way, these colleagues will be the feet on the ground supporting sharing of the offers available.

Focus areas for Q3 and Q4:

- Develop support model for champions.
- Develop project plan for wellbeing rooms.
- Develop business case to access funds to support health and wellbeing.

Risks and issues:

- No budget associated with the health and wellbeing offer.

17. Strategic priority: People

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: As we continue our journey to become Anti Racist, Anti discriminatory we will embed achievements from 22/23, launch the Anti Racist framework and modernise our systems to enable the culture shift.

Transforming our Culture and Staff Experience

Key achievements:

- ✓ Anti-racist framework developed in collaboration with Bliss and Airey.
- ✓ The framework was been socialised with senior leaders and networks and shared with senior leaders, networks and unions for feedback.
- ✓ Feedback taken on board that further consultation is required before this is launched.
- ✓ A consultation roadshow will take place during Quarter 3 with plans to launch in Quarter 4.

Focus areas for Q3 and Q4:

- Undertake consultation period across the organisation with support of roadshows, posters and communication campaign
- Launch the anti-racist framework via dedicated communications campaign.

Risks and issues:

- Lack of focus on an enabling an anti-racist, anti-discriminatory culture.
- Inability to change processes that enhance discrimination.
- Lack of focus on identifying and addressing health inequalities.

Goal: Develop a range of digital solutions to streamline or automate people processes.

Modernising our people practice

Key achievements:

- ✓ Initial mapping identified three local people systems to review: internal casework tracker, sickness tracker and leavers questionnaire platform.
- ✓ Work commenced on all three systems from existing resource within the team.
- ✓ Started to explore the use of chatbot technology for HR processes.
- ✓ Initiated a new case work tracker.
- ✓ About to launch a new automated workforce dashboard.

Focus areas for Q3 and Q4:

- Review case work tracker.
- Review automated chat bot technology.
- Review automated workforce dashboard.
- Roll out.

Risks and issues:

- Limited resource and lack of expertise within the current team.

18. Strategic priority: Quality

Goal: Empowering patients through inclusion of Patient Safety Partners in the patient safety framework.

Improving service user experience

Key achievements:

- ✓ Role specification for Patient Safety Partners developed collaboratively with EBEs.
- ✓ Five Patient Safety Partners in post.
- ✓ They have completed e-learning in information governance, safeguarding children and adults, and equality, diversity and human rights.

Focus areas for Q3 and Q4:

- Patient Safety Partners to complete patient safety training and a team strengths finding exercise.
- To start attending Trust meetings where their presence is required.

Risks and issues:

- None identified.

Goal: Complete Expert by Experience (EBE) observer project, utilising EBEs to assess ward culture to reduce restrictive practice and improve quality and experience.

Improving service user experience

Key achievements:

- ✓ Job description develop and submitted for job matching.

Focus areas for Q3 and Q4:

- Job matching to be completed.
- Begin recruitment to roles.

Risks and issues:

- Funding was secured for 2 years, and there has been a significant delay in recruitment due to the job matching process, hampering progress and putting the project at risk.

Goal: Use data to understand health inequalities in relation to incidents.

Improving service user experience

Key achievements:

- ✓ This quarter's patient safety report to the Quality Patient Experience and Safety (QPES) committee includes health inequalities information for the first time.

Focus areas for Q3 and Q4:

- Formulation of a data dashboard in collaboration with the Performance and Information Team.

Risks and issues:

- Information is limited at this stage as the dashboard is needed to fully realise this goal.
- Use of data and knowledge of delivering system changes.

Goal: Implement the Patient Safety Incident Response Framework (PSIRF) to pursue excellence in learning and understanding of incidents including cross-organisational learning.

Preventing harm

Key achievements:

- ✓ Band 7 Patient Safety Manager recruitment.
- ✓ Governance structures mapped and have been tested using QI methodology.
- ✓ Terms of reference have been produced.
- ✓ Policy and response plan have been drafted.

Focus areas for Q3 and Q4:

- Policy and response plan to be approved.
- Implementation of new processes.

Risks and issues:

- Capacity and engagement of partners.

19. Strategic priority: Quality

Goal: Review and implement a safe staffing model across all inpatient wards.

Preventing harm

Key achievements:

- ✓ Safer staffing project under way.
- ✓ Clinical Lead for Safer Staffing appointed, allowing for an increase in clinical engagement and co-production.
- ✓ Data from the Mental Health Optimal Staffing Tool (MHOST) scrutinised with each of the service areas.
- ✓ Work has taken place around increasing health care assistants (HCAs) and looking at having peripatetic staff.
- ✓ Discussions as to how we can achieve 3 qualified staff on day shifts and 2 on night shifts.
- ✓ SafeCare training delivered to Steps to Recovery and 14 acute wards – this is an additional module to Healthroster which supports staffing decisions in real time.

Focus areas for Q3 and Q4:

- Establishment to be completed by December.
- SafeCare training for older adults and specialties.

Risks and issues:

- New tools/processes are dependent on clinical buy-in and operational management support.
- If staff don't proactively undertake training, the roster data won't improve.

Goal: Review the organisation's safety culture to understand how safe our staff feel at work and engage with them to provide a safe working environment where they can flourish.

A patient safety culture

Key achievements:

- ✓ Initial working group set up with the Associate Director for EDI and OD.
- ✓ An options appraisal has been developed for the roll out of a safety culture survey to staff within the Trust - this includes options for doing this internally vs an external provider.
- ✓ This will be presented at the Executive Team meeting.
- ✓ This work will link with the work on health inequalities led by the Associate Director of EDI and OD.

Focus areas for Q3 and Q4:

- Decision on the options.
- Agree a roll out plan.

Risks and issues:

- Capacity and engagement.

Goal: Implementation of new learning from deaths processes aligned with PSIRF.

Quality assurance

Key achievements:

- ✓ Learning from deaths criteria revised and is awaiting Clinical Governance Committee (CGC) approval.

Focus areas for Q3 and Q4:

- Building and testing new tools on Eclipse.

Risks and issues:

- No current risks to delivery identified.

20. Strategic priority: Quality

Goal: Demonstrate improvement against CQC action plans.

Quality assurance

Key achievements:

- ✓ We continue to report monthly on action plan progress to Trust CGC and QPES committee.
- ✓ Following updates in September we had a total of 12 actions showing as overdue. This is because in some cases the agreed actions have been taken however the service has not reached the expected compliance standards.
- ✓ We have seen some improvements in appraisal, clinical and managerial supervision in some teams.
- ✓ Reports detailing progress for all actions are provided monthly to QPES committee.

Focus areas for Q3 and Q4:

- The compliance team will continue with its programme of assurance testing to review those actions marked as complete.
- Ongoing work required to maintain improvements in appraisal, clinical and managerial supervision.
- The Trust had 2 Section 29As issued in August following the CMHT inspection, which suggests we need to continue with improvement plans around medicines management, risk assessments and care plans.

Risks and issues:

- Actions for appraisal, clinical and managerial supervision remain a concern and more robust monitoring is required at service level to enable improvement.
- While the actions in the plan are being completed per the target dates, we cannot demonstrate sustained improvement without ongoing programmes of peer reviews, assurance testing, improvement/changes in incident data, improvement/ changes in staff and service user experience.

Goal: Develop and embed the principles of 'Think Family'.

Quality assurance

Key achievements:

- ✓ Think Family Standard and delivery plan developed per the recommendations of the review into the murder of Arthur Labinjo-Hughes in Solihull.
- ✓ As part of addressing themes from external reviews, audits undertaken in specific services to provide assurance that domestic abuse is considered, Think Family principles are applied and referrals are made where safeguarding concerns exist.
- ✓ Think Family awareness campaign developed ready for launch with a suite of information, including a PowerPoint for use in team, digital posters, leaflets and a short video which are all available on Connect.
- ✓ Child and sibling form has been refreshed and simplified.

Focus areas for Q3 and Q4:

- Campaign to launch on 13 November to include:
  - Information pack distributed in all clinical areas.
  - Stall at Trust induction on 21 November
  - Listen Up Live on 12 December.
- Approach to be embedded through training, supervision and attendance at relevant meetings Trustwide.
- Uptake to be monitored and awareness raising to be ongoing.

Risks and issues:

- None identified.

21. Strategic priority: Quality

Goal: Scope, introduce and embed a Quality Management System (QMS), including our strategic approach to Quality Improvement (QI) with our new Quality Improvement strategy.

Using our time more effectively

Key achievements:

- ✓ Business case and quality management System (QMS) and quality improvement (QI) strategy presented to the Executive Team.
- ✓ Job descriptions and person specifications completed for Quality Improvement Facilitator (QIF) and admin roles.
- ✓ Admin role is out to advert.
- ✓ Two meetings held to develop QMS implementation plan (action plan amnesty work).
- ✓ Linked in at the Senior Nursing and Midwifery Meeting in July to understand the national plan for NHS Impact.
- ✓ First stages of integrated Statistical Process Control (SPC) charts available for restrictive practice dashboard.
- ✓ Work to date shared with Executive Team, QPES Committee and Strategy and Transformation Management Board.

Focus areas for Q3 and Q4:

- Completion due in January with presentation at Senior Leaders Forum (SLF).
- Recruit and start to map through the support in service areas with new roles.
- Release time for QI leads to start thematic review and take on level 1 and 2 QI projects.
- Work on the data set being integrated to provide consistency on a defined data style - starting with Reducing Restrictive Practice.
- Further work to develop SPC charts for other workstreams.
- Ensure that all reporting within the organisation moves towards SPC charts.

Risks and issues:

- Delays to advertising QIF roles due to unresolved job matching issues.

Goal: Use quality improvement approaches to develop our pathways to improve access to services.

Using our time more effectively

Update on this goal:

- This quality goal is a workstream that will sit within the overarching QMS goal and are highlighted in the action plan amnesty work, as well as prevention of future deaths reports, serious incident reviews and safeguarding.
- They are also included in the new PSIRF safety priorities.

Focus areas for Q3 and Q4:

- Develop plans to involve service users and other stakeholders, aligning with engagement on wider Trust strategy work.
- Progress after discussion at the Senior Leaders Forum (SLF) in January.

Risks and issues:

- System engagement, pace of change required.

22. Strategic priority: Sustainability

Goal: Connect the Trust and the Shared Care Record for BSol to all NHS primary and secondary care providers and the local authorities, to improve data sharing across our organisations for direct patient care

Transforming with digital

Key achievements:

- ✓ Funding secured for 2023/24 across the ICS.
- ✓ Finance model has created for ongoing funding, agreed at ICS level.
- ✓ West Midlands Ambulance Service and Birmingham Women's and Children's NHS Foundation Trust are now on board.
- ✓ Only remaining gaps are consumption by Royal Orthopaedic Hospital (ROH) staff and provision of Solihull community data.
- ✓ All other primary and secondary care organisations are consuming and provisioning the Shared Care Record.
- ✓ We have expanded the data sets and enriched the offering, including discharge medications and structured data for meds and allergies and vaccinations.

Focus areas for Q3 and Q4:

- Review all data feeds and plan for changes to better inform clinical decision making.
- Continue to expand the data sets and enrich the offering.
- Work with ROH and Solihull community on remaining gaps.
- Finance model to be promulgated to provider organisations for inclusion in next year's financial plan.

Risks and issues:

- Capacity across organisations to deliver.
- Organisational buy-in and support across the ICS.
- Financial cost to achieve.
- If we don't have all organisations data flowing into the Shared Care Record we have an incomplete picture of the patient.

Goal: Embed clinical engagement and influence in relation to ICT and digital strategy, transformation and developments

Transforming with digital

Key achievements:

- ✓ First draft of the Digital Strategy completed – this is a joint strategy across BSMHFT and Birmingham Community Healthcare NHS Foundation Trust (BCHC) given our joint senior post, common electronic patient record system (RiO) and synergies of service offerings across multiple sites.
- ✓ Following completion of the first draft of the Digital Strategy, it has been circulated in both organisations and generally socialised with feedback being incorporated.

Focus areas for Q3 and Q4:

- The Strategy is going through the committees and Boards at both organisations as part of final agreement and sign off.

Risks and issues:

- Digital still needs to be embedded in how we transform our services and this is a slow process with a small team.

23. Strategic priority: Sustainability

Goal: To implement the framework for transformational change.

Balancing the books

Key achievements:

- ✓ Two dedicated meetings between non-executive directors and other members of FPP Committee to discuss opportunities for transformational change.
- ✓ Paper received from Deputy Director of Commissioning and Transformation at FPP Committee setting out potential future workstreams and roadmap for development.
- ✓ Work continues on identifying priorities and opportunities for transformational change.
- ✓ Framework is not yet developed, however work is ongoing within the BSOL Mental Health Provider Collaborative for a longer term strategy.

Focus areas for Q3 and Q4:

- To have implemented the framework for transformational change.

Risks and issues:

- Capacity and capability of organisation to consider new ways of working that will deliver efficiency savings.

Goal: Implement the Green Plan

Caring for the environment

Key achievements:

- ✓ Small steps being made towards the Green Plan's ambitious set of NHS targets up to 2040. These include:
  - ✓ A Public Sector Decarbonisation Fund bid for heat decarbonisation has been accepted and is now under review with grant offer letters expected in March 2024.
  - ✓ Centralisation of some medical associated items established.
  - ✓ B1 Trust headquarters decommissioning under way with furniture being re-allocated where possible across the Trust estate, reducing wastage and mitigating costs associated with purchase of new furniture and disposal of unwanted items.
- ✓ Green Plan Steering Group monitors progress against the workplan with good attendance from corporate leads.
- ✓ Carbon footprint reduced: 6,107 tCO2e in 2022/23 compared to 8,775 tCO2e in 2019/20.
- ✓ To support engagement, Listen Up Live focused on the Green Plan and green agenda on 11 July 2023.
- ✓ Summerhill Services Ltd (SSL) is supporting the ICS with developing its Green Plan and scoping options.

Focus areas for Q3 and Q4:

- Continue to progress actions in the Green Plan (recognising the 3-5 year journey we are on to progress heat decarbonisation plans).

Risks and issues:

- Need to have Trust clinical engagement.
- Funding to invest and manage initiatives - capital and revenue.
- Prioritisation – having a number of valid priorities and deciding what to focus on first.

24. Strategic priority: Sustainability

Goal: Deliver strategic priorities agreed by the West Midlands Provider Collaborative (WMPC).

Changing through partnerships

Key achievements:

- ✓ Framework agreed for development of an all-age West Midlands Mental Health, Learning Disability and Autism Strategy.
- ✓ Regional bed strategy: discussions with operational and clinical leads of Trusts are taking place to collate softer intelligence about local bed plans.
- ✓ Joint initiative agreed to roll out CAMHS Intensive Residential Outreach Care (IROC) model across region.
- ✓ Development of the Regional Supervision Hub for psychological therapies - Two-day awareness courses for c1,350 staff commissioned.
- ✓ Additional supervision capacity secured from accredited practitioners and institutions.
- ✓ The first phase of the Developing Health Care Talent Programme for clinical support worker development is coming to an end; c100 staff trained with positive feedback from staff and managers.

Focus areas for Q3 and Q4:

- Executive Teams of each Trust to agree common areas for future collaboration – workshop to be held in December 2023.
- Development of regional Trust based bed strategy aligned with ICB work to ensure plans are robust and there are agreed areas for joint development.
- Staff and managers' engagement sessions taking place at the end of September and in early October to finalise the Competency Framework and implementation plans for clinical support workers for each Trust.
- Expansion of the Developing Health Care Talent Programme.

Risks and issues:

- Delays in developing the strategy.
- Agreement of strategic priorities across the provider collaborative.
- Buy in and resource committed from all partners.

Goal: Embed the BSOL Mental Health Provider Collaborative (MHPC), including clinical engagement and clinically informed models, corporate governance, finance, contracts, quality arrangements etc

Changing through partnerships

Key achievements:

- ✓ The BSOL MHPC went live on 1 April 2023 along with the formal governance arrangements to oversee the delivery.
- ✓ The focus has been on getting into a steady state in relation to day-to-day activities, risk management, and oversight and assurance.
- ✓ Establishment of the Commissioning and Transformation hub.
- ✓ Ongoing work to prepare for taking over payment responsibilities from the ICB and to formalise arrangements for the Risk and Gain Share agreement.
- ✓ Workshop held with chairs of all meetings within the governance structure to review arrangements and information flows and ensure fit for purpose.

Focus areas for Q3 and Q4:

- ✓ The MHPC is meeting with the ICB on a quarterly basis as part of the Lead Provider Oversight Arrangements.

Risks and issues:

- Internal capacity to deliver requirements - gaps in the team, particularly around quality.
- Managing the financial position and cost pressures.
- Ensuring robust governance.

25. Strategic priority: Sustainability

Goal: Review of the Trust`s Risk Management arrangements including risk appetite, training, escalation/de-escalation, governance, oversight and assurance.

Good governance

Key achievements:

- ✓ Risk appetite development session held.
- ✓ Risk appetite survey designed, approved by the Board and circulated to Board members.
- ✓ Risk management flow chart designed and inserted into the Risk Management Policy.
- ✓ Board approved Risk Appetite Framework.
- ✓ Risk Management Policy ratified by Board, communicated and disseminated across the organisation.
- ✓ Focus and priority has been given to encouraging risk escalation and the design of the Trust Corporate Risk Register.
- ✓ Risk Manager has been appointed as a development opportunity as we seek to `grow our own workforce'.

Focus areas for Q3 and Q4:

- Risk Manager to support services/directorates at pace in updating and sanitising their risk registers.
- Risk Management Group to be re-booted with a meeting on 25 October 2023.
- Risk Management Policy to be implemented across the Trust.
- Design and delivery of risk management training.

Risks and issues:

- Potential risk that increases in clinical activities may impact staff involvement in updating and reviewing their service, directorate and divisional risks.

Goal: Undertake a review of the governance arrangements of the organisation from ward to Board, including standardisation of reporting mechanisms.

Good governance

Key achievements:

- Scoping of the challenge and preliminary readings in the domain of reviewing governance arrangements completed.
- Terms of reference for the review of the Trust governance arrangements redefined to remove review of the Clinical Governance sub-Committee (CGC) as Internal Audit are undertaking a review of CGC effectiveness.
- Redefined terms of reference approved by the executive lead.

Focus areas for Q3 and Q4:

- Terms of reference to be presented at the Executive Team meeting on 31 October and QPES in November.
- Review to commence at pace.

Risks and issues:

- Potential risk of not meeting timescales due to capacity issues and increase in clinical activities leading to inability to implement all the recommendations at pace.

Part B:

Measuring the impact of our Trust Strategy

26. What we said in the strategy

27. What do we mean by impact framework?

Our impact framework will be:

- A framework to tell us:
  - Where do we want to be at the end of the five-year strategy?
  - How will we know we've got there? What will good look like?
  - Are we doing the right things to get there?
  - How far have we got on that journey? How do we know?
- Built on the engagement we have already done with staff, experts by experience and stakeholders about their expectations on where we should be
- Applicable at organisational and local level – services, teams and individuals can think about their impact.
- Linked to our strategy accountability framework so it resonates at every level and staff can connect work they are doing to the strategy.
- Something to help us improve our governance e.g., what committees are focussed on, BAF risks.

What the framework is not:

- About refreshing the strategy or its strategic aims.
- About determining annual goals, plans or projects at this stage (although we will use the framework when developed to sense check year 4 and 5 goals).

To be determined (once we are clearer on the content of the strategy impact framework):

- Number of measures.
- Frequency of measuring impact.
- Relationship between the strategy impact framework, the quality management system and the integrated performance dashboard.

28. Principles for framework development

Structure

Straightforward, simple and easy for anyone to understand and use.

Iterative, with the initial framework to focus on organisational view, later looking at how it could apply to services/teams/individuals.

For each aim we will define:

- Clear, specific statements to define what good will look like after 5 years.
- Measures of success with SMART ambitions and targets for each measure for the end of the strategy (and any interim targets).
- How often we will collect data on each measure.
- The baseline for each measure (with the starting point to be agreed).

Measures

Includes a mixture of metrics to ensure it is holistic and meaningful:

- Quantitative, e.g. performance and demographic data
- Qualitative, e.g. staff and patient stories, focus group and survey narrative feedback

Not constrained by what information we already collect vs don't collect – to make sure we are measuring the right things.

Allows different frequencies of data collection e.g. monthly/quarterly/ annually.

Where we already have measures of success defined for developments and transformations these will inform measures of success.

Takes account of interdependencies of measures across the four priorities.

Engagement

Strategy Impact Framework Task and Finish Group established to coordinate the work and ensure joined up and consistent approach.

Aim to develop framework through engagement with:

- Staff
- Experts by experience
- Executives and non-executives

Engagement focussed on measuring impact, not the strategy itself which has already had extensive engagement (so building on this).

Combination of:

- Priority/aim specific engagement with selected subject matter expert groups/teams/ individuals; and
- Joined up engagement considering the framework as a whole.

Utilise a Quality Management approach where it's helpful

Balancing developing the framework in a timely way, with doing it thoroughly

29. A staged approach to development

Stage 1	**Develop methodology and test** • Task and Finish Group discuss and agree methodology for development of the framework ✓ • Incorporate feedback from Committee chairs ✓ • Priority leads develop draft measures for one aim per priority ✓ • Measures reviewed through subject matter teams, Task and Finish Group and August Committees ✓ • Methodology amended as necessary based on feedback **N/A**	July/ August Completed ✓
Stage 2	**Wider development of all aims and testing through engagement** • Development of draft measures for all aims, led by priority leads ✓ • Engagement with leads for quality management system to understand links with this work to avoid potential duplication ***In progress*** • Engagement with relevant groups and committees • Engagement with staff e.g. service area FPPs/CGCs, professional forums, staff networks • Engagement with experts by experience – led by our strategy champions	September - January In progress
Stage 3	**Set baselines and targets** • Confirm date of baseline • Confirm baselines • Confirm interim targets (Year 3 and 4), and targets for end of strategy	January
Stage 4	**Establish arrangements for monitoring and reporting** • E.g. who, how, what, when, where • Linking the impact framework to our strategy accountability framework	January/ February

Stage 5	**Review where we are and where we are going**
	• Measure progress against impact framework for year 3 (2023/24)
	• Use framework to help test/ set annual goals for year 4 (2024/25)
	  ◦ Are we focussed on the right things
	  ◦ Check we have the right enabling support for our strategy e.g. PMO, QI, R&D etc
	• Wider comms and engagement across the Trust about the impact we are having
		January – April

30. Appendices - worked examples

As part of Stage 1 on the previous page, we produced a worked example for **one strategic aim in each strategic priority**, to test our methodology for development of the framework. These can be seen on the following pages and were shared with Board Committees who supported the approach.

These are drafts to test, demonstrate and share our thinking on the **methodology** and template rather than the detail of the content, which will be further developed and tested through the engagement outlined in Stage 2.

We have reviewed these initial worked examples for consistency of approach across the four priorities and have developed initial drafts for the remaining strategic aims within each priority. We are currently identifying any overlaps or duplications in the proposed measures. Per Stage 2 we will be undertaking much wider engagement on this, which may include prioritisation/filtering of the identified measures.

Alongside this, we are working with the leads for development of the Quality Management System (QMS) to be clear on the links between these pieces of work and avoid duplication of purpose, content and engagement. We have mapped all four strategic priorities onto the themes arising from the action plan amnesty, and this is due to be presented to a range of meetings in November and December, and to the Senior Leaders Forum in January.

A. Worked example – Clinical services

Aim	Aim description	What will good look like at the end of the strategy?	Measures of success	Type of measure	Is this currently collected? If so how often?
Prevention and early intervention	We will provide help at the earliest opportunity before mental health problems escalate or become more complex, through access to a range of treatment options whether with us or one of our partners.	Everyone who needs it will be able to access support quickly and easily at the earliest opportunity.	Numbers accessing 24/7 helpline	Quantitative	Yes monthly
			Service user, carer, family and partner feedback	Qualitative	Yes partly
			Dashboard data, e.g. CAMHS, Talking Therapies, EIS access targets	Quantitative	Yes
			Numbers accessing self-help guides/online resources	Quantitative	Yes?
		People experiencing mental health crisis will be able to get timely support.	Numbers accessing 24/7 helpline, call before convey, Place of Safety, crisis house, crisis café	Quantitative	Yes
			Number of suicides in the community	Quantitative	Yes
			Service user, carer, family and partner feedback	Qualitative	Yes partly
		People will access care in the most appropriate setting at a time and place that works for them.	Numbers being diverted from acute hospital, e.g. home treatment, PDU, care home liaison, CERTs	Quantitative	Yes
			Numbers accessing treatment in a range of settings, e.g. school, community venue, online/apps	Quantitative	Yes?
			Numbers receiving interventions/signposting in primary care.	Quantitative	Yes
			Service user, carer, family and partner feedback	Qualitative	Yes partly
		There will be specialist pathways in place for particularly vulnerable groups in our population, provided by the most appropriate organisation to meet their specific needs.	Numbers accessing specialist pathways/services, e.g. veterans, homeless/rough sleepers, dual diagnosis, integrated offender health, refugee, counter terrorism formulation service, OPD pathway	Quantitative	Yes
			Service user, carer, family and partner feedback	Qualitative	Yes partly

Note: Additional columns will be populated to show the baseline, target at the end of the strategy and any interim targets, e.g. at the end of year 3 and 4. We will be defining these during Stage 3.

B. Worked example - People

Aim	Aim description	What will good look like at the end of the strategy?	Measures of success	Type of measure	Is this currently collected? If so how often?
Shaping our future workforce	Developing a diverse, innovative, and agile workforce with the right skills and experience to meet our changing demands and where differences are valued to enhance service user experience and recovery.	All colleagues will have appropriate training to support them to be effective in their role.	Training compliance rates for different staff.e.g: - first line management training - fundamental training	Quantitative	Yes monthly
			- HR casework numbers	Quantitative	Yes monthly
		Flexible working will be available to all colleagues	ESR flexible working statistics	Quantitative	No but available
			Staff survey satisfaction scores: - opportunities for flexible working patterns - organisation is committed to helping balance work and home life - ability to approach immediate manager to talk openly about flexible working	Quantitative	Yes annually
		No colleagues will experience discrimination or its effects in recruitment and career progression.	Positive action priorities embedded in recruitment to eliminate or reduce discrimination or its effects	Quantitative	Yes Quarterly
			WRES and WDES data: - Staff workforce representation - relative likelihood of being appointed from shortlisting. - Percentage believing that the Trust provides equal opportunities for career progression or promotion	Quantitative	Yes Quarterly
		We will recruit and retain the right workforce to meet the needs of our local population.	Discovery interview themes	Qualitative	No
			Exit interview themes	Qualitative	Yes Quarterly
			Workforce KPIs: Vacancy rates Turnover rates	Quantitative	Yes Quarterly
			Annual workforce plans co-produced and signed off routinely with targeted initiatives, e.g: Grow your own RMN capacity plan	Quantitative	Yes Quarterly
			Number of people lived experience employed roles in the workforce	Quantitative	Yes?
			Bank and agency usage	Quantitative	Yes Monthly
			Workforce data compared to local population data	Quantitative	Yes Quarterly

Note: Additional columns will be populated to show the baseline, target at the end of the strategy and any interim targets, e.g. at the end of year 3 and 4. We will be defining these during Stage 3.

C. Worked example - Quality

Aim	Aim description	What will good look like at the end of the strategy?	Measures of success	Type of measure	Is this currently collected? If so how often?
Preventing harm	We will reduce unwarranted variations and reduce harm across our services. We want to reduce the level of harm and suicide rate amongst our service users. We want to reduce harm that sometimes comes to our staff during the delivery of care.	An effective governance structure around our response to patient safety incidents will focus on improvement and learning	Number of people in oversight roles to have received appropriate training.	Quantitative	No
			Compliance with patient safety syllabus training	Quantitative	No
			Self-assessment for effectiveness of governance structure.	Quantitative	No
		We will have effective systems and processes through the PSIRF for responding to and learning from patient safety incidents and identifying our safety priorities.	Patient safety data	Quantitative	Yes
			Number and category of patient safety incidents	Quantitative	Yes
		We will have compassionate engagement with anyone affected by patient safety incidents	Staff, service user and family feedback	Qualitative	Yes partly
			Numbers of staff trained in restorative and just culture	Quantitative	No
		We will be using the latest methods to develop our learning from and responses to safety incidents.	Introduction of new learning from safety methods, e.g. after action review, SWARM huddles.	Qualitative	No
			Number of staff trained in after action reviews and other learning responses	Quantitative	No
			Number of peer supervision sessions	Quantitative	No
			Staff confidence/competency to facilitate learning responses	Qualitative	No
		We will be using quality improvement to support the prevention of harm.	Number of QI projects relating to patient safety.	Quantitative	No but data available

Note: Additional columns will be populated to show the baseline, target at the end of the strategy and any interim targets, e.g. at the end of year 3 and 4. We will be defining these during Stage 3.

D. Worked example - Sustainability

Aim	Aim description	What will good look like at the end of the strategy?	Measures of success	Type of measure	Is this currently collected? If so how often?
Balancing the books	We will spend less than we earn on an ongoing basis and generate sufficient cash to invest in the transformational development of facilities, technology and clinical services for the benefit of our staff, service users and carers, and the local system.	We will continue to deliver in line with our financial plans and ambitions	Compliance with annual and medium-term financial plan	Quantitative	Yes - monthly
		We will deliver a regular stream of financial and other benefits from our transformation of services and processes	Annual statement of plans and delivery	Quantitative	No
		We will maintain strong cash balances and improve the use of investment	Remain above minimum cash headroom and delivering target rate of return	Quantitative	Cash yes - monthly, rate of return via interest receivable monthly
		Finance and efficiency is seen as an integral element of all business decisions	Positive customer feedback	Qualitative	No

Note: Additional columns will be populated to show the baseline, target at the end of the strategy and any interim targets, e.g. at the end of year 3 and 4. We will be defining these during Stage 3.

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**22 November 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Integrated Performance Report • Finance Report • Planning and Budget Setting 2024/25 • Digital Quarterly Report and Digital Strategy • Sustainability Strategy Progress and Impact Report • Clinical Services Strategy Progress and Impact Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Month 7 financial position showed a **deficit** of £426k, which was adverse to the breakeven plan. The forecast breakeven position would be achieved through non-current savings and benefits, however **significant transformational change** was needed for 24/25. • Challenges remained significant spend related to **Out of Area placements** and **agency use**, however significant improvements had been reported. • A response to NHSE had been submitted on the Trust's plan to manage the financial and performance pressures created by industrial action. • The **Digital Strategy** was received, with a clear focus on enhancing digital services for staff. There were some challenges related to greater utilisation of digital enhancements, and costs associated with larger projects.
Assure:	The Committee was assured on the following areas of performance and financial sustainability: • Significant improvements had been made with bank and agency usage, with further reductions expected on medical and nursing agency staff paid above capped rates. The Committee was assured by the planned trajectory. • The Committee commended the work of the teams who had delivered continuous improvements in Out of Area Placements,

	noting that performance had been significantly improving over the last 11 weeks. • The Committee was encouraged by the progress of Planning and Budget Setting for 2024/25, although reduced flexibility and additional challenges for the new financial year were acknowledged. The Committee was again assured by transformational approaches being taken to ensure robust financial strategy for future years. • The Committee was encouraged by the progress made in specific areas of the Trust's performance and the intervention plans that had been developed and implemented. • An update on Sustainability and Clinical Services strategic priorities was received; the Committee noted the progress and improvements, and anticipated impact reports in the new year. • The Committee was assured by the approach to cyber security, noting the number of phishing and other spam attacks which had not affected the Trust's systems.
Advise:	Further refinements to the metrics and presentation of the Integrated Performance Report would be made for greater clarity and assurance.
Board Assurance Framework	Improvements continued to ensure a fully embedded Board Assurance Framework, with positive feedback to date. The Board Assurance Framework would be reviewed regularly and begin to inform and focus agendas, strategic goals and risk registers. A quarterly review process would be implemented to monitor improvements, prominent issues, risk reductions and increases over time.
	New risks identified: no additional risks were identified.
Report compiled by:	Bal Claire Deputy Chair
Minutes available from:	Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**18 October 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Integrated Performance Report • Finance Report • Business Development and Partnerships Report • Sustainability Strategy Progress Report • Clinical Services Strategy Progress Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • Despite the Trust's efforts around increasing WTE levels, **temporary staffing** spend continued to increase, with a forecast £46m spend for 2023/24. • **Out of area placements** remained a key challenge, with significant expenditure of £9.5m year-to-date highlighted. • The Month 6 financial position showed a **deficit** of £497k, which was adverse to the breakeven plan. The forecast breakeven position would be achieved through non-current savings and benefits, however **significant transformational change** was needed for 24/25. • Metrics for the **Integrated Performance Report** would be reviewed, with the intention to streamline and reformat the report for greater clarity. • Given the progress in H1, the known internal/external forces at play and the ongoing financial challenges for the remaining H2 and 24/25, the Committee challenged the executive to develop an integrated transformation agenda which underpinned the Trust's strategy to financial sustainability. This optic will be reviewed at the November committee meeting, in line with the commencement of the 24/25 budget setting process.
Assure:	The Committee was assured on the following areas of performance and financial sustainability: • Although significant challenges remained, the Committee was encouraged by the transformational approach that was being taken with quality improvement methodology; this would contribute

	towards a robust financial strategy for future years. Progress against planning and budget setting for 24/25 would be received each month for continued monitoring and assurance. • The Committee was encouraged by the progress made in specific area of the Trust's performance and the intervention plans that have been developed and implemented. • The Committee received an update on business development and partnerships, noting that the financial implications of bids and tenders would be reviewed to ensure clear timescales and achievability. • An update on Sustainability and Clinical Services strategic priorities was received, with progress and impact reports due to be received in November for discussion at Board of Directors in December.	
Advise:	The Committee was advised of recommendations received through an audit report into short-term financial recovery; these related to out of area reduction, agency reduction and corporate service transformation.	
Board Assurance Framework	The Committee discussed the need to integrate the BAF more clearly in agendas, noting particularly the frequency of Digital and Environment reviews.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Bal Claire Deputy Chair	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Board of Directors**		
Agenda item	**16**		
Paper title	Month 7 2023/24 Finance Report		
Date	6 December 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 7 2023/24 Group position is a deficit of £426k year to date. This is £426k adverse to the break-even plan. The position comprises a £971k surplus for the Trust, £151k surplus for Summerhill Services Limited (SSL) and a £146k surplus position for the Reach Out Provider Collaborative. The year to date position for the Mental Health Provider Collaborative is £1.6m deficit, driven by the cost of section 117 packages of care.

Alert:

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

- Temporary staffing – YTD bank and agency spend is £26m. We are in breach of all of the NHSE agency rules except for agency framework – we have no off framework bookings. There has been a reduction in temporary staffing spend over the last two months but YTD agency expenditure has breached the NHSE ceiling by £611k. Agency spend as a percentage of the pay bill is 4.1% YTD compared to a ceiling of 3.7%. Good progress has been made to address non clinical agency in the Trust with only 1 in post. Work is ongoing to reduce non clinical agency in SSL. Biggest challenge to address is 36 above cap agency bookings, in particular medical.

- Savings - YTD delivery of £7.2m which is a shortfall against plan of £1.4m driven by non-achievement against out of area savings target. Although full savings delivery of £14.7m is forecast for the year, this is mainly

driven by non-recurrent delivery. The total non-recurrent forecast achievement is £9.7m for 2023/24. This will roll over as a brought forward savings target for 2024/25. Attempts to develop initial 2024/25 savings plans via a 1% savings target have been disappointing – only £0.8m identified to date, a shortfall of £1.7m.

- Out of area expenditure – Significant out of area expenditure is continuing and is also driving the shortfall in recurrent savings delivery (£5m out of area savings target set for 2023/24). YTD spend of £11m, straight lined for the full year, would equate to £19m. This would result in a potential overspend of £11m against a plan of £8m.

- PFI expenditure run rate increase is continuing due to water management costs related to ongoing monitoring at the Highcroft site.

- The forecast position for 2023/24 is currently held at break even, in line with plan. On 8.11.23, NHSE issued a letter to confirm funding and actions to be taken to manage the financial and performance pressures created by industrial action. £800m funding will be allocated nationally to ICBs, with the BSOL share being £25m. Systems have been requested to complete a rapid two-week exercise to agree actions to achieve financial balance for the remainder of the year. Work is underway across the BSOL ICS to meet the deadline of 22.11.23.

Advise:
The Committee is asked to note the following:

- Transition to PFI liability measurement under IFRS 16 (international financial reporting standard for leases) had been delayed to allow finalisation of HMT guidance but will now be effective from 1 April 2023. Guidance from NHSE has stated a requirement to report PFI liabilities on an IFRS 16 basis for the first time at month 9. A piece of work on the impact of the application of IFRS16 to PFI liability measurement is currently underway.

Capital position
Month 7 2023/24 Group capital expenditure is £3.5m. This is £2.8m adverse to plan due to works progressing ahead of plan, mainly related to risk assessment works including door set expenditure.

Cash position
The month 7 Group cash position is £88m.

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

To review month 7 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 31st October 2023

Month 7
Group financial position

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Group Summary	Annual Budget	1.6% Pay Award Funding	0.7% Medic Pay	Revised Plan	YTD Position		
					Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
Patient Care Activities	566,227	10,085	3,388	579,700	338,156	336,774	(1,382)
Other Income	18,832	-	-	18,832	10,986	16,720	5,734
Total Income	**585,060**	**10,085**	**3,388**	**598,533**	**349,142**	**353,494**	**4,352**
Expenditure							
Pay	(270,159)	(5,943)	(2,289)	(278,391)	(162,395)	(157,081)	5,314
Other Non Pay Expenditure	(277,459)	(4,142)	(1,099)	(282,700)	(164,906)	(174,790)	(9,884)
Drugs	(6,077)	-	-	(6,077)	(3,545)	(4,279)	(734)
Clinical Supplies	(795)	-	-	(795)	(464)	(346)	118
PFI	(12,611)	-	-	(12,611)	(7,356)	(8,669)	(1,313)
EBITDA	**17,959**	**-**	**-**	**17,959**	**10,476**	**8,329**	**(2,147)**
Capital Financing							
Depreciation	(9,906)	-		(9,906)	(5,778)	(5,676)	102
PDC Dividend	(1,717)	-		(1,717)	(1,002)	(1,002)	(1)
Finance Lease	(5,693)	-		(5,693)	(3,321)	(3,330)	(10)
Loan Interest Payable	(1,060)	-		(1,060)	(618)	(630)	(11)
Loan Interest Receivable	797	-		797	465	2,107	1,642
Surplus / (Deficit) before tax	**380**	**-**	**-**	**380**	**222**	**(202)**	**(423)**
Taxation	(380)	-		(380)	(222)	(224)	(2)
Surplus / (Deficit)	**(0)**	**-**	**-**	**(0)**	**(0)**	**(426)**	**(426)**

Month 7 2023/24 Group Financial Position

The month 7 consolidated Group position is a deficit of £426k year to date. This is £426k adverse to the break-even plan. The 2023/24 forecast remains at break even, in line with plan.

Temporary staffing expenditure remains high. There has been a reduction in spend over the last two months but year to date expenditure has breached the NHSE ceiling by £611k. Significant out of area expenditure is continuing and is also driving the shortfall in recurrent savings delivery (£5m out of area savings target set for 2023/24). PFI expenditure run rate is continuing to increase, driven by ongoing water management costs at the Highcroft site.

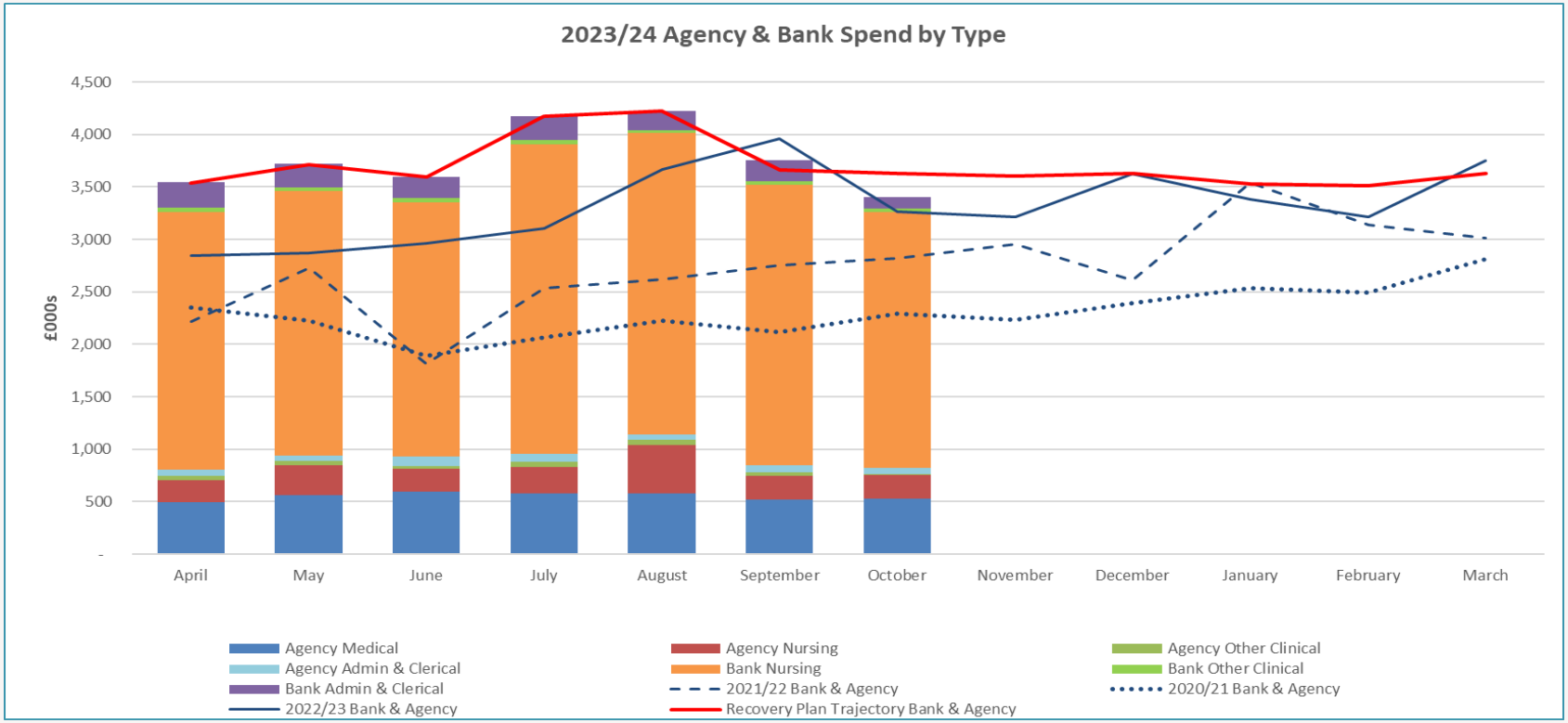
Transition to PFI liability measurement under IFRS 16 (international financial reporting standard for leases) had been delayed to allow finalisation of HMT guidance but will now be effective from 1 April 2023. Guidance from NHSE has stated a requirement to report PFI liabilities on an IFRS 16 basis for the first time at month 9. A piece of work on the impact of the application of IFRS16 to PFI liability measurement is currently underway.

The Group position includes a £971k surplus for the Trust, £151k surplus for the wholly owned subsidiary, Summerhill Services Limited (SSL), and a £146k surplus position for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads. The year to date position for the Mental Health Provider Collaborative (MHPC) is a deficit of £1.6m, driven by the cost of section 117 packages of care, in line with the forecast presented to commissioning committee. For a segmental breakdown of the Group position, please see page 3.

Month 7 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	201,017	-	86,723	217,961	(168,928)	336,774
Other Income	15,931	17,563	-	1,269	(18,042)	16,720
Total Income	**216,948**	**17,563**	**86,723**	**219,230**	**(186,970)**	**353,494**
Expenditure						
Pay	(148,259)	(7,314)	(902)	(1,393)	787	(157,081)
Other Non Pay Expenditure	(48,724)	(4,948)	(85,676)	(219,454)	184,011	(174,790)
Drugs	(4,482)	(1,737)	-	-	1,939	(4,279)
Clinical Supplies	(346)	-	-	-	-	(346)
PFI	(8,669)	-	-	-	-	(8,669)
EBITDA	**6,469**	**3,564**	**146**	**(1,617)**	**(233)**	**8,329**
Capital Financing						
Depreciation	(3,836)	(1,782)	-	-	(57)	(5,676)
PDC Dividend	(1,002)	-	-	-	-	(1,002)
Finance Lease	(3,322)	(223)	-	-	214	(3,330)
Loan Interest Payable	(630)	(1,184)	-	-	1,184	(630)
Loan Interest Receivable	3,292	0	-	-	(1,184)	2,107
Surplus / (Deficit) before Taxation	**971**	**375**	**146**	**(1,617)**	**(76)**	**(202)**
Taxation	-	(224)	-	-	-	(224)
Surplus / (Deficit)	**971**	**151**	**146**	**(1,617)**	**(76)**	**(426)**

Temporary staffing expenditure



The month 7 year to date temporary staffing expenditure is £26.4m. There has been a reduction in spend over the last two months, from the peak in July and August, with October being the lowest monthly spend of the year to date.

If the year to date average expenditure continued for the full year, this would equate to £45m. The financial recovery plan assessment in September included a trajectory for reduction in bank and agency spend, with a total trajectory of £44m. The year to date expenditure is £119k less than the trajectory, with an adverse variance on agency spend of £133k offset by bank spend being £251k less than trajectory year to date.

Bank expenditure £20m (76%) – the majority of bank expenditure relates to nursing bank shifts - £18.3m

Agency expenditure £6.4m (24%) – the majority of agency expenditure relates to medical agency - £3.9m.

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

Agency Rules compliance

Agency Rules

What are the Agency Rules?

The agency rules were introduced in April 2016 to support trusts to reduce their agency expenditure and move towards a more sustainable model of temporary staffing. The main points of the rules are:

- system ceilings – the total amount a system can spend on agency workers during the financial year.
- approved frameworks – trusts should only use agencies awarded to approved frameworks to supply temporary staff.
- price caps – the total amount trusts can pay per hour for an agency worker.
- admin and estates workers – trusts should only use substantive or bank workers to fill admin and estates roles, with some exceptions.

On 10.10.23, NHSE issued an agency reduction letter, with the following actions for Trusts to be completed by 31.10.23:

- Demonstrate compliance to report progress on temporary staffing expenditure on a routine monthly basis to board, with specific reference to the progress to reduce agency off framework procurement, admin and estates agency and price cap breaches.
- Confirm in writing that the Agency Rules and the Toolkit is understood by the Executive Team, and that there is evidence of a commitment to the application of this policy to the activities of their organisation.
- Provide a gap analysis detailing any variation between the organisation's current compliance and the Agency Rules requirements.
- Provide a plan with clear actions, timescales and trajectory to achieve full compliance with the agency rules requirements.

		Reported to NHSE 31.10.23	
KPIs	**Target**	**Sep-23**	**Oct-23**
Agency spend as % of pay bill (YTD)	**3.7%**	4.2%	4.1%
Agency framework breaches	**0**	0	0
Above price cap agency bookings - medical	**0**	19	20
Above price cap agency bookings - nursing	**0**	19	16
Admin & Estates bookings - Trust	**0**	2	1
Admin & Estates bookings - SSL	**0**	17	15

The gap analysis of the agency rules KPIs are shown opposite, with the September numbers being the position as reported to NHSE on 31.10.23 and the October numbers being the current position.

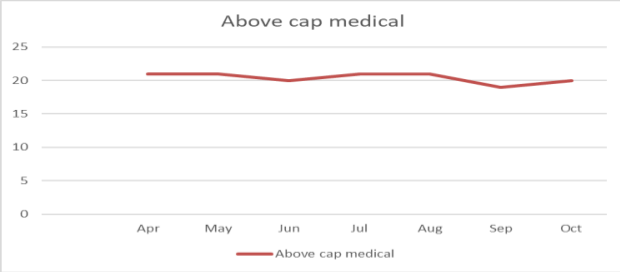
Agency ceiling - Agency spend for October year to date exceeded the ceiling of 3.7% of pay bill by 0.4%, this is a slight improvement on September and equates to a £611k breach of ceiling year to date.

Above price cap agency bookings are a particular challenge. There has been a worsening in position for medical and an improvement in nursing, compared to September. In total we have 36 over cap at the end of October, for further detail see pages 6–7.

Admin and estates agency – good progress has been made in the Trust to reduce the number of non clinical agency workers. There is now only 1 in post, due to end on 1.12.23. There are 15 in SSL, a reduction of 2 from September. For further detail, see page 8.

Above cap agency bookings Medical

Consultant - above cap	Total No. in post above price cap	1-10% above price cap	11-30% above price cap	31-50% above price cap	51-70% above price cap	71-90% above price cap
Consultant - above cap						
ICCR - CAMHS SOLAR	**2**					2
ICCR - CMHT	**9**		1	2	3	3
Older Adults	**1**		1			
Secure Care	**1**				1	
Acute & Urgent Care	**1**		1			
SAS Grade - above cap						
ICCR - East AOT	**1**		1			
ICCR - CMHT	**2**	2				
Older Adults	**3**	1	2			
Total Medical above cap	**20**	**3**	**6**	**2**	**4**	**5**



- For October, there are 20 above cap medical agency bookings, 14 are within the ICCR service area, mainly CMHT.
- Almost half of the bookings are being paid at a rate that is 51-90% above cap.
- The planned trajectory for above cap medical bookings is shown in the table below. The actual number for October is 1 above trajectory due to the commencement of a new booking on 30.10.23 (planned in the trajectory to commence in November).
- The current trajectory forecasts 13 above cap medical agency bookings by the end of the financial year.

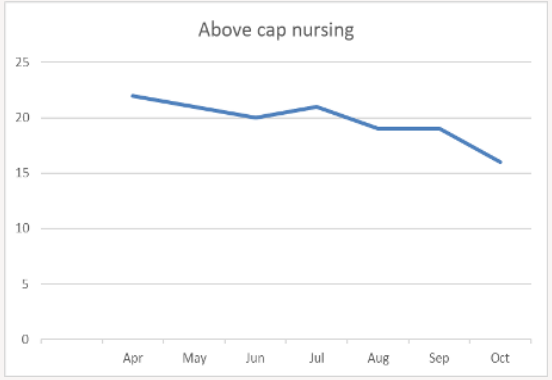
Trajectory for above cap medical bookings

Staff_Group	Metric	Oct'23	Nov'23	Dec'23	Jan'24	Feb'24	Mar'23
Above cap - Medic	**Total agency WTE in post ast the start of the month - TRUST**	**19**	**19**	**20**	**19**	**19**	**15**
Above cap - Medic	Total agency WTE to end during the month	0	0	2	0	5	2
Above cap - Medic	Total agency WTE to be added (in line with NHSE guidance on allowable exceptions)	0	1	1	0	1	0
Above cap - Medic	**Total agency WTE in post at the end of the month**	**19**	**20**	**19**	**19**	**15**	**13**

Above cap agency bookings Nursing

Nursing above cap	Total No. in post above price cap	No. 1-10% above price cap	No. 11-30% above price cap	No. 31-50% above price cap	No. 51-70% above price cap	No. 71-90% above price cap
ACUC	**3**		3			
ICCR	**2**		2			
SCOH	**6**		5	1		
Specialties	**5**		5			
Total	**16**	**0**	**15**	**1**	**0**	**0**

- For October, there are 16 above cap nursing agency bookings (22 at the start of the financial year).
- All above cap nursing bookings require prior approval from Executive Director for Strategy, People and Partnerships.
- 94% of the bookings are being paid at a rate that is 11-30% above cap.
- Over half of the over cap nursing bookings are due to end by November 2023, with all due to end by January 2024, subject to agreement of Executive Director approval of booking renewals, see trajectory below.



Trajectory for above cap nursing bookings

Staff_Group	Metric	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Above cap - Nursing	**Total agency WTE in post at the start of the month**	**16**	**13**	**7**	**3**	**0**	**0**
Above cap - Nursing	Total agency WTE to end during the month	3	6	4	3		
Above cap - Nursing	Total agency WTE to be added (in line with NHSE guidance on allowable exceptions)						
Above cap - Nursing	**Total agency WTE in post at the end of the month**	**13**	**7**	**3**	**0**	**0**	**0**

Non-clinical agency

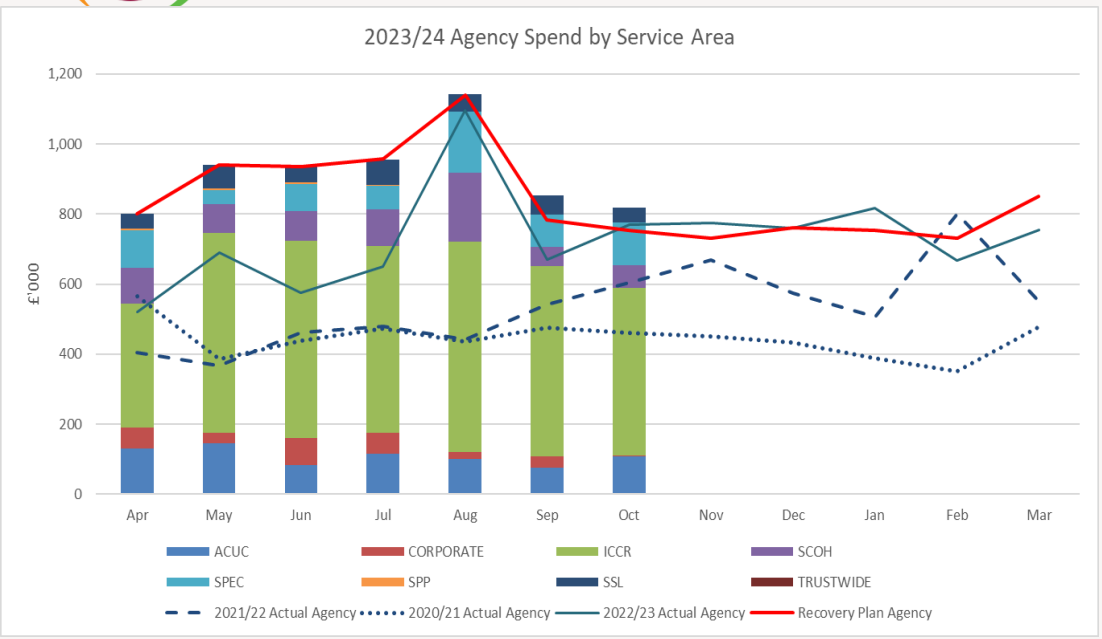
Non-clinical agency bookings - Trust
There is 1 non-clinical agency booking within the Trust, with a planned end date of 1.12.23.

Non-clinical agency bookings – SSL
There are 15 non-clinical agency bookings in SSL, a reduction of 2 from September. This is in line with the trajectory that SSL have developed to reduce agency bookings. It is anticipated that 12 will be removed by December 2023 as a result of recruitment to substantive posts. The remaining 5 relate to domestics and transport bookings covering long term sickness, with sickness end date unknown.

Trajectory for non-clinical agency bookings

Staff_Group	Metric	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Admin & Estates - TRUST	**Total agency WTE in post at the start of the month**	**2**	**1**	**0**	**0**	**0**	**0**
Admin & Estates	Total agency WTE to end during the month	1	1				
Admin & Estates	Total agency WTE to be added (in line with NHSE guidance on allowable exceptions)						
Admin & Estates	**Total agency WTE in post at the end of the month**	**1**	**0**	**0**	**0**	**0**	**0**
Admin & Estates - SSL	**Total agency WTE in post at the start of the month**	**17.43**	**14.76**	**11.42**	**7.18**	**5.18**	**5.18**
Admin & Estates	Total agency WTE to end during the month	2.67	3.34	4.24	2	0	0.5
Admin & Estates	Total agency WTE to be added (in line with NHSE guidance on allowable exceptions)	0	0	0	0	0	0
Admin & Estates	**Total agency WTE in post at the end of the month**	14.76	11.42	7.18	5.18	5.18	4.68

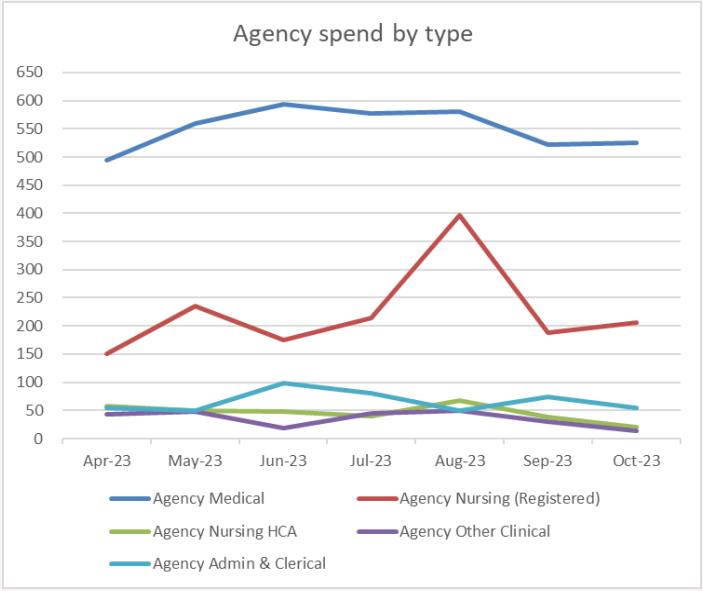
Agency expenditure analysis



	2023/24 YTD
	£'000
Agency Expenditure	6,446
NHSE Ceiling (3.7% of pay bill)	5,835
Variance to NHSE ceiling	(611)
Agency Medical	3,852
Agency Nursing (Registered)	1,564
Agency Nursing HCA	321
Agency Other Clinical	248
Agency Admin & Clerical	462
Agency Expenditure	6,446

Total agency spend as % of pay bill (YTD)	4.1%

Agency spend as % of pay bill YTD	Oct-23
ACUC	2.5%
CORPORATE	1.2%
ESTATES	-
ICCR	10.5%
SCOH	2.0%
SPEC	2.4%
SPP	0.5%
SSL	5.2%

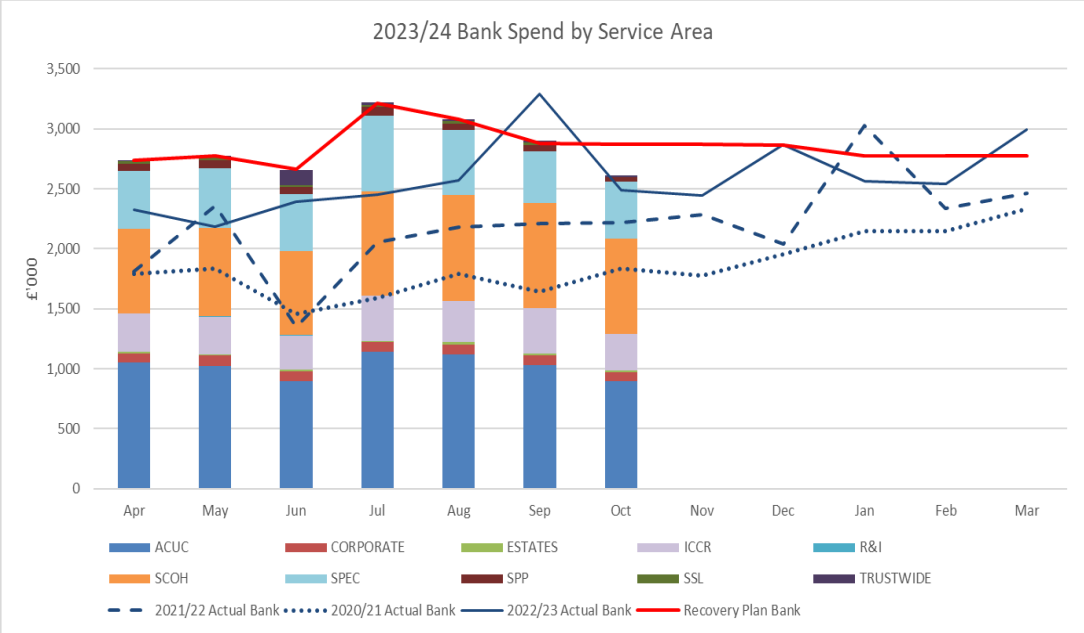


- Agency expenditure is £6.5m year to date. This is 4.1% of the year to date pay bill, compared to the NHSE ceiling of 3.7% - total breach of £611k.
- 56% of the year to date expenditure was incurred by ICCR (11% of the ICCR pay bill year to date). 60% of total spend relates to medical agency.
- Expenditure in October was £819k, this is £100k less than the year to date average and almost in line with April when spend was at the lowest of the year to date.
- A straight line forecast of year to date expenditure would give a total spend of £11m. The financial recovery plan trajectory is £10m. Year to date spend is £133k above this trajectory.

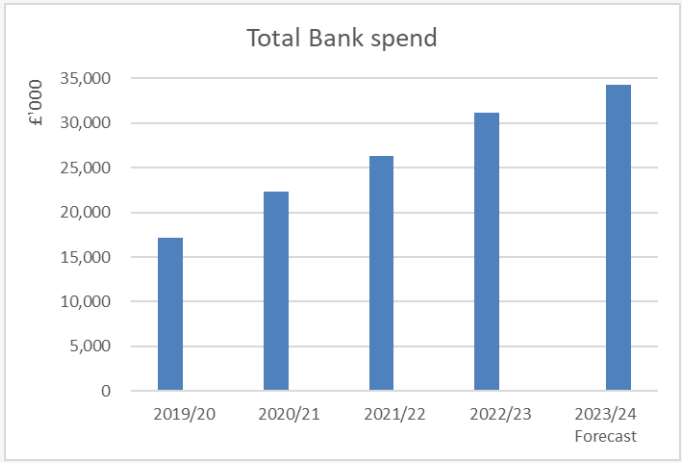
Current initiatives to address agency spend:

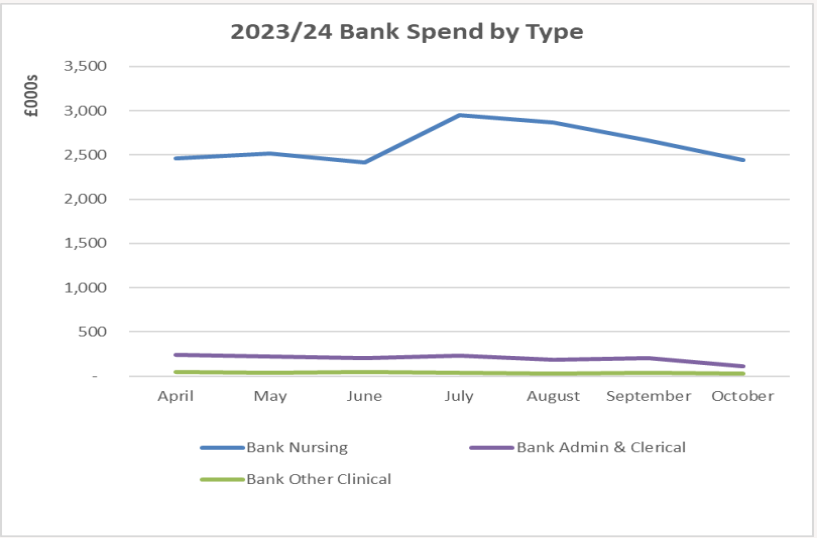
- Direct Engagement – in discussion with potential providers – VAT savings on medical agency.
- Preliminary discussions around partnering with NHSProfessionals to transfer existing nursing agency bookings – reduction in fees.
- Work being carried out to identify vacancies advertised compared to agency block booking requirements and usage.
- HCA agency requests authorised by Executive Director for Strategy, People and Partnerships.
- TSS to Substantive initiative - focused upon using an SOP to expedite recruitment process should the candidate have been working regular shifts in an area and they are supported by Ward Manager.

Bank expenditure analysis



Type	YTD £'000	% of spend
Bank Nursing	18,316	92%
Bank Other Clinical	258	1%
Bank Admin & Clerical	1,401	7%
Grand Total	**19,974**	**100%**

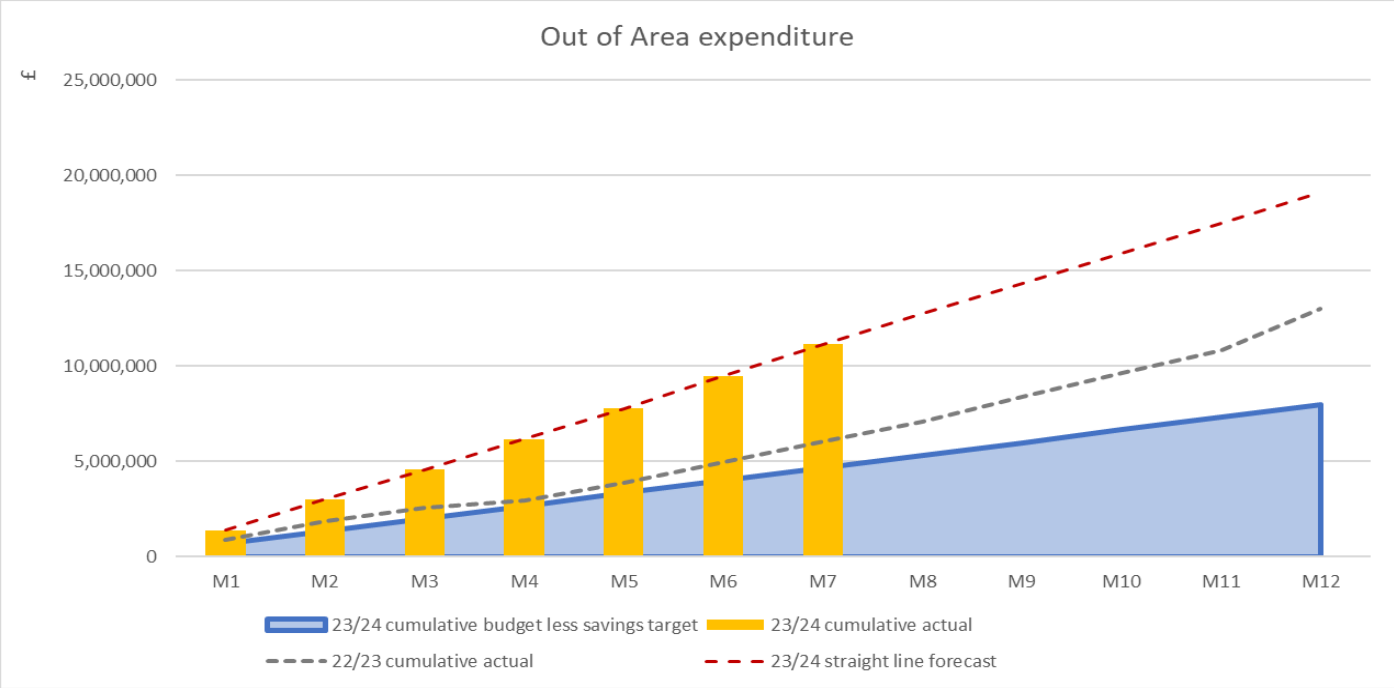


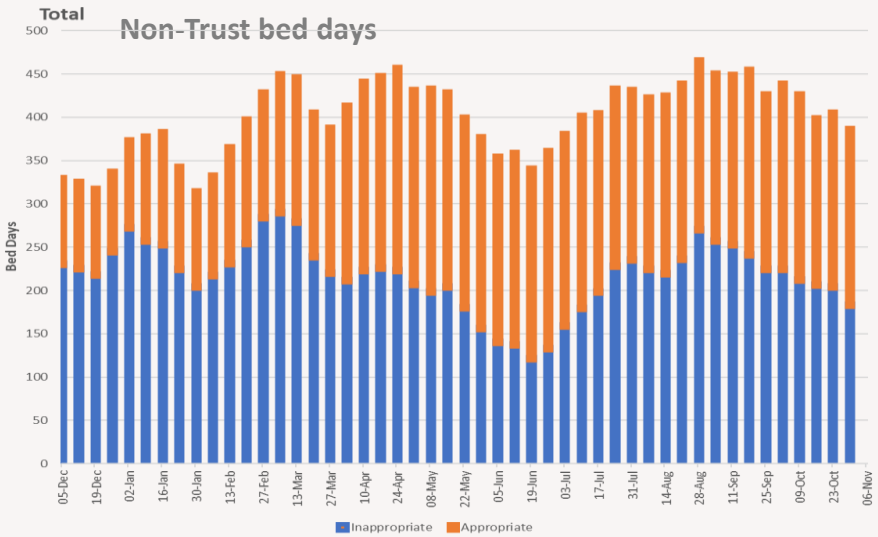


Bank expenditure

- Month 7 year to date bank expenditure is £20m. A straight line of year to date spend would result in £34m total spend.
- Year to date bank expenditure is £251k less than the trajectory as per the financial recovery plan.
- October has seen the third consecutive drop in monthly bank spend. Spend has decreased by £323k compared to September. £228k reduction in nursing spend (mainly in Acute and Urgent Care and Secure and Offender Health) and £111k reduction in admin and clerical (mainly in SSL).
- Year to date bank expenditure has predominantly been incurred within the following service areas: Acute & Urgent Care £7.2m, Secure and Offender Health £5.6m and Specialities £3.5m.

Out of Area overspend

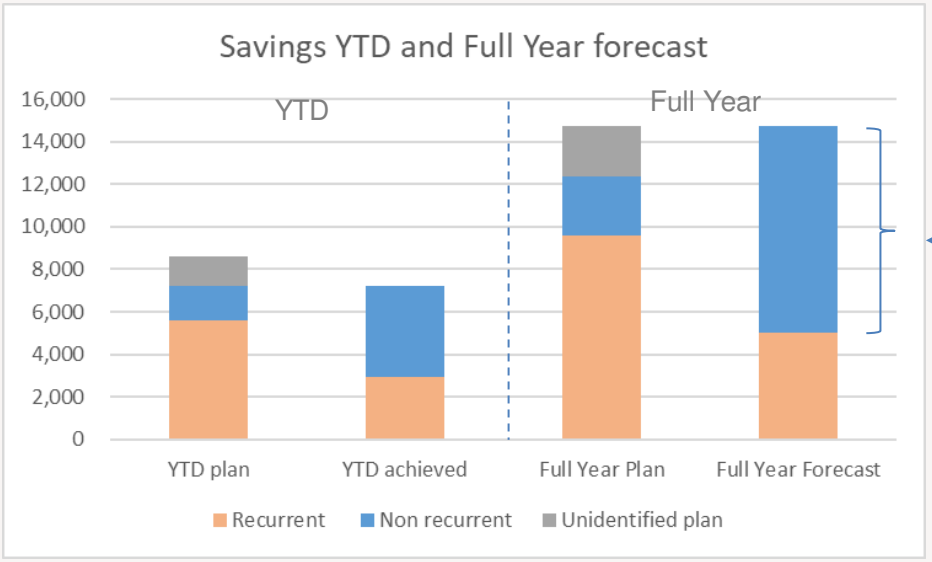




- Year to date out of area expenditure as at month 7 is £11m.
- Total 2023/24 plan for out of area, including a £5m savings target, is £8m.
- Year to date overspend is £6.5m. If spend were to continue at the year to date average, total expenditure would be £19m; an overspend of £11m.
- In preparation for the end of the Priory contract, supplier reconciliations are being brought up to date and we continue to review the impact of out of contract arrangements with Priory and Active Care Group.

Efficiencies

Recurrent/ Non-Recurrent	Scheme Name	Sum of YTD Plan	Sum of YTD Actual	Sum of YTD Variance	Sum of Annual Plan	Sum of Full Year Forecast	Sum of Forecast variance
Non-recurrent	Budget setting pay review (not wte)	292	292	-	500	500	-
	Budget setting pension review	817	817	-	1,400	1,400	-
	Interest receivable (1%)	146	146	-	250	250	-
	PFI - commercial performance settlement	350	619	269	600	1,357	757
	Unidentified	1,376	-	(1,376)	2,358	154	(2,205)
	Additional interest receivable	-	1,643	1,643	-	1,643	1,643
	NR income	-	761	761		4,396	4,396
Non-recurrent Total		**2,980**	**4,277**	**1,297**	**5,108**	**9,699**	**4,591**
Recurrent	Budget setting non pay review	729	729	-	1,250	1,250	-
	Budget setting pay review (not wte)	618	602	(15)	1,059	1,033	(26)
	Estates budget for Ross House (disposal)	88	44	(44)	150	75	(75)
	Interest receivable (@2.25%)	117	117	-	200	200	-
	OH contribution	1,138	1,138	-	1,950	1,950	-
	Out of Area reduction	2,917	-	(2,917)	5,000	-	(5,000)
	Additional OH contribution	-	298	298		510	510
Recurrent Total		**5,605**	**2,927**	**(2,678)**	**9,609**	**5,018**	**(4,591)**
Grand Total		**8,585**	**7,204**	**(1,381)**	**14,717**	**14,717**	**(0)**



£9.7m forecast non- recurrent savings achievement will rollover as savings target into 2024/25

The 2023/24 efficiency target is £14.7m. The savings plan submitted to NHSE comprised £9.6m recurrent savings plans and £5.1m non-recurrent (including £2.4m unidentified plans).

Year to date achievement

Savings achievement at month 7 totals £7.2m, a shortfall of £1.4m year to date. The shortfall is driven by £2.9m non-delivery against the out of area savings target which is part offset by additional non-recurrent savings.

Forecast

It is forecast that the full £14.7m savings target will be achieved in year. However, there will be an under achievement of £5m against recurrent plans (due to out of area slippage) which will be offset by non-recurrent savings. Therefore, the total non-recurrent forecast achievement is £9.7m for 2023/24. This will roll over as a savings target brought forward for 2024/25.

2024/25 Savings

As agreed at August FPP, a 1% savings target was set for all operational and corporate areas for 2024/25. Initial plans were due to be submitted for review at Sustainability Board on 26.10.23. Plans totalling £782k were submitted compared to a target of £2.5m; a shortfall of £1.7m. For further detail, see planning and budget setting update paper.

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-23 £m's	NHSI Plan YTD 31-Oct-23 £m's	Actual YTD 31-Oct-23 £m's	NHSI Plan Forecast 31-Mar-24 £m's
Non-Current Assets				
Property, plant and equipment	214.2	212.5	212.1	211.3
Prepayments PFI	1.3	1.3	2.0	1.3
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	0.0	-	-	-
Deferred Tax Asset	(0.1)	-	-	-
Total Non-Current Assets	215.4	213.8	214.1	212.6
Current assets				
Inventories	0.6	0.6	0.3	0.6
Trade and Other Receivables	28.2	28.2	20.8	28.2
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	59.0	57.3	88.4	56.8
Total Curent Assets	87.9	86.2	109.5	85.7
Current liabilities				
Trade and other payables	(55.9)	(56.0)	(69.3)	(55.9)
Tax payable	(5.0)	(5.0)	(5.4)	(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)	(51.5)	(40.4)
Total Current Liabilities	(106.5)	(106.7)	(131.0)	(106.6)
Non-current liabilities				
Deferred Tax Liability	-	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(25.1)	(23.3)	(23.3)	(23.0)
PFI lease	(45.7)	(44.6)	(44.6)	(43.8)
Finance Lease, non current	(7.9)	(7.2)	(7.2)	(6.8)
Provisions	(3.7)	(3.7)	(3.4)	(3.7)
Total non-current liabilities	(82.4)	(79.0)	(78.6)	(77.4)
Total assets employed	114.4	114.4	113.9	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)	(42.3)	(41.9)
Total taxpayers' equity	114.4	114.4	113.9	114.4

SOFP Highlights

The Group cash position at the end of October 2023 is £88.4m, 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 14 to 15.

Current Assets & Current Liabilities

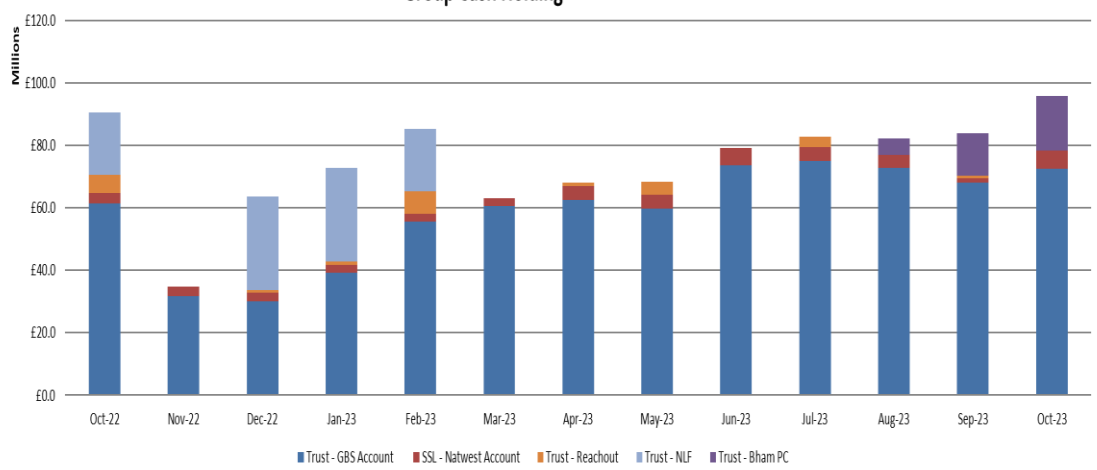
Ratios

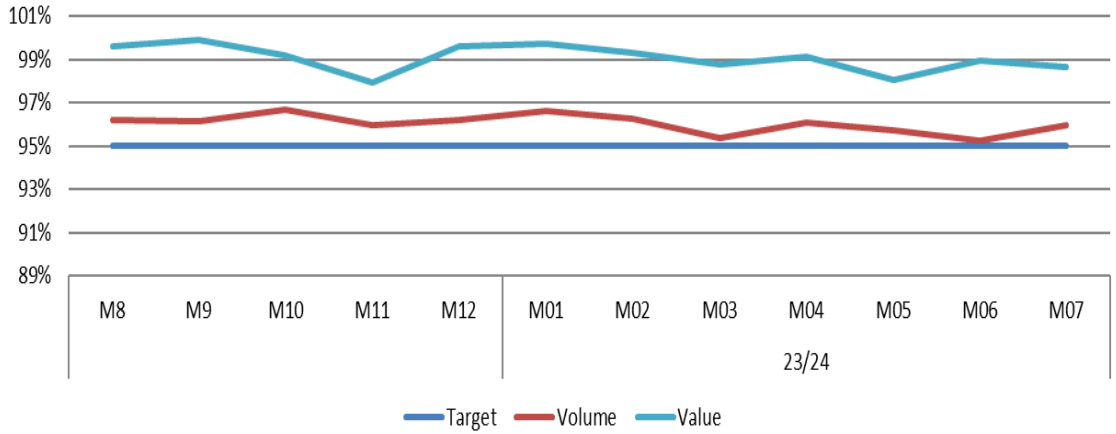
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	109.5
Current Liabilities	-131.0
Ratio	0.8

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of October 2023 is £88.4m.

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

Better Payments

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

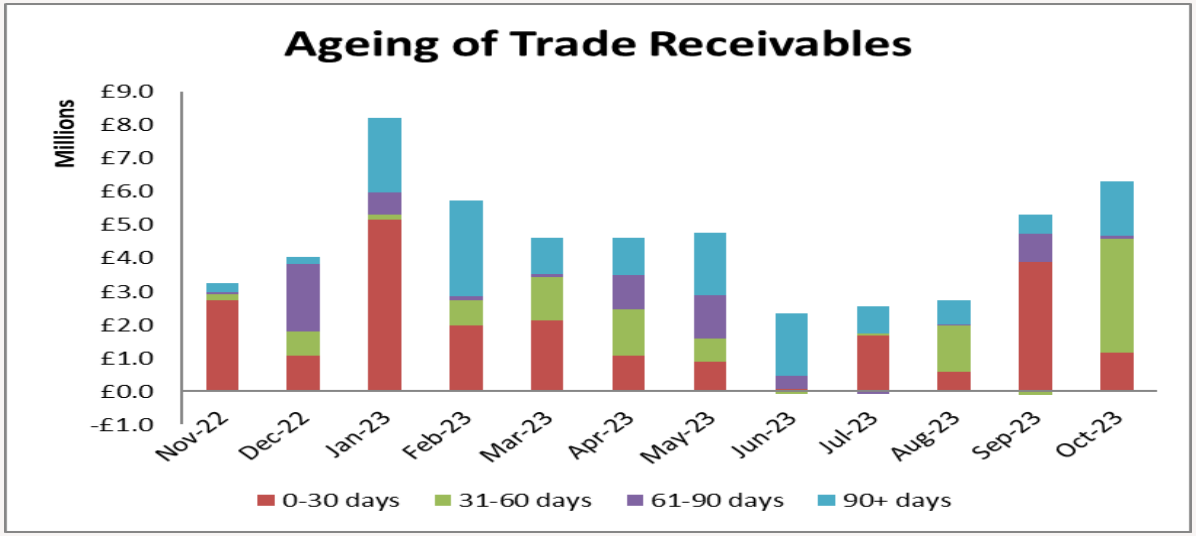
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

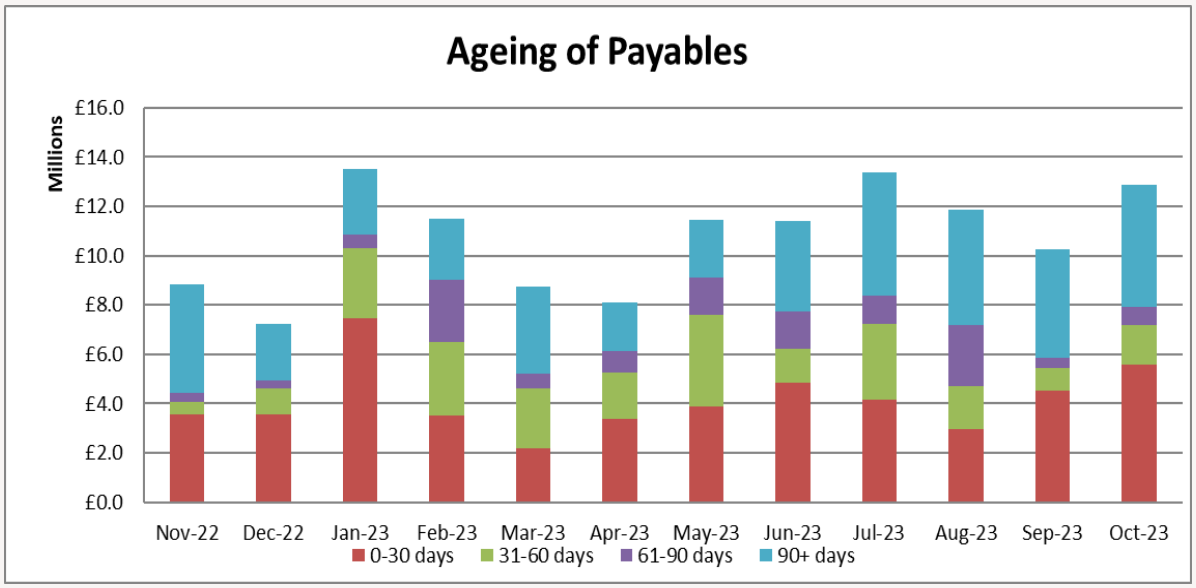
NHSE wrote to the Finance Team in September 2023 to commend them on this consistent performance throughout the year.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	95%	✓	99%	✓
Non - NHS Creditors within 30 Days	96%	✓	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-** Decrease in balance due to some outstanding invoices moving in to 31-60 days. The balance relates to ad hoc invoices raised in month with no known disputes/payments received as from Nov 23 £208k.
- **31-60 days-** Significant increase in balance – BWC £959K authorisation on hold, SWBH £359k invoice on next payment run, UHB £976k invoices raised without contracts agreed and no purchase orders in place so anticipated delays in payment, balance relates to staff overpayments (on payment plans)
- **61-90 days-** significant decrease in month mainly due to UHB £49k, balance mainly relates to staff overpayments (on payment plans)
- **Over 90 days –**overall balance due to queries with UHB £1.1m, BUPA £62k, Nottinghamshire NHS £48k, South Warwickshire Partnership Trust £24k, SDSmyhealthcare £35k, balance staff overpayments (on payment plans).

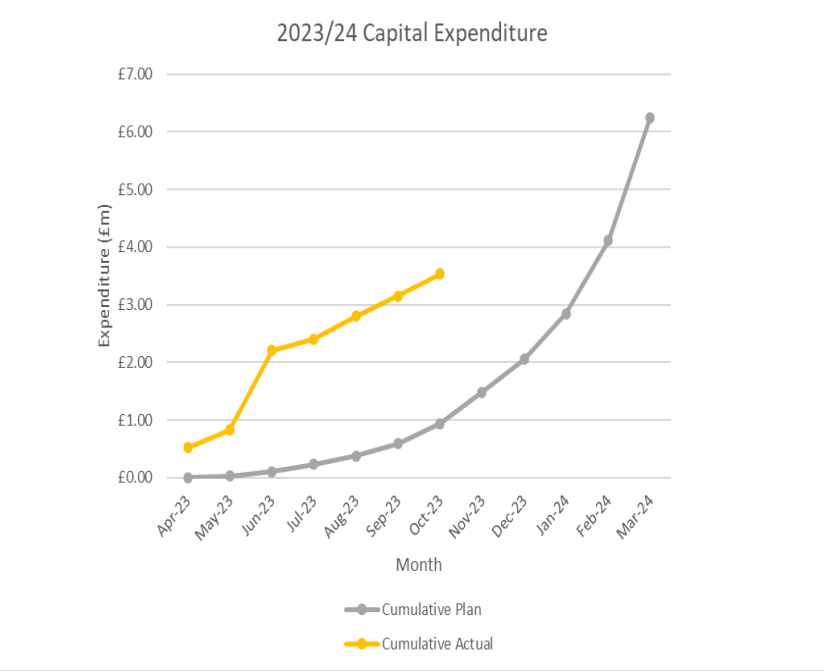
Trade Payables:

Over 90 days -

- Coventry & Warwickshire -£960k Reach Out related awaiting approval, BWCH £424k awaiting new PO & credit note, NHS Property £282k-historic invoices, UHB £146k awaiting approvals, SWBH £146k settled in Nov 23
- Non-NHS Suppliers (61+) £2.8m – mainly bed fees invoices in query, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in November 2023.

Month 7 Capital Expenditure

Capital schemes	Annual Plan	YTD Plan	Total Actual	Variance to plan
	£'m	£'m	£'m	£'m
Approved Schemes:				
Minor Projects (inc Carry-Forward)	1.7	0.2	0.9	0.7
SSBM Works	2.0	0.4	0.7	0.3
ICT Projects	0.9	0.0	0.7	0.7
Risk Assessment Works	0.4	0.0	1.3	1.3
CAMHS Seclusion Suite (PDC Funded)	1.3	0.2	0.0	-0.1
Total	6.3	0.8	3.5	2.8
R&D Capital Grant	0.7	0.0	0.0	0.0



Group Capital Expenditure

Group capital expenditure is £3.5m year to date. This is £2.8m adverse to the year to date plan due to works progressing ahead of plan, mainly related to risk assessment works including door set expenditure.

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 was 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, while we await confirmation, expenditure is being monitored against the £6.25m envelope.

An additional £440k of capital expenditure will be incurred this year due to non emergency patient transport vehicle lease renewals. Under IFRS 16 (the international financial reporting standard for leases), which became applicable to NHS accounting from 1 April 2022, operating leases must be capitalised on the balance sheet. We are currently forecasting that this capitalisation will be offset by SCIF but a reprioritisation of the current capital plan may be required depending on the outcome of the system decision on SCIF allocation.

Trust Service Area analysis

Group Summary	Annual Budget	YTD Budget	YTD Actual	YTD Variance
	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000
Acute and Urgent Care Services				
Other Income	(148)	(86)	(437)	351
Pay	43,709	25,423	30,803	(5,381)
Non Pay	17,199	9,982	14,100	(4,118)
Acute and Urgent Care Services Total	**60,760**	**35,319**	**44,466**	**(9,147)**
ICCR				
Other Income	(4,851)	(2,830)	(3,326)	497
Pay	57,538	33,546	34,645	(1,098)
Non Pay	10,386	6,043	6,623	(580)
ICCR Total	**63,073**	**36,760**	**37,941**	**(1,181)**
Specialties Services				
Other Income	(3,375)	(1,969)	(1,829)	(140)
Pay	42,906	25,028	28,698	(3,669)
Non Pay	3,243	1,892	2,146	(254)
Specialties Services Total	**42,774**	**24,951**	**29,015**	**(4,064)**
Secure Serv & Offender Health				
Other Income	(479)	(280)	(1,415)	1,135
Pay	54,919	32,036	34,063	(2,027)
Non Pay	8,828	5,150	4,867	283
Secure Serv & Offender Health Total	**63,268**	**36,906**	**37,515**	**(609)**
Corporate Services				
Other Income	(12,852)	(7,497)	(11,732)	4,235
Pay	43,070	25,124	27,576	(2,452)
Non Pay	37,860	22,085	25,697	(3,612)
PFI	12,611	7,356	8,669	(1,313)
Capital Financing	12,335	7,195	5,498	1,697
Corporate Services Total	**93,023**	**54,263**	**55,708**	**(1,444)**
HCI Total	**(331,164)**	**(193,179)**	**(198,209)**	**5,030**
Trustwide total	**8,711**	**5,239**	**(7,406)**	**12,645**
Surplus / Deficit - Trust	**444**	**259**	**(971)**	**1,229**

The month 7 year to date Trust position is a £971k surplus, this is £1.2m better than 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) £9.1m overspent

- Pay is £5.4m overspent (including pay award). £7.5m temporary staffing overspend (£6.8m bank), £2.1m substantive underspend.
- Non pay is £4.1m overspent, predominantly due to out of area expenditure. This does not take into account the £5m out of area savings target, which is held centrally. Including non-delivery against this target, out of area total overspend year to date is £6.5m.

Integrated Community Care & Recovery (ICCR) £1.2m overspent

- Pay is £1m overspent (including pay award). £4.9m substantive underspend, including Service Development Funding (SDF) is offset by £6m temporary staffing spend (£3.6m agency, £2.3m bank).

Specialties £4m overspent

- Pay is £3.7m overspent (including pay award). £3.9m temporary staffing overspend (£3.2m bank).

Secure Care and Offender Health (SCOH) £0.6m overspent

- Other Income is £1.1m ahead of plan, mainly relating to specialling income.
- Pay is £2m overspent (including pay award). £4.4m temporary staffing overspend (£3.7m bank) and £2.4m substantive underspend.

Corporate £1.4m overspent

- Pay is £2.5m overspent (including pay award). £1.2m substantive overspend and £1.3m temporary staffing overspend (£1m bank).
- Non pay is £3.6m overspent, this is offset by other income £4.2m and interest receivable £1.7m.
- PFI expenditure is £1.3m overspent mainly due to water management costs.

DRAFT System position

At the time of writing, the draft Month 7 revenue position for Birmingham and Solihull Integrated Care System (BSOL ICS) is £61m deficit. This is a deterioration of £9m compared to month 6 and is mainly driven by the draft UHB position of £57m deficit year to date. The system forecast is currently held at break even.

On 8.11.23, NHSE issued a letter to ICBs and Trusts to confirm system funding allocations to help manage the financial and performance pressures created by industrial action. Systems have been asked to complete a rapid two-week exercise to determine action plans for achieving financial balance for 2023/24. For further detail, see next page.

Organisation	Surplus / (Deficit) - Adjusted Financial Position						Prior Month		Movement	
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Actual YTD £000	Variance YTD £000	Actual YTD £000	Variance YTD £000
Birmingham And Solihull ICB - System Risk Reserve	6,543	4,193	(2,351)				3,877	-2,462	316	111
Birmingham And Solihull ICB - Other	(4,167)	(2,118)	2,050	-	-	-	-842	381	(1,276)	1,669
Birmingham and Solihull ICB	2,376	2,075	(301)	-	-	-	3,035	-2,081	-960	1,780
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(423)	(423)	-	-	-	-495	-495	72	72
Birmingham Community Healthcare NHS Foundation Trust	308	(523)	(831)	-	(0)	(0)	-443	-707	(80)	(124)
Birmingham Women'S And Children'S NHS Foundation Trust	0	(1,496)	(1,496)	0	0	0	-1,507	-1,507	11	11
The Royal Orthopaedic Hospital NHS Foundation Trust	383	(3,272)	(3,655)	0	-	(0)	-3,026	-3,361	(246)	(294)
University Hospitals Birmingham NHS Foundation Trust	(7,000)	(57,311)	(50,311)	0	0	0	-49,128	-40,428	(8,183)	(9,883)
ICS Total	(3,933)	(60,950)	(57,018)	0	1	0	(51,564)	(48,579)	(9,386)	(8,438)

2023/24 Non Recurrent Industrial Action funding

On 8.11.23, NHSE issued a letter to ICBs and Trusts to confirm the funding and actions that the NHS has been asked to take, following discussions with Government, to manage the financial and performance pressures created by industrial action. The key messages of the letter and the associated guidance are as follows:

- The agreed priorities for the remainder of the financial year are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

- By 22.11.23, systems must complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year, with the working assumption that there is no further strike action.

- From 27.11.23 onwards, ICB and provider Executives to meet with NHSE to agree proposed actions.

Funding

- A total of £800m nationally will be allocated to ICBs sourced from a combination of reprioritisation of national budgets and new funding.
- The distribution of funding within a system should be determined by each system, taking account of all financial pressures and risks.
- The elective activity target for 2023/24 will be reduced to a national average of 103%.

- The BSOL ICB share of the funding allocation is £25.2m.

Programme funding flexibilities

- If systems require the use of programme funding flexibility to achieve financial balance it should be specified as part of November discussions with NHSE. The ability to use underspend non-recurrently to support wider system financial performance is subject to a number of criteria. For mental health, these are:
  - systems must continue to meet their MHIS targets
  - Adult crisis service development funding (SDF) – excluded as it supports urgent and emergency care performance
  - Funding for employment advisers in Talking Therapies is DWP funding and any underspends should be discussed with DWP.

Work is now underway across the BSOL ICS to agree the actions for completion of the submission on 22.11.23.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Trust Board Meeting		
Agenda item	17		
Paper title	Summerhill Services Limited (SSL) Business Report		
Date	6 December 2023		
Author (s)	Shane Bray		
Executive sponsor			
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).	

Birmingham and Solihull Mental Health NHS Foundation Trust

Summerhill Services Limited (SSL) Business Report

April 2023– October 2023

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

The first half 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 and winning new contracts externally, within the BSol ICS and nationally.

SSL external revenue and opportunities continue to be developed, 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.

Over the past 6 months, SSL has continued to invest in new systems with the implementation of our new estates monitoring system (CAFM) and the development of our master catering program. The CAFM system which will go live early 2024, will enable all trust staff to log new estates jobs and review status of existing requests live. The Master Catering Program will deliver a new 4 weekly menu developed with the Trust team as well as enabling service users to order meals online.

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 (Forward House) has been more challenging more than others. Forward House provides the Trust and SSL with challenges in water management. These challenges are managed via the Trust Water Safety Group (TWSG) examining the options available and agreeing the appropriate actions and recording the decisions.
The Trust Water Safety Group have agreed that the SSL, Amey and Severn Trent teams should install a new Dosing Plant into the water system with results due January/ February 24. However, we have installed inline filters on all sanitary outlets until this new system is in place.

SSL also actively contract manages the Trust's two PFI's, which has resulted in several financial settlements totalling over £2m in the past 12 months. Our PFI team are also working with other Trusts to support them with their PFI contract management.

SSL has continued 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. In line with the Trust, SSL has also implemented regular reviews on all outstanding posts and all agency spend. All of these measures have enabled to significantly reduce our agency spend over the past few months.

SSL has recently upgraded and implemented a prescription tracking system which allows clinical staff to track all prescriptions. SSL Pharmacy is also reviewing options for a new Pharmacy Robot to replace our existing one which dispenses compliance aids and prescriptions to all Trust community teams

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, ICS and Primary Care. The key services include:

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

Review April 23 to Oct 23

Facilities Management

Domestic and Housekeeping Services

- Successful implementation of the New National Cleaning Standards completed.
- SSL have an accredited training course– thought to be the only provider in the country with a fully accredited training course for the New National Cleaning Standards
- Level 2 Infection prevention in cleaning training offered to all Facilities teams.
- SSL have an approved NHS Cleaning Standards Training Course which is included in inductions.
- SSL- Sue Ladkin and Trust IPC-Zalika Geohaghon have won the ACHP Infection Prevention and Control Initiative award for their comprehensive work on the cleaning roadshows.
- Access Card Management review completed with additional resources required due to Trust demand on Agency and new staff.

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.
- Compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS “Plastic Pledge”.
- Catering apprentice chef programme to commence (August 2023) across 5 production kitchens in partnership with Solihull College and Trust L&D

Laundry and Linen Management
Regular contract, service quality and performance meetings are conducted Trust wide supplier for laundry and linen Elis, by SSL, the Trust and PFI Partners with the supplier.

- 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 for 22/23. With concerns over quality, performance, KPI compliance and 39% cost increases.
- Initial discussions held with a new supplier Oxwash using a national NHS framework agreement. Initial costing, contractual terms and KPI's favourable. Contract proposal 23/24.

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.
- Winter snow clearance and salt application contract in place. Full grit and salt provision topped up with contingency held.

Transport & Logistics

- Non Urgent Patient Transport (NEPT) – expansion of NEPT and Taxi core hours from 06:00 am to 22:00 is still available, proposal submitted to the Trust.
- We have progressed a NEPT vehicle replacement programme as the vehicles are over 5 years old and now starting to cost in downtime and extra maintenance.
- Tissue Viability Products, logistic contract 6-month trial agreed and progressing from August 23.
- SSL Warehouse – logistics, Trust uniforms, PPE, etc now operate from SSL HUB. Birmingham Community PPE service, possible Medical Devices, plus the Trust ICT team 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: Blood pressure monitors, Bins for Recycling, Ecig, Food, and sharps, and Physical health equip.
- Potential future provision: Dressing, Nutrition's/ Supplements, SSL Dry Goods, Cleaning Products
- SSL still able to provide Trust General Transport service – pharmaceutical, specimen, samples, post – additional activity undertaken during COVID with delivery of samples for testing to acute hosps.

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 Trust Water Safety Group (TWSG) 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, 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 legionella positive results, we have followed the industry guidance, Trust 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 Trust Water Safety Group have agreed that the SSL, Amey and Severn Trent teams should install a new Dosing Plant into the water system with results due January/ February 24. With inline filters kept until this new system is in place.
- SLAs in place for Juniper (on Moseley Hall Hospital site). SLAs haven't been reviewed by Community Trust since 2017. Considerable cost increases anticipated.
- Trust Medical Equipment (EBME) 42% of equipment not presented for SSL Contract service and PA Testing. Issue escalated to Trust.

Capital Projects

- Capital Programme 22/23 completed successfully.
- Capital Programme 23/24 progressing ahead of plan.
    - The 2023/24 BSMHFT Total Capital Plan is £6.25m. This consists of the following elements;
    - Minor/Risk Projects (inc. carry-forward) £1.98m
    - SSBM Works £2.00m
    - ICT Projects £0.93m
    - Doorsets £0.40m
    - FCAMHS Seclusion Suite (PDC Fund) £1.25m
    - VAT Reclaim/Slippage £0.50m (-)
    - Contingency £0.19m

- A number of the Minor/Risk Projects have been split over two financial years following the Trust prioritisation process, due to the availability of insufficient funding.
- 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 several further options developed following Trust brief 18 bed (12 and 6) 12 bed (6 and 6) Total 30 beds- considerable resource support and commitment to develop the Business Case.
- Concern regarding securing of Capital funding for Highcroft and Reaside developments
- 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. To 'stand-still' (compliance, backlog, lifecycle) we need to invest hundreds thousands per annum, this doesn't address aged poor functional building.
- Bids totalling circa £8m supported through Reach-out for Ardenleigh, Reaside and conversion of Hollyhill for Secure First Team.

SSL PFI/Contract Management

- ERIC has been challenging in gaining required data for submission, but this is now progressing.
- SSL contract and performance manages two significant and complex PFI contracts
- SSL is finalising Settlement Agreements across both PFI's following performance management challenges of services. These agreements will deliver a high six figure settlement values. Plus Energy Management settlement of six figure sum. Total circa **£2m** income to the Trust.
- 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 relationships with other trusts to assist them with their PFI needs and requirements.
- PFI Health Check Paper external projects underway with commissions from Trusts, DoH, and Private sector SPVs. Intellectual Rights achieved to protect the document for SSL.
- SSL are starting our 9th Market Test, this being the BNHP Joint Services Market Test. Challenging, with significant cost avoidance, whilst retaining positive relations with all stakeholders.

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 Locality Clinical and separately Estates 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.
  - Void and Underused Bookable Space reports completed on CHP/ NHS PS properties.
  - SSL is also leading a project to assess the accuracy of the information held for system wide void and bookable space. National rollout of ADEPT with BSol as a pilot in scope.
- Capital Programme, Working in conjunction with NHS PS, SSL are overseeing the refurbishment of Saltley Health Centre.
- 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 Apr-23 to Oct-23

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 7 externally reportable incidents during this period. 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 underway upgrading both its Prescription tracker and compliance aid machine.
- SSL robot continues to deliver an accuracy of 99% on compliance aids (see appendices)

Feb-23	Mar-23	Apr-23	May-23	June-23	July-23	Aug-23	Sep-23	Oct-23
99%	99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance

SSL over £1.6m ahead of budgeted revenue after the first 6 months of this financial year. This is mainly due to the National NHS Unconsolidated Pay Award which was paid out during this period. In addition, there have been continuing cost pressures from Energy and General Inflation. Revenue from External work is steady for our 3 main revenue streams , Primary Care, Trusts/ICS and PFI Consultancy.

- Primary Care – We continue support over 270 GPs across BSOL, as well as maintaining a small number COVID vaccine sites in preparation for the next vaccination campaign planned for winter 2023
- Trust/ICS – We are supporting the ICB with their Sustainability/Green plan along with providing Project Management support for two key ICS developments. We have also been commissioned to provide Consultancy Support to The Black Country NHS Trust, Capital Team
- 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 line with the Trust, SSL is focusing on reducing its agency costs, which has been reduced to 3.7% over the past few months. We have also implement following additional processes around recruitment to ensure strict financial controls are maintained.

In relation to our Trust contracts expenditure, with the exception of the pay award costs, all other areas is stable with small variances and 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.

Resourcing

- SSL since April continues to grow and has increased its strength from 370 to 381 continuing to reduce reliability on agency.
- SSL has also launched its own Recruitment Microsite to attract external candidates and widen external candidates knowledge of the Company.
- SSL continues to work with charities and organise local recruitment events to ensure it develops its workforce.

- In September SSL has seen six apprentices commence with five Chef and one Soft Facilities Monitoring officer.
- SSL has developed and approved its first Graduate Scheme. SSL is looking to commence 3 graduates 2024/2025, focussed on current business needs and where there is external growth in revenue. The graduate schemes are also aimed to assist the organisation to grow leadership capacity for future due to 55% of the organisation being over 55. SSL will also offer current graduates the opportunity to experience mentoring and additional soft skills training.
- To assist SSL to further reduce reliance on agency spend, SSL has proposed an SSL weekly payroll whereby extra staff will be recruited on an SSL workers agreement and rates to cover vacancies and sickness. This has been approved by the Remuneration Committee and work now need to progress with the Trust to implement the payroll, prior to recruitment commencing of additional workers.
- SSL is also introducing a Leadership Strategy to be implemented in fourth quarter of 2023/24 to support growth of talent population and supervisors and managers.

Reward

- SSL in August undertook a benefit survey followed by benefit workshops with a quarter of its workforce attending to identify what benefits they value and to consider whether it can improve its offering further. As a result of findings SSL has reviewed it's family friendly policies and offering and is also reviewing its NEST pension scheme to evaluate whether it is "Best in Class".
- SSL has also reviewed its on-call policy and has consulted with the workforce. SSL is currently in the process of writing to all employees who are on-call to advise them the policy has been agreed and will be actioned in January 2024.
- SSL in April 2023 introduced Job Families for Hotel Services and Catering and developed a clear salary progression scheme for SSL C Grades which ensures all C grade employees are paid a new entrants and competent rate based on bench marking data.

Equality, Diversity & Inclusion

- SSL has undertaken a range of EDI training for Supervisors and Managers in Sept/October based upon a package developed by Inclusive Employers and has additional sessions planned in December 2023.
- SSL EDI Advocates also undertook additional training in October 2023 in relation to the role of the Advocate in dealing with microaggressions, and the role of a Companion should they wish to support members in HR processes.
- A range of concerns which have been raised by employees in relation to SSL values, and fundamental behaviours have actively been supported by EDI advocates. .

Policies and Procedures

- SSL is in the process of reviewing all its People policies and procedures which will be concluded by December 2023.
- Policies reviewed include Drug and Alcohol, Disciplinary, and Family Friendly policies to date.

- SSL from January onwards will be increasing its employee's entitlement under Family Friendly and time off schemes as highlighted below:
    - Compassionate Leave up to a maximum of five days
    - Paternity Leave after a years' service to 2 weeks full pay
    - Maternity Leave after a years' service to 6 weeks full pay and 12 weeks ½ pay
    - Adoption Leave after a years' service to 6 weeks fully pay and 12 weeks ½ pay

Communication and Engagement

- SSL has planned and agreed via its Remuneration Committee, its employee offering for Xmas 2024/25 which will include an individual Christmas Card, Voucher for a Supermarket and is based upon feedback from our employees during the benefits workshops.
- Suite of marketing materials for ICS B2B promotion being developed which consists of a series of booklets covering SSL Our Services and Operations, SSL People and Culture, SSL our numbers and statistics, SSL Corporate. A general presentation is also being produced which can then be utilised externally to market SSL.
- SSL has developed its intranet site, with specific pages for SSL staff with focus being HR Team, Policies and procedures, Communication and News, Transport, EDI, Values. Blog launch and website update to be launched January 2024.
- SSL internal newsletter next edition to be released 15th December 2023.

Corporate, Property and Sustainability

- SSL will be developing further the 'Green Plan' for the Trust set against baseline data & target.
- Birmingham Council leased premises- Phoenix used as bid for enhanced Secure service provision Erdington.
- For the Trust and BSoL ICS – SSL have reviewed, gathered information and completed in full- and on-time returns required by NHSE. Including Transport, Green NHS, and Property.
- PAM submission returns complete containing 400+ compliance and assurance reviews.
- PLACE review under way complete end November 2023.

- It should be recognised that the volume and detail of the returns requested / required by NHSE is becoming ever more onerous to feed the NHSE 'machine'
- 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 issue of free bus passes for all new SSL and Trust starters – encouraging sustainable travel
- SSL developing an EV charge-point option for Trust to consider for staff, visitors , and patients.
- SSL are developing its 'fleet' to support BSMHFT Services by adopting Plug in Hybrid and/or electric vehicles where it can, within costs and range permit.
- SSL has managed energy procurement on behalf of the Trust with 100% directly procured electricity from Zero Carbon sources.

- B1 open-days progressed for recycling and reusing furniture and stationary saving the Trust financially.
- Trust Strategic Property Group held it's inaugural meeting.
- SSL developed Sustainable Development Strategy & Action Plan (Green Plan) on behalf of Trust
- SSL have developed B1 Options have appointed Management Surveyors to carry out multi-million vacation negotiations, looking for Trust early exit from their lease obligations.

Business Development, Opportunities and Plans

PFI Consultancy

- SSL continues to develop our PFI consultancy services which includes PFI Health check (Trademarked), PFI Handback and LIFT Co Consultancy.
- We have a number of contractual and performance commissions including
    - Newham
    - Gloucestershire
    - North Staffordshire
    - West Birmingham
    - Black Country
- We have also been approached by leading PFI finance providers SPVs to deliver healthchecks on their portfolios – we are evaluating the resources required and the potential contract value.
- In addition, we are supporting another local trust with their Capital programme, details to be confirmed.

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 several facility contracts within BSOL primary care.
- We are also exploring opportunities with one of the largest PCN's in the UK
- Negotiations underway to support Midlands Charities with their compliance requirements on their HMOs

ICS/ICO BSol Strategic Delivery

- SSL is currently reviewing our business structure to enable SSL to be a successful ICS partner and service provider 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix A – Financial Statement April 23 – Oct 23

SSL Financial Position	Annual budget	M6		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	14,682	7,341	8,158	816
Lease & Long License	3,023	1,511	1,669	158
Contract Management	1,992	996	1,281	285
Facilities Services	3,237	1,619	1,951	332
Grounds and Garden	399	200	156	(44)
PPE & Warehouse	149	74	81	7
Pharmacy	3,235	1,618	1,654	36
External Services - Head of Assets	0	0	66	66
External Services - STP	97	49	22	(26)
External Services - CCG Vaccine Pro	435	218	187	(31)
External Services - PFI	80	40	25	(15)
External Services - FM	37	19	8	(11)
Total income	27,368	13,684	15,256	1,572
Pay costs	(10,419)	(5,209)	(6,458)	(1,249)
Drug costs	(2,854)	(1,427)	(1,479)	(52)
Non pay costs	(7,935)	(3,967)	(4,239)	(272)
Internal Recharge	57	28	(14)	(42)
Total Expenditure	(21,151)	(10,575)	(12,190)	(1,614)
EBITDA	**6,217**	**3,108**	**3,066**	**(42)**
Depreciation	(3,105)	(1,552)	(1,528)	25
Interest Payable	(2,010)	(1,005)	(1,017)	(12)
Interest Receivable	0	0	0	0
Finance Lease	(382)	(191)	(191)	(0)
Profit / (Loss) before tax	**720**	**360**	**330**	**(30)**
Taxation	(380)	(190)	(192)	(2)
Profit / (Loss) after tax	**340**	**170**	**138**	**(32)**

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 Oct-23	Not Achieved to date/time Oct-23	Percentage Achieved to date/time Oct-23	Percentage Achieved to date/time Sep-23	Percentage Achieved to date/time Aug-23
Aston and Nechells Community Team	87	5	95%	95%	97%
Central Assertive Outreach	42	2	95%	96%	96%
East hub Older Adults	2		100%	100%	100%
East Assertive Outreach	23	1	96%	95%	100%
Handsworth AOT	50	2	96%	100%	100%
Kingstanding & Erdington CMHT	206	7	97%	97%	95%
Ladywood & Handsworth CMHT	82	4	95%	100%	95%
Longbridge CMHT	109	7	94%	97%	95%
Lyndon CMHT	68	3	96%	97%	100%
Newbridge Clinic	77	4	95%	97%	95%
Newington CMHT	50		100%	96%	98%
North Assertive Outreach	65	3	96%	95%	96%
North Hub Older Adults	7		100%	100%	100%
Reaside Community	100	5	95%	97%	96%
Riverside CMHT	34		100%	100%	97%
Small Heath CMHT	24		100%	95%	94%
Solihull Assertive Outreach Team	43	2	96%	95%	95%
Solihull Early Intervention Service	160	10	94%	95%	95%
South Assertive Outreach Team	35	2	95%	98%	95%
Sutton Coldfield Community Team	106	3	97%	98%	100%
The Homeless Team	12		100%	100%	100%
Warstock Lane CMHT	80	4	95%	95%	95%
West Hub Older Adults	4		100%	100%	100%
Yewcroft CMHT's	53	2	96%	100%	94%
Zinnia CMHT'S	46		100%	95%	97%
South Hub Older adults	2		100%	100%	100%
Wilson Lodge	5		100%	100%	100%
MHSOP Solihull Hub (was John Black Day Unit)	1		100%	100%	100%
Intensive Community Rehab Team	12		100%	100%	100%
Grand Total	**1585**	**66**	**96%**	**97%**	**96%**

Compliance Aids – KPI – 72 hours

Compliance Aids	Achieved to date/time Oct-23	Not Achieved to date/time Oct-23	Percentage Achieved to date/time Oct-23	Percentage Achieved to date/time Sep-23	Percentage Achieved to date/time Aug-23
Aston and Nechells Community Team	14		100%	100%	100%
Central Assertive Outreach @Small Heath	15		100%	100%	100%
East Assertive Outreach	14		100%	100%	100%
Handsworth AOT	28	1	97%	92%	100%
Kingstanding & Erdington CMHT @Northcroft	21		100%	91%	96%
Ladywood & Handsworth CMHT @Osborne House	33	1	97%	100%	96%
Longbridge CMHT	29	1	97%	100%	96%
Lyndon CMHT (Solihull South)	24	1	96%	95%	100%
Newbridge Clinic @ Small Heath Centre	27	1	96%	100%	100%
Newington CMHT	15		100%	100%	100%
North Assertive Outreach	22	1	96%	100%	95%
North Hub Older Adults	1		100%	100%	100%
Reaside Community	34	2	94%	93%	100%
Riverside CMHT	2		100%		100%
Small Heath CMHT	1		100%		100%
Solihull Assertive Outreach Team	15	1	94%	94%	100%
Solihull Early Intervention Service	7		100%	100%	100%
South Assertive Outreach Team	28	1	97%	96%	89%
Sutton Coldfield Community Team @Northcroft	7		100%	100%	100%
Warstock Lane	17		100%	95%	94%
Yewcroft CMHT's	10		100%	100%	90%
Zinnia CMHT'S	21		100%	97%	94%
Intensive Community Rehab Team	2		100%	100%	100%
Grand Total	**387**	**10**	**97%**	**97%**	**97%**

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**22 November 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • CQC Update and Action Plan Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Quarterly Risk Report • Infection, Prevention and Control Quarterly Report • Strategy Update: Quality Priority • Strategy Update: Clinical Services Priority • Integrated Performance Report • NHS Impact Report • Quality Management System • Clinical Governance Committee Report • Mental Health Act Quarterly Report • Review of Governance Arrangements: Service/Directorate and Division • QPES Integrated Action Plan
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The Suicide Strategy Annual Report had not been received. This had been deferred until January 2024.
Assure:	The Committee was assured on the following key areas: • A positive staff story, supported by services users, highlighted the positive feedback following the development of the Acute Care Patient Council. The co-production of the Council had allowed a wide range of staff and service users to discuss ongoing challenges, areas for development and highlighted the great work of staff. Magnolia Ward was highlighted as an area of particularly outstanding service delivery. • Comprehensive regulatory reporting around the CQC had progressed to allow for oversight and key escalations to the Committee. • A proposal for the review of governance arrangements across divisions was approved. • An Integrated Action Plan was being developed to provide a holistic review of associated actions for the Committee and allow for additional assurance. • The Quality and Clinical Services Strategy Update provided assurance on the trajectory of Trust goals and achievements. • The Committee was assured that although Q1 remained a very busy period for the MHL department, with an average of 906 people under detention per month of the quarter and an average of 223 people on a Community Transformation Order per month. Analysis of the data showed a further 1%

	reduction in the number of black patients under a Community Transformation Order, following the 2% reduction in Q1. • The Infection, Prevention and Control Quarterly Report provided assurance with the positive implementation of centralised reporting.	
Advise:	• NHS Impact work was progressing well and was on trajectory. This would remain a key area of focus for the Committee and form a strategic session for the Board of Directors. • The Committee was assured by the improved approach to risk management and was advised of further data cleansing to produce a fully accurate register. • The MHOST Tool update would be presented to People Committee and will be presented to Quality, Patient Experience and Safety Committee in January 2024 following feedback.	
Board Assurance Framework	Improvements continued to ensure a fully embedded Board Assurance Framework, with positive feedback to date. The Board Assurance Framework would be reviewed regularly and begin to inform and focus agendas, strategic goals and risk registers. A quarterly review process would be implemented to monitor improvements, prominent issues, risk reductions and increases over time.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Hannah Sullivan, Governance and Membership Manager	**Minutes available from:** Hannah Sullivan, Governance and Membership Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**18 October 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • CQC Update • Infection Prevention and Control Report • Patient Safety Incident Response Framework • PALS and Serious Incidents • Integrated Performance Report • Performance Framework • Learning from Clinical Audit • Freedom to Speak Up Report • Customer Relations Deep Dive
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Changes in recommendations from authorised engineers had delayed the reopening of Forward House; additional work was underway to ensure that the presence of legionella was under control. A full report had been commissioned into the timeline, interventions and management actions required. The Committee would receive a consolidated summary of the report for additional assurance. • The arrangements for the Mental Health Act Committee were debated and a formal proposal would be discussed at November's meeting, with a recommendation to be made to Board of Directors.
Assure:	The Committee was assured on the following key areas: • Clear plans were in place to implement the Patent Safety Incidents Response Framework (PSIRF) from 1 November. The Committee received and approved the Patient Safety Incident Response Plan submission to NHS England. • New quality metrics were proposed; a streamlined approach would be implemented to align with regular reporting through the Integrated Performance Report; a broader range of metrics would be measured through divisional deep dives. • A comprehensive review of the Customer Relations team was received, highlighting challenges and plans in place to address historical issues. The Committee was assured that patient safety

	indicators were closely monitored whilst actions to improve performance were implemented.	
Advise:	The Committee was advised of the plans to refine CQC reporting. This would include a revised template which would detail actions and outcomes to provide a higher level of assurance.	
Board Assurance Framework	The risk score for *BAF02/QPES* was discussed and agreed to increase from 12 to 16. This was due to identified gaps with central oversight of Mental Health Act compliance risks.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Kat Cleverley Company Secretary	**Minutes available from:** Kat Cleverley, Company Secretary

Meeting	**Board of Directors**
Agenda item	**19**
Paper title	Patient Safety Incident Response Plan
Date	6 December 2023
Author	Samantha Munbodh –Head of Patient Safety; Lisa Pim – Deputy Director of IPC, Patient Safety, Clinical Quality/Governance
Executive sponsor	Steve Forsyth – Chief Nurse for Quality and Safety

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

Executive summary & Recommendations:

Introduction

The previous Serious Incident Framework mandated when and how to investigate a serious incident whereas PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles which we need work to but outside of that, we determine what we will investigate and how.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new name. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from other patient safety insights.

There are 2 mandated requirements for providers as we transition over to PSIRF in October 2023, these are production of a Patient Safety Incident Response Plan and a PSIRF Policy.

The Policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF.

- Inclusive and compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues

• Supportive oversight focused on strengthening response system functioning and improvement. The patient safety incident response plan describes how they intend to respond to patient safety incidents, including the methods to be applied and rationale, and clearly articulates the Safety priorities for the Trust. The Board is asked to approve the patient safety incident response plan.
Reason for consideration:
For approval of the PSIRF response plan
Previous consideration of report by:
Quality, Patient Experience and Safety Committee on 18 October 2023.
Strategic priorities (which strategic priority is the report providing assurance on)
QUALITY:
Financial Implications *(detail any financial implications)*
Financial implications of PSIRF have previously been considered

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
none
Equality impact assessments:
Full equality impact assessment to be included in core documents
Engagement *(detail any engagement with staff/service users)*
Local service engagement at Divisional level – approved at Patient Safety Advisory Group

Birmingham and Solihull Mental Health NHS Foundation Trust

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	Samantha Munbodh	Head of Patient Safety		
Reviewer	Lisa Pim	Associate Director for Nursing and Governance		
Authoriser	Steve Forsyth	Chief Nurse		
Authoriser	Roisin Fallon-Williams	Chief Executive		

Contents

1.0 Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), which replaces the NHS Serious Incident Framework. This document is our Patient Safety Incident Response Plan (PSIRP). It sets out how BSMHFT intends to respond to safety incidents over the next 12 –18 months. This plan is not a permanent rule that cannot be changed. We remain flexible and consider the specific circumstance in which patient safety issues occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on reporting, management of incidents and the new Trust Patient Safety Incident Response (PSIRF) policy.

The Serious Incident Framework mandated when and how to investigate and provided structure and guidance on how to identify, report and investigate an incident. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that supports continuous improvement in patient safety.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better in a small number of areas of highest patient safety risk for us as organisation. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associated policies and guidelines will describe how it all works.

Carrying out investigations for the right reasons can and does identify new insight and learning. Removal of the serious incident process does not mean “do nothing”, it means respond in a proportionate way depending on the type of incident and associated factors.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is a psychologically safe culture shown in our leaders, our Trust-wide strategy, and our reporting systems.

We have developed our understanding and insights about our patient safety profile over the past two years. In September 2023, this plan provides a description of how PSIRF will be applied at BSMHFT for the purpose of learning and improvement. There is not remit for preventability or cause of death with the learning responses.

2.0 Our services

BSMHFT provides comprehensive mental healthcare services for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond. With more than 40 sites, we serve a culturally diverse population of 1.3 million, spread out over 172 square miles. We have a dedicated workforce of around 4,000 staff and a range of local and regional partnerships, making us one of the most complex and specialist mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

3.0 Defining our patient safety incident profile

We reviewed our data and intelligence from various sources to understand the trusts profile and priorities for the year 2023/24.

Learning from early adopters that 2-3 years of data seemed to be about right to understand patient safety risks and issues; in January 2023 we identified the period 1st April 2020 to 31st March 2022 for our thematic data analysis which include serious incidents, prevention of future deaths, compliments and complaints, claims, freedom to speak up, mortality case note reviews, safeguarding, quality assurance activities, research for example the National Inquiry into suicides and safety in mental health 2023 annual report.

We were keen to involve our staff as key stakeholders in identifying our key patient safety risks and issues. Staff engagement sessions ran throughout the summer of 2023 and staff were asked to tell us about their main patient safety concerns.

The emphasis when analysing this information was to look for opportunities for improvement; areas where gaps in care and treatment and/or types of incidents remain a concern due to the impact on service users, families, carers. Where possible we have also considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered any new and emergent risks relating

to future service changes and changes in demand that the historical data does not reveal.

The trust held meetings to agree priorities these included representation from corporate and clinical teams. Unfortunately, our EBE Safety Partners were not in role in time to develop our first PSIRP plan but will be involved in patient safety and in the development of future plans.

The plan has been ratified through the trust Clinical Governance Meeting XX, QPES Committee on XX and trust public Board on XX

4.0 Our patient safety incident response plan: national requirements.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, which the Trust fully endorses as it fits with our aim to learn and improve within a just culture.

National guidance recommends that 3-6 investigations per priority are conducted per year. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors. Attempting to do more than this will impede our ability to adopt a systems-base learning approach from thematic analysis and learning from excellence.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

National priorities		
Patient safety incident type	Approach	Anticipated Improvement Route
Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support	Refer to local authority safeguarding lead via BSMHFT named safeguarding lead BSMHFT will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide	

needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	
Perpetrators of homicide (up to 6mths post discharge)	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, BSMHFT will contribute as required by the DHR panel.	
Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation	Create local organisational recommendation
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care		
Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care		

5.0 Our patient safety incident response plan: local focus

Apart from the national criteria for PSII above, the decision to carry out a patient safety incident investigation should be based on the following:

- the patient safety incident is linked to one of the Trust's Patient Safety Priorities that were agreed as part of the situational analysis.
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Our Patient Safety Priorities:

Priority	**Approach**	**Local and system improvement route**
Co morbidity with drug/alcohol – people in active treatment at BSMHFT	Patient Safety Investigation where agreed	Create local organisational actions in quality improvement strategy plus a system wide response to improving services for this cohort
Incidents resulting in harm or deaths by suspected suicide where care is fragmented/multiple contacts across the pathway		
Incidents of disengagement prior to death by suspected suicide		
Harm or death of a service user with an emerging risk and no management /escalation of risk		
Patient safety incident resulting in serious to severe harm/death involving access/transfer/discharge concerns		
Lack of family involvement, not		

heeding/taking on boarding warnings of concerns from family, resulting in harm		

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Death	Review by Mortality process and possible SJR/SJR plus (including family input) and Mortality MDT Thematic review to be identified for particular service user groups Review as PSII where index case or meets national priority criteria	create local safety actions and feed these into the quality improvement strategy
Service provision	Review by operational managers in conjunction with service leads and cross system reporting as necessary Continued monitoring through operational working groups Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	Inform ongoing improvement efforts
Inappropriate behaviour	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through safety huddles, consider inclusion of EDI in huddle where appropriate	Inform on going improvement effort

	Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit if required where patient safety compromised	
Violence and aggression	Review by operational managers in conjunction with Health and Safety or relevant subject matter experts Continued monitoring through safety huddles, EDI to be considered as part of huddle for racially abusive incidents For Secure Services ensure reporting according to set requirements Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	Inform ongoing improvement efforts
Medication	Review by operational managers in conjunction with Medicines Management and cross system reporting as necessary Continued monitoring through medicines safety meetings and safety huddles Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised Review as PSII where index case	
Missing patient/Abscond/AWOL	Review by operational managers in conjunction with	inform ongoing improvement efforts

	relevant subject matter experts Continued monitoring through safety huddles For Secure Services ensure reporting according to set requirements Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised Consideration for PSII where felt appropriate	
Access / admission/ transfer / discharge	Review by operational managers in conjunction with service leads and cross system reporting as necessary Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	Inform on going improvement
Sexual incidents	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through safety huddles and Sexual Safety group For Secure Services ensure reporting according to set requirements Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	
Infection control	Review by operational managers in conjunction with Infection Control and	

	Prevention team and cross system reporting as necessary Continued monitoring through safety huddles Continue post infection reviews for outbreaks Continue nationally required external reporting for specific infection groups Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	
Patient care and treatment	Review by operational managers in conjunction with relevant subject matter experts and cross system reporting as necessary Continued monitoring through safety huddles Restrictive interventions – harm has occurred, excessive force, overuse or lack of rationale, ethnicity or gender bias is suspected (see Use of Force Act 2019) to be reviewed by toolkit item For Secure Services ensure reporting according to set requirements Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	create local safety actions and feed these into the quality improvement strategy Review as PSII where index case

Self harm	Review by operational managers in conjunction with subject matter experts Continued monitoring through safety huddles For Secure Services ensure reporting according to set requirements Continued monitoring of patient safety incident records to determine any emerging risks/trends Thematic analysis Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised Escalate for review to PSII where required	create local safety actions and feed these into the quality improvement strategy
Slips, Trips and Falls	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through Divisional/Trust safety huddles and Falls Harm free group	create local safety actions and feed these into the quality improvement strategy

Appendix B

Improvement Programmes

Theme	Existing work stream
Violence and Aggression	NHS Violence prevention and reduction standard Mental Health Safety Improvement Programme (MHSIP) Scale up reduction of incidence of restrictive practice in I/P MH and LD services Local improvement workstream - reducing restrictive practice includes meaningful day and Positive behavioural support (PBS)
Inappropriate Behaviour	Meaningful day and PBS
Self harm	Support assessment of ligature anchor points and other environmental risks for I/P MH services
Medication	MSIP Clozapine QI group ICCR Clozapine clinic FIRST QI project (local) QI ESCA FP10 project ICCR (local)
Slips/trips and falls	Local improvement plan
Infection control	Local improvement plan National COVID guidelines Staff flu vaccination planning
Sexual Safety	MHSIP

Patient safety incident response plan

	Sexual safety standards working groups
Risk Management	Task and finish group for • Training • Policy • QI for barriers to completion of tool
Dual diagnosis	Working group with CGL
Access to services	Standardising triage of referrals at CMHT Reducing out of area admissions QI project to improve decision making at the point of admission to reduce inappropriate admission to acute instead of PICU
Physical health	
Discharge	Prison reach out 28 – day transfers
Treatment	Offender Health personality disorder pathway
	Roll out of dialogue

Committee Escalation and Assurance Report

Name of Committee	**Report of the Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 December 2023**
Date(s) of Committee Meeting(s) reported	**12 October 2023**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Head of Internal Audit Opinion • Internal Audit Progress Report • Internal Audit Recommended Action Tracker • Options Appraisals for Additional Internal Audit Reviews • Counter Fraud Report • External Audit Report • Single Tender Waivers and Losses and Special Payments Report • Changes to Scheme of Reservation and Delegation • Board Assurance Framework • Commissioning Board Assurance Framework • SSL Board Assurance Framework • CQC Section 29a Notices
Alert:	The Committee wished to alert the Board of Directors to the following: • A deep dive into the secure patient transport contract was requested for additional assurance.
Assure:	The Committee was assured on the following areas: • A positive Head of Internal Audit Opinion was received, and the Committee was assured by the adequacy and effectiveness of internal controls. Additional improvements were identified to enhance the risk management framework, including the Board Assurance Framework, and governance arrangements for the Provider Collaborative. Both of these were developing areas for the Trust. • The Trust Board Assurance Framework, Commissioning Board Assurance Framework, and SSL Board Assurance Framework were received and assurance taken from the process of risk management and escalation. • The Counter Fraud Report highlighted positive, proactive action taken by the Trust with regards to scam alerts. The Conflicts of Interest exercise also highlighted good compliance across the organisation, although there were improvements to be made in relation to secondary employment and private practice declarations.

Advise:	The Committee discussed an options appraisal and agreed the following additional internal audit reviews: • Financial culture (which would be reviewed as part of the planned Key Financial Controls and CIP audits); • Clinical governance effectiveness (which would be reviewed alongside the internal work of the Clinical Governance Committee); • Delayed transfers and discharge planning arrangements. Additional reviews into Reach Out Commissioning governance arrangements and Vacancy Controls would be deferred. The option to review Executive Capacity would be considered following further exploration with the CEO.	
Risks identified	The Committee reviewed and noted the highest scoring SSL, Commissioning and Provider risks.	
Report compiled by:	Kat Cleverley Company Secretary	**Minutes available from:** Kat Cleverley, Company Secretary