Board of Directors Public Meeting

Schedule Wednesday 3 April 2024, 9:00 AM — 12:30 PM BST
Organiser Hannah Sullivan

Agenda

Agenda

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Board of Directors Public Meeting 09.00, Wednesday 3 April 2024 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 7 February 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 7 February 2024**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Director of Operations*	Assurance	Enc	09.50
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	10.00
8.1	**Corporate Risk Register** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	10.10
Quality				
9	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.15
People				
10	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.25
11	**Staff Survey Results** *Patrick Nyarumbu, Director of Strategy, People and Partnerships*	Assurance	Enc	10.35
Sustainability				
12	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.00
13	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.10
14	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.30
Reflections				
15	**Living the Trust Values** *Monica Shafaq, Non-Executive Director*		Verbal	11.50
16	**Board Assurance Framework reflections**		Verbal	12.00
17	**Any other business**		Verbal	12.15
18	**Questions from Governors and members of the public**			
Close by 12.30 **Date and Time of Next Meeting: Wednesday 5 June 2024, 09.00-12.30**				

Service User Story 09.00-09.30

1. Chair’s Welcome and Introduction

2. Apologies for absence

3. Declarations of interest

4. Minutes of meeting held on 7 February 2024

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 7 February 2024, 09.00, Uffculme Centre			
Members	Philip Gayle	PG	Chair
	Sue Bedward	SB	Non-Executive Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Linda Cullen	LC	Non-Executive Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Thomas Kearney	TK	Non-Executive Director
	Lisa Pim	LP	Deputy Director of IPC, Patient Safety, and Clinical Quality/Governance
	Dave Tomlinson	DT	Executive Director of Finance
	Imran Waheed	IW	Deputy Medical Director
	Jenny Watson	JW	Deputy Director of Commissioning and Transformation
	Winston Weir	WW	Non-Executive Director
Attending	Emmanuel Agiam	EA	Clinical Nurse Manager, North (item 1 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Emma Randle	ER	Freedom to Speak Up Guardian (item 15 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
Observers	Three governors and one member of staff observed the meeting in person.		

Ref	Item
1	**Staff Story** EA attended Board to share his story. EA told the Board that he had been with the Trust for six months, and had initially been attracted to the organisation by the advert and the emphasis on values. EA was very impressed by the interview process but had some suggestions for improvement for the general induction. EA noted particularly that he had waited for four hours on his first day at Northcroft before anyone realised he was there; this was mostly because of staffing shortages. IT access had also been an issue and it had taken some time before EA had received a device and access to the relevant software to be able to carry out his job. EA noted that he had worked as a general nurse during his first few weeks to support patient care. EA felt that there were some challenges to opportunities available, particularly around changing the perception of the north of the area. EA felt that the north was isolated and staff needed to be taken on a journey to feel part of the Trust. There were concerns that there would not be enough nurses on shifts, and that the geography of the north made it difficult to share resources. EA particularly noted the need to ensure male nurse presence on wards. EA asked how staff could do more with less, and make the best use of what was currently available. EA felt the key was retaining staff, developing our own, and ensuring trust and close working relationships between the north and the rest of the organisation. EA had incorporated some of these practices by optimising and maximising staff through utilisation of the health roster; this had improved planning for staff. EA wished to emphasis the fantastic work that was taking place in the north and felt that this should be celebrated. PG thanked EA for sharing his journey and noted how inspirational it had been. DT asked how the organisation could replicate the work that EA had undertaken, and the passion and energy that EA brought to his work. EA felt that all staff were leaders in their own right, and it was important to empower staff at all levels.

	BC asked what the Board could do to help EA be even more successful in his role. EA felt it was about basics, supporting the team, recognition that staffing was a significant issue and investing ore financial support in George Ward, Eden acute wards, and Eden PICU. EA felt that greater focus and care of the north services was required. RFW noted that she would meet with EA to discuss thoughts on the induction process. The Board thanked EA for attending.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
3	**Apologies for absence** Fabida Aria, Medical Director (IW attending), Steve Forsyth, Interim Chief Nurse (LP attending), Patrick Nyarumbu, Director of Strategy, People and Partnerships (JW attending), and Monica Shafaq, Non-Executive Director.
4	**Declarations of interest** None.
5	**Minutes of meeting held on 6 December 2023** The minutes of the meeting were approved as a true and accurate record.
6	**Matters arising from meeting held on 6 December 2023** All matters arising were updated.
7	**Board Assurance Framework** The Board received the BAF and took assurance from the ongoing development and work underway to reframe and revise the risks to ensure they were fit for purpose. DTi advised that the Risk Management Group was now meeting regularly and was beginning making a significant difference to risk processes within the Trust, particularly now that a dedicated Risk Manager was in place.
8	**Chair's Report** The Board received the report for information. PG highlighted key points as follows: • The Board had held a constructive strategy session in January 2024, focused on the Trust's Estates Strategy. • PG continued meeting with the Lead Governor to discuss governor development. They had both attended a site visit together last week. • A series of Council of Governors development sessions had been agreed for the year. The first of these had taken place in January. • PG noted that he continued to visit services across the organisation, and celebrated the outstanding care that was ongoing across the Trust. Colleagues were happy to share successes, along with suggestions for improvement. • PG highlighted the work of Recovery Near You, a service based in Wolverhampton. Staff were very passionate about the care they were providing. PG had suggested inviting them to share their story at a future Board meeting. • A meeting with NHSE had taken place recently; the Trust had been congratulated on its out of area trajectory. • PG continued to meet regularly with Healthwatch. • PG also continued to meet regularly with the Freedom to Speak Up Guardians.
9	**Chief Executive and Director of Operations Report** Key points were highlighted as follows:

- Integrated Community Care and Recovery Services: transformation work continued to be embedded, and feedback and data would be collected as the delivery of the work was carried out. Teams were working on remedial action plans following a recent CQC visit to community services and steps to recovery rehabilitation wards. Clinical leadership had been strengthened in community teams, with two additional dedicated matrons embedded who would focus on quality of risk assessments, care plans and medicines management.
- Secure and offender health: challenges were noted in relation to staff vacancies. Students and internationally recruited nurses had taken up posts, which was positive. Acuity and staffing ratios were continuously monitored and changes had been made to accommodate service need.
- Acute and urgent care: the Trust continued to work with acute colleagues regarding service users who present at A&E. There had been a challenging period over Christmas and New Year, but the patient flow position had been held.
- Right Care Right Person: collaborative working continued to be developed across partners, including the police and the ambulance service.
- The Board was advised on potential further industrial action, noting that the pay offer had been voted against. The pay offer for specialist doctors was currently out to vote.
- The national staff survey had closed at the end of December. Results were embargoed but would be shared when available.
- A number of nominations had been received for the Trust's Values Awards 2024. Colleagues were encouraged to celebrate their successes.
- The plan for 2024/25 was under development for the BSOL system. A challenging position was acknowledged for the next financial year.
- RFW confirmed that the latest CQC inspection reports had been published. The Trust had publicised these, alongside a media response that made it clear that the Trust had met the requirements needed to remove the Section 31 warning notices. The Board wished to thank the teams who had worked so hard to achieve this.
- Awareness-raising for measles had been taking place across the organisation.
- NHSE had visited the Trust twice during 2023 which had been prompted by warning notices, particularly around development of staffing models. NHSE had provided positive feedback on the improvements that they had seen. The Trust had since received an NHS Pastoral Award for Quality.
- NHSE would undertake a review of the Nottingham attacks case. The review would inform learning across all mental health trusts.
- The Greater Manchester independent review had been published at the end of last week. The Trust was reviewing this and would incorporate any learning for the organisation.

WW noted that there was positive news regarding the CQC, but asked about how the plans would be monitored to ensure everything was on track. RFW noted that the plans were taken through local governance routes and monitored by Quality, Patient Experience and Safety Committee. WW noted that Audit Committee would receive an internal audit review into Clinical Governance Committee effectiveness, and stressed the need for good governance arrangements in this area and real focus and monitoring of the CQC action plans. RFW agreed and noted that alongside the usual governance arrangements, the Trust also met with the CQC on a monthly basis to discuss progress.

WW asked about the Right Care Right Person approach, and the impact on the Trust's resources. VD responded that the Trust was working very closely with the police and ambulance service; a strategic group had been established so that good, structured conversations could take place to monitor this. A vulnerability hub had been set up to signpost and support people into the right area and service. The service went live on 5 February, and regular calls continued with partners to monitor quality assurance. VD noted that this had been discussed at the Senior Leaders Forum earlier in the week and would be discussed with the Operational Management Team to ensure the right checks and balances were in place.

PG added that there was recognition that levels of acuity in the community were increasing.

	LP advised the Board that the decision had been taken to offer vaccinations to all service users against measles, following a positive service user case within the organisation. WW commend the work of the prison staff; the Board extended its thanks and appreciation to colleagues. RFW encouraged members of the Board to visit.
10	**Integrated Performance Report** The Board received the report for information. VD advised that the Out of Area steering group met every week to monitor and manage the productivity plan and trajectory. The Board was assured that locality team arrangements were working well. Some discharges had been challenging, particularly those fit to be discharged which was a significant pressure point. PG asked about the place of safety and how this linked to the Right Care Right Place approach. VD noted that the fifth and final rollout of this was currently underway. RFW commented that the focus remained on improving patient experience. TK asked how the Trust was defining inappropriate out of area criteria. VD responded that there was national guidance on criteria, but the main focus was on distance. A standard operating procedure was in place to determine placements, however there was an acute awareness of the need for service users to see family. PG asked about the waiting list for Talking Therapies. VD responded that it was improving, although challenges around workforce remained. RFW noted that discussions around flexibility and doing things differently to meet the needs of service users were ongoing.
11	**Finance, Performance and Productivity Committee Report** BC advised of the key points discussed at January's meeting. Many key challenges remained, however improvements were being seen through performance metrics. The Trust was not seeing the level of impact required regarding bank and agency spend, however there was a real focus on transformational approaches to workforce. BC advised the Board that there was a clear plan to drive recurrent savings, with a vision to bring everything together with the Trust's strategy refresh and the alignment of provider and commissioning strategies. RFW commented that alignment was particularly important, and that mental health was one of the five system strategy priorities.
12	**Finance Report** Key points were highlighted as follows: • The month nine position reported a surplus of £768k year to date. This included a £1.2m surplus for the Trust, a £392k deficit for Summerhill Services Ltd (SSL) and a £188k surplus for the Reach Out Provider Collaborative. The year-to-date position for the Mental Health Provider Collaborative was a £136k deficit. • Although there had been positive progress in relation to non-clinical and over cap nursing agency bookings, The Trust remained in breach of all but one of the NHSE agency rules. The key challenge related to over cap medical bookings, which had increased during the last quarter. • A year-to-date delivery of £9.8m was reported, which was a shortfall against a plan of £1.2m driven by non-achievement against the out of area savings target. The Committee noted that the full savings delivery of £14.7m was forecast for the year and would mainly be achieved through non-recurrent delivery. • The Board of Directors had approved a formal adjustment of the 2023/24 forecast from the original breakeven plan to a £4m surplus, in line with the NHSE reset exercise in November. BSOL Integrated Care System had submitted a financial trajectory to deliver a breakeven position for 2023/24.

	LP commented that a significant focus on rostering was a fundamental element to address significant agency nursing spend. DT advised that the Finance, Performance and Productivity Committee had approved the Network Firewall and Proxy Infrastructure Refresh capital scheme; it had become clear that there was an urgent need to address some emerging shortfalls in the Trust's ICT infrastructure. A significant cost of approximately £1m was needed and an opportunity had arisen to make a substantial saving if the commitment was made this financial year. Partners within the ICS had been approached to discuss funding for the infrastructure, and they had agreed to provide £900k of funding over and above the current allocation for 2023/24. The money was to be used solely for ICT and would reduce pressure on the 2024/25 capital programme. The Board formally **approved** the scheme.
13	**BSOL ICS Green Plan** The Board received the BSOL ICS Green Plan for approval. DT advised that the Trust had its own Green Plan which was in line with the ICS. The Board formally **approved** the plan.
14	**People Committee Report** The Board received the report and SB updated the Board on key points from January's meeting, noting particularly that the Trust remained below trajectory for recruitment of registered mental health nurses, and some challenges related to the current Occupational Health provider. SB advised that the Committee's strategy session in February would be dedicated to a deep dive into Board Assurance Framework risks. The Board received the report with no further discussion.
15	**Freedom to Speak Up Guardian Report** The report provided an update on activities between October and December 2023. ER advised that a significant increase in overall activity and cases had been reported. Nursing staff made up the majority of contacts, followed by administrative and clerical staff. The Board noted that Northcroft was a particular hot spot area. ER advised that the team was aware of the need to demonstrate diversity within the Freedom to Speak Up Guardians, and this would be addressed through the recruitment of another role that would focus on community teams. The Board considered the development plan. BC asked how this aligned with patients and service users, and RFW responded that this would involve a strategic view of forums that were already in place, such as the Patient Council. SB commented that the triangulation with PALS and complaints would be useful and noted that the Trust might want to consider the use of a FTSUG app as another route for people to report through. RFW noted that it was encouraging to see that awareness and confidence in the FTSUG process was working and felt that the increase in contacts was positive. The Board **endorsed** the development plan.
16	**Quality, Patient Experience and Safety Committee Report** The Board received the report and LC updated the Board on key points from January's meeting. The Committee had been alerted to the increase in staff assaults, which was being monitored and supported through the reducing restrictive practice approach and working in partnership with the police. The Board received the report with no further discussion.
17	**Audit Committee Report** The Board received the report and WW updated the Board on key points from January's meeting, noting particularly the number of internal audit reviews that had been received. The Committee had been encouraged by the amount of work underway to make significant improvements. The Board received the report with no further discussion.

18	**Caring Minds Committee Report** The Board received the report and WW updated the Board on key points from January's meeting, noting particularly that the Committee had approved the charity's Annual Report and Accounts for 2022/23, and changes to governance arrangements including the name of the committee, scheme of delegation and terms of reference. The Board received the report with no further discussion.
19	**Living the Trust Values** BC reflected that his recent visit to the Zinnia Centre had encapsulated all three Trust values; he had received a warm welcome as soon as he arrived, and noted that staff really demonstrated passion and dedication to achieving the right outcomes for service users. The teamwork and support for each other's wellbeing was obvious. WW also reflected on today's Board meeting, particularly EA's story that had demonstrated such commitment and passion for service users and colleagues. The Freedom to Speak Up Guardian Report also demonstrated all of the Trust's values, particularly through the support for Recovery for All and demonstration of kind and compassionate behaviours.
20	**Board Assurance Framework reflections** No further reflections were noted.
21	**Any other business** None.
22	**Questions from Governors and members of the public** • A Governor had submitted the following question in writing: *The largest minority community in Birmingham has a Muslim heritage. What can the Trust do to support Muslims and people of the jewfish faith who are deeply affected by Israel's war against the Palestinians? In my work across the city, I've noticed many Muslims, including myself, are suffering greatly from the daily news about the war for last four months. It's jarring to see the videos of the abuse of human rights and the mass killings in Gaza and the West Bank. What can we as a trust do to support our Muslim staff and communities' mental health during this time?* The Board responded as follows: ○ Ongoing support was in place for colleagues who are affected by the ongoing crisis in the middle east. ○ Colleagues were reminded who they can access for support, with bespoke Freedom to Speak up spaces available. The Trust was committed to keeping these. ○ The Trust had also promoted signposting that highlighted ways that staff can donate towards aid for those impacted by the war in the middle east. ○ RFW reminded members that the Trust was not a political organisation; this had been made clear to staff, however we can demonstrate compassion in our actions of support for all affected. ○ The Trust was always open to ideas on what more support can be provided. • The Board was asked about internationally recruited nurses and whether additional support would be provided to ensure that colleagues were appropriately trained in mental health. Assurance was provided that training and support would be provided, and competencies monitored to identify any further training needs. • A question was asked about the change to Caring Minds Committee terms of reference, particularly in relation to the change of purpose. WW responded that there was no change to the fundamental purpose of the charity, but to refocus the committee.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Finance Report	The Board formally approved the Network Firewall and Proxy Infrastructure Refresh capital scheme		
	A sharing resources report would be received at Board in the new year for consideration.	DT Apr 24	Scheduled
BSOL ICS Green Plan	The Board formally approved the plan.		
Freedom to Speak Up Guardian Report	The Board endorsed the development plan.		

5. Matters arising from meeting held on 7 February 2024

6. Chair’s Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	Item 6
Paper title	**CHAIR'S REPORT**
Date	3 April 2024
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 the Board 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)

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)*

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

COUNCIL OF GOVERNORS CHAIR'S REPORT

1. INTRODUCTION

I am pleased to provide a written report to the Board of Directors which covers some key updates for members' attention and assurance. I have been busy undertaking many site visits which I thoroughly enjoy additionally representing BSMHFT at key events.

2. Governance Matters

Our committees continue to provide oversight and assurance on matters of quality and safety, patient experience, of finance productivity performance, of people and culture, as well as audit and internal controls continue. I have arranged for the committee chairs to meet monthly to share cross-cutting issues and prioritise areas for further discussions within committees or agree a focused deep dive area where further assurance is required.

I meet with the Lead Governor monthly to discuss any issues or concerns raised with him by the members of the council.

NHS England (NHSE) published a new NHS leadership competency framework for board members. This document is intended to support NHS organisations in recruiting, appraising and develop board members. It was published alongside a revised chair appraisal framework, incorporating the new competencies, as part of NHSE's planned suite of management and leadership development frameworks, tools and resources.

The competency domains are expected to be used in all Board member appraisals and to support the development of individuals and the whole board. A 'newly' appointed board member appraisal framework will support this but will not be available until autumn 2024. The Leadership Competency Framework (LCF) sets out specific responsibilities for different board members. I have included the LCF document with this report for your perusal. This document also supports the revised Fit and Proper Person Test which was launched late last year.

3. SERVICE VISITS

3.1 Visits to our Trust services continue to be scheduled with the NEDs, although both the NEDs and I would welcome more governors joining us where possible on these visits over the coming months. The visits schedule will focus on ensuring ward/service visits are scheduled and planned to ensure increased Board visibility. This is a really an important element of our role as NEDs, as we are keen to see and listen to staff, patients, and service users about our services, both positive aspects and areas for improvements.

Listening to staff

3.2 My visits to the different services continue on a weekly basis as they provide me with an opportunity as chair to see the great work we provide across both Birmingham and Solihull. I always enjoy spending time with our staff, and patients to listen and understand what some of the challenges are, but also hearing about the great work they are providing.

3.3 I visited the Heath Exchange and was honored to meet with staff who provide complex services including homeless provisions. The team ethics and culture were a privilege to witness, it was also inspiring to see how the team have developed.

3.4 I was pleased to visit Ardenleigh and meet with the teams across the wards. It was great to see staff working together to deliver the best services possible whilst staff shortages remain a key issue and a challenge for them.

3.5 I visited the Oleaster and was pleased to be able to meet with staff from a range of services and learn of the positive improvements being developed. I also met with patients who were very complementary of the staff and the service they receive which was heartwarming.

3.6 I visited Dan Mooney and David Bromley and was pleased to meet with a range of staff. It was great to be able to see the ongoing developments within the services. I am looking forward to seeing the completed refurbishment work at Dan Mooney particularly the redesign of their garden.

3.7 I was pleased to be able to visit the Barberry Centre and meet with the teams across the wards. It was great to see staff working together to deliver services as demand continues to grow.

4. Partner and System Development / Stakeholders

4.1 I attended the NHS Integrated Care Board and Trust Chairs' event in London hosted by Amanda Pritchard NHS CEO and the chair and NEDs of NHSE Board. This was an opportunity for them to share with the chairs data around performance of regions and the challenges ahead for the NHS particularly around productivity and expenditure.

4.2 I attend the weekly NHS Confederation Mental health Chairs Network meetings which is a great platform to hear and share learning from different mental health trusts across the country.

4.3 I attended the Summerhill Supplies Limited (SSL) Stakeholders meeting where we received an overview of the proposed changes for agreement for the proposed corporate structure. These proposed changes are required to position SSL for the potential opportunity to support the ICS with their shared service projects.

5. Stakeholder Engagement

5.1 I maintain my regular monthly meetings with Shane Bray from SSL which I find very informative and I'm pleased with the developments and the plans they are looking to embark in for the future.

5.2 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.

5.3 I continue to meet with Rebecca Farmer, NHS England, on a bimonthly basis, to discuss the key areas of focus for the Trust.

5.4 I am pleased to confirm I chaired the recruitment panel for the Chief Nursing Officer (CNO) for our Trust and following the interview process we have appointed an excellent CNO Lisa Stalley- Green.

5.5 I was pleased to be able to Chair the Council of Governors meeting where we dedicated time to receiving assurances from the Non- Executive Director colleagues on key areas of focus for the Trust and updating the Council on escalation matters from our Mental Health Provider Collaborative Commissioning Committee.

6 **PEOPLE / QUALITY**

6.1 All Non- Executive Directors 1:1 have been completed with key objectives agreed as mentioned in my last report.

6.2 I meet with the Freedom to Speak Up Guardians monthly to ensure I continue to have oversight of the key themes from concerns raised and offer my support where I can in addressing these.

PHIL GAYLE
CHAIR

7. Chief Executive and Director of Operations Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**Item 7**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	3 April 2024
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

The 10th period of Industrial Action by Junior Doctors took place on 24th – 28th February 2024. At the time of writing this report 42% of junior doctors had taken part in strike action. This is a reduction on the average for the January strikes which was 49% of eligible junior doctors participating in industrial action.

All junior doctor clinics are cancelled with cancellations reviewed by the responsible Consultant to ensure patients who require prioritisation are seen in alternative clinics. A back up rota to cover out of hours duties is arranged and all duties were covered.

Medical Agency Locums

We currently have 30 agency locums engaged at BSMHFT, 21 of which are over the agency price cap.
22 of the 30 agency locums are working within ICCR. We are working with the Midlands and Lancashire Commissioning Support Unit (MLCSU) on our agency reduction plans.

Of our 30 existing agency locums;

- There are exit plans in place, with minimal risk to achievement for 14 locums
- Exit plans for 8 locums are to be finalised but should be possible
- Exit plans for a further 8 locums are to be determined but will require a radical change i.e. service re-design, post re-design

GMC Sponsorship

An application has been submitted to act as a sponsor on behalf of the General Medical Council (GMC) for International Medical Graduates. Once approved this will enable us to enhance our international recruitment activity.

Values Awards

Nominations have now closed for our 2024 Values Awards. Judges have reviewed all nominations submitted and look forward to celebrating staff at the awards ceremony which will be held in June 2024.

LGBTQ+ and Womens History Months

We launched our involvement in these in recent weeks and our LGBTQ+ and our Women's Staff Networks educating, raising awareness and celebrating colleagues across health services as part of this years LGBTQ+ theme of Medicine +underthescope and Women's theme of 'women who advocate for equity, diversity and inclusion'.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

We are pleased to share that Renu Bhopal- Padhiar current community transformation lead has been successfully recruited into the role of ICCR Associate Director and will take up post on the 7th May when Elaine Murray retires. Handover is underway to ensure a smooth, seamless transition. We are also delighted to share that both ICCR Clinical Directors, Sadira Teeluckdharry and Selvaraj Vincent have been successful in promotions

to deputy Medical Director posts. Interviews to recruit to vacancies this creates for clinical director posts are planned.

The neighborhood pathway of our community mental health and well-being services have now seen over 24,000 people which is phenomenal achievement in a 12month period. The services have received some wonderful feedback from service users about the service provided:
"If it weren't for the service what they provided for me at the surgery I think I'd be dead. I don't think I'd be here. That's me being brutally honest.
"It's made me feel as if I had more value in myself. Made me feel that it is possible to move onwards and change things instead of just sitting here and accepting fate"
"It's bringing me back to my real self… To me, I saw it as saving me"

We are delighted that we have recruited both new community Matron posts. The post holders will support with the oversight and focus for our 12 adult CMHTs, ensuring good quality assurance. Initially, they'll be concentrating on reviews of care plans, risk assessments and medicines management processes and ensuring compliance and progress with CQC actions.

ICCR have continued to support the Community Care Collaborator initiatives. Currently, we are working with acute and urgent care colleagues to identify staff to support the connected community hub initiative that has seen those who call in crisis being offered direct and speedy mental health support. These initiatives will be evaluated via the community care collaborative steering group.

We have reconfigured resources to identify investment for our steps to recovery wards. We have recruited additional Psychology, occupational therapy, Art psychotherapy and activity worker staff. We are also sourcing recovery focused, trauma informed training for our inpatient teams to enhance the offer to our service users who require rehabilitation. We believe that the additional multidisciplinary team members and training will lead to an enhanced offer that will aide recovery and support achievement of all CQC expectations around the therapeutic offer.

Our Intensive rehabilitation team (ICRT) has had significant impact on bed flow across our mental health rehabilitation system. There are obviously significant quality and service user experience benefits that have been realized with the introduction of the ICRT in providing the least restrictive care closer to home.

The ICCR leadership team continue with their drive and commitment to engaging teams in discussions around staff wellbeing, equality, diversity, and inclusion. The directorate are pleased to see the improvements in this year's staff feedback in the staff survey. The ICCR team are working on enhancing the staff experience and have developed a robust workforce plan that is leading to improved recruitment and retention of staff. The directorate have held workshops to support the development of an ICCR inequalities plan, this plan gives focus to inequalities for both service users and staff.

Secure Care & Offender Health (SCOH)

Secure inpatient services continue to experience Registered Mental Health Nurse (RMN) shortages across the men's and women's services impacting on clinical activities. Continuous recruitment is taking place with new students and more internationally educated nurses taking up posts in our division. Ward managers and Clinical Service Managers/Matrons are meeting daily on each site to prioritise work and assess shortfalls. Ward Managers are working within numbers where necessary, and occupational therapists and activities workers are being used to support activities on wards.

Two recent Deaths in Custody NHS England (NHSE) reports indicate exceptional care at HMP Birmingham and no recommendations have been received. There is continued pressure in the prison with late receptions, increased use of psychoactive substances and an increase in violence which has been effectively managed. Prison estates remain a point of escalation.

Recruitment has begun for Enhanced Reconnect services. Phoenix House has been cleared in preparation for IT infrastructure, decoration and improvements to begin. A draft mobilisation plan has been shared with commissioners and a plan to involve service users in the mobilisation is also underway.

Tamarind are operating at capacity with high clinical activities. Cedar Ward won 'Team of the month' for its effective management of infection prevention and control measures following a case of measles. At Reaside and Ardenleigh acuity is high but managed well. At Ardenleigh, CCTV upgrade and seclusion works are ongoing and progressing ahead of schedule. Citrine ward is on an enhanced monitoring support. Sam Bailey has been appointed as interim Clinical Service Manager for Ardenleigh as Emma Watts is moving to our Head of Quality role within the Provider Collaborative.

FIRST community services building remains unfit for purpose due to the lack of space and noise levels. NHSE have been approached for capital funding support and a decision is awaited. Service users in the community are facing some difficulties in accessing support during unsocial hours. An improvement plan is in place to help address this issue.

Following a scoping exercise with service users the Criminal Justice Recovery Service has been renamed to Health and Justice Vulnerability Service (HJVS). Following learning from a multi agency serious case review, the standard operating procedure of the Prison Discharge Co-ordinator team is in the process of being updated. Data captured from custody activity demonstrates increased and sustained improvements in KPI linked activity over the past 3 months.

Staff survey results have improved compared to the previous year. The division has made improvements in 45 out of 96 indicators. Staff survey action plans for 2024 have been developed. The division has submitted 86 nominations for value awards. Reaside had a positive quality visit from Reach Out which commended on significant improvements in the last 12 months.

Acute and Urgent Care

There is increasing pressure for beds within the directorate, with demand for beds increasing steadily since January. The directorate continues to work within the locality model which has now rolled out to all localities and the feedback from all staff groups has generally been positive, although there are still some improvements to be made. Through the Out of Area Steering Group, further opportunities for improvements are being identified and the focus is now on reducing DTOCs (to be classified under the new Clinically Ready For Discharge system from April) through collaborative working with colleagues from Birmingham City Council and Solihull Local Authority and MIND. The current respite contracts and private bed contracts are also being reviewed as part of this workstream.

There have been improvements in staffing across the directorate, with teams successfully recruiting to vacancies. The directorate are embarking on a Quality Improvement project to improve health rostering, reduce reliance on bank and agency and the associated spend with the support of Deputy Chief Nursing Officer, Head of Nursing and Allied Health Professional and Clinical Nurse Managers holding a confirm and challenge panel ahead of roster publication.

Recent staffing reviews have indicated there are some deficits in the staffing establishments in some teams. These have been highlighted as risks on the divisional risk register and plans are being developed to consider opinions for addressing these by team/service.

The seclusion room on Caffra PICU (at Oleaster) is going to be offline for 4 weeks from June'24 whilst necessary improvement works occur. An options appraisal outlining mitigation plans has been developed to support during this period.

The directorate are championing the introduction and expansion of the Professional Nurse Advocate (PNA) role within the Trust, recognizing the value this has for the individuals in these posts and also those who the PNAs can support.

Specialties (PCDS)

Older Adults

Inpatient wards have recruited a number of Internationally Educated Nurses to RMN vacancies and approparite support is in place including to enable individuals to develop the additional UK MH specific competencies and confidence to undertake the role. The inpatient wards continue to have patients with high acuity which is being reviewed regularly. Recently, the service successfully hosted a wellbeing event for staff which has supported new ideas from staff on how to improve their wellbeing at work. This offer will continue on a monthly basis and ideas from staff will be followed up.

Community Mental Health Teams

We are expanding our successful Silver Sunday event via roadshows. The service is in the process of scoping appropriate venues with good transport links and parking. The focus is to showcase the variety of services within the localities to support our service users and reduce health inequalities. We are also happy to announce we will have Birmingham Community Health Care and SDSmyhealthcare frailty team joining us to strengthen physical health offer.

Veterans

The partnership collaborative are planning a whole Midlands Annual away day. The collaborative is planning to use underspend to finance additional third sector places for Veterans needing additional regional/national help and support that cannot be provided by our respective organizations. As we near the end of the financial year we want to prioritize staff training/wellbeing initiatives as identified in the staff survey.

Birmingham Healthy Minds

There will be significant changes to the key performance indicators for NHS Talking Therapies services from April 2024 (these are currently in draft form). There will be two measures of recovery: reliable recovery and reliable improvement. There is ongoing work with clinicians to prepare them for this change and to increase the staff in the teams with 6 further individuals recruited in recent weeks.

Barberry services

The service is in the process of trialing the use of a Discharge Manager and there has already been a significant reduction in delayed transfers of care across the specialty wards. This will continue to be evaluated. The waiting list continues to improve for both neurology and eating disorders services following successful recruitment and the implementation of improved pathways. The eating disorder service recently had a Binge eating tester weekend which was a success. The collaboratives mini conference for eating disorders also proved to be very effective in bringing all partners together to consider changes in this specialist area.

Learning Disability and Autism (LDA)

We continue to work with our ICB colleagues to ensure that we are fully compliant with the support and planning requirements for our service users in our care, who have a diagnosis of leaning disability and/or autism. We have re-established our LDA steering group which holds the responsibility for delivering against our plan, in line with the national requirements. Oversight of this sits with our Operational Management Group (OMT) and Clinical Governance Committee (CGC).

SUSTAINABILITY

Funding and Finances

Planning for the new financial year has been complicated by the absence of the national planning guidance – while key messages have been issued, the formal documents usually issued before Christmas have yet to issued. This has meant that it is not yet possible for commissioners to confirm allocations and how any new funding for mental health will be allocated. In addition, due to changes in national inflation assumptions, the amount of funding we are expecting to receive to cover the increased costs of pay and non pay items has reduced again to just 0.6%.

We continue to work hard with our local partners across Birmingham and Solihull to assess opportunities for reducing the system deficit still further and are committed to ensuring that mental health continues to receive and use its fair share of funding.

West Midlands Mental Health and Leraning Disabilities & Autism Provide Collaborative Update

The West Midlands wide Provide Collaborative Board continues to strengthen collaborative working and in addition to the strategic priorities agreed during 2023 we brought all executive teams together during December to identify key areas of focus for the coming year.

We agreed that groups would come together and work for the next few months on developing the ideas from the day into firmer recommendations so that the issues we identified can be prioritised and addressed throughout 2024. Executive teams will meet again to consider progress and develop further during April.

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.

The Trust is currently responding to reports received from the Care Quality Commission to demonstrate that actions are being taken against areas that has been identified as requiring improvement.

The Trust will continue to keep the CQC appraised of our work streams related to our Section notices as well as providing updates on progress at the monthly CQC Steering Group.

LOCAL NEWS

Executive Director of Quality and Safety (Chief Nurse)

Following a rigorous selection process for our new Executive Director of Quality and Safety (Chief Nurse) and I am pleased to announce that we have appointed Lisa Stalley-Green to this role in Team BSMHFT. Lisa is already familiar with BSMHFT in her current role of Deputy Chief Executive and Chief Nursing Officer at the Integrated Care Board. With a focus on reducing health inequalities and working in partnership across Birmingham and Solihull Integrated Care System, Lisa has led improvements in safeguarding partnerships and practice as executive lead for quality, patient experience, workforce and infrastructure. Lisa also leads on anti-racism in professional practice and chairs the West Midlands Regional Global Majority Improvement Group.

Her drive for excellence in care, service improvement and shaping positive and inclusive working cultures has shaped her 20-year career in the NHS, which has included roles in A&E, community services, prison health, commissioning, and acute services. From May 2022, having led an acute group through the COVID-19 pandemic, Lisa took on the role of Deputy Chief Executive and Chief Nursing Officer at NHS Birmingham and Solihull Integrated Care Board.

NATIONAL NEWS

News from the Office for Health Improvement and Disparities

The Public Health Outcomes (Framework examines indicators that help us understand trends in public Health)

The Public Health Outcomes Framework sets out a vision for public health, that is to improve and protect the nation's health, and improve the health of the poorest fastest.

This data tool currently presents data for available indicators at England and local authority levels, collated by the Office for Health Inequalities and Disparities. Read the reports specifically for Birmingham and Solihull.

My Voice Matters: The power of a youthdriven approach to children's mental health

'My Voice Matters' was the theme of this year's Children's Mental Health Week, placing a spotlight on empowering children and young people, equipping them with the essential tools to express themselves and ensure their voices are heard.

According to latest prevalence data, approximately one in five children and young people in England now have a probable mental disorder. This is up from one in six in 2021, and one in nine in 2017. Just shy of half a million children and young people are currently on mental health waiting lists, 85% higher than before the pandemic. Almost three times as many children and young people have been referred to crisis care than before the pandemic.

NHS Networks

Discharge from mental health care: making it safe and patient-centred

This guidance outlines how the Health Services Safety Investigations Body will conduct investigations into the deaths of patients and/or potential mistreatment of patients during periods of inpatient care in mental health care settings, during transition to or from other health care services, or immediately following the discharge from such inpatient mental health care services.

Mental health services in the UK in 2023:
What the latest NHS benchmarking findings tell us?

Every year, the NHS Benchmarking Network presents data to mental health services across the four UK nations, including the services they provide, the resources that go into them, and some of the issues they face on a daily basis countrywide.

The results for 2023 present a picture of services that are working at a relentless pace to keep up with growing demand for mental health support. While the Benchmarking Network's data provide raw numbers, they tell an important part of a story that is as yet unfinished, of how mental health services in the UK are changing and responding to unprecedented levels of need.

Last year, referrals to adult community mental health services rose by some 11% on the previous year – with 625,000 people referred to 'generic' community mental health teams (CMHTs) alone. A further 213,000 children and young people were on waiting lists for Children and Young People's Mental Health Services (where referrals rose by 7% last year).

News from the King's Fund

Given England's growing and ageing population, the NHS and social care sector need a lot of staff to deliver high-quality health care or social care at the required volume.

But in both sectors, there are staff shortages – a difference between the number of posts in the sector and the number of posts that are filled. This shortage in staff can be seen by looking at vacancy rates. In September 2023, the overall NHS vacancy rate was 8.4%, or 121,000 full-time equivalent (FTE) roles. In 2022/23, the overall social care vacancy rate was 9.9%, or 152,000 roles. These are both substantially higher than the overall UK vacancy rate of 3.4% in 2022/23.

Parity of esteem

The Department of Health and Social Care and NHS England have now provided a definition of parity of esteem to the Public Accounts Committee as 'Everyone can access MH services in a timely way and waiting times are on par with physical mental health, and everyone can access evidence-based treatments'.

This definition has been developed in response to a request by the Public Accounts Committee inquiry following a 2022 NAO report on Progress on Improving Mental Health Services. This new definition is important as parity of esteem is a term widely used, but with different understandings of its meaning. However, the words alone mean little, it is how it is utilised that is important. Government, national bodies and systems need develop plans that move towards achieving this definition.

The department and NHSE have also set out the building blocks needed to ensure parity of esteem:

- Access and waiting time standards are on par with physical health and treatment is evidence based
- Care is patient centric and quality of services is on par with physical health services
- Every part of the NHS recognises and prioritises mental health on par with physical health, and patients can access services through pathways from primary care to UEC.
- Data in the MH sector is on par with physical health
- Funding decisions are made to close the gap between mental and physical health, allowing for sufficient workforce, capital to ensure therapeutic environments and equal payment systems.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

8. Board Assurance Framework

Report to the Board of Directors							
Agenda item:	**8**						
Date	3rd April 2024						
Title	Updated Board Assurance Framework						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*					
Alert		**Advise**		**Assure**	✓

1. Purpose:

The Board Assurance Framework (BAF) is one of the most important tools in the Board of Director`s toolkit that can enable it to gain assurance, evidence and confidence that principal risks to the delivery of the Trust`s strategic goals are effectively mitigated and managed in a structured, comprehensive, agile and proportionate way in line with the Trust`s Risk Management Policy and best practice. The BAF is thus an assurance tool that brings together in one place all the relevant information on the principal risks to the board`s strategic objectives.

Members of the Board and Board Committees in delivering their key function of oversight and scrutiny are using their different BAF reports as drivers for effectively prioritising discussions, debates and gaining assurance while triangulating the intelligence gleaned with what the various reports on their agendas are telling them. Effective corporate governance requires the Board of Directors to pay as much attention to risks and the BAF as they do to performance and the financial health of the Trust.

2. Introduction:

The FRC (Risk Guidance 2014) states that “the Board [and its committees have] ultimate responsibility for risk management and internal controls including the determination of the nature and extent of principal risks [they are] willing to take to achieve [the Trust`s] strategic objectives.” The BAF thus serves as an effective tool for members of the Board to interrogate and assure themselves that the systems, processes, architecture and arrangements in place for mitigating, managing and governing risks aligned to the delivery of the Trust`s strategic priorities are fit-for-purpose. Board Committees at their last review of the BAF noted its current holding position which reflects updates captured in February/March 2024 and expressed satisfaction with the progress being made.

Members of Board Committees at their meetings in February/March 2024 (including BAF review meetings), and following effective review and scrutiny of their BAF reports recommended that BAF Leads,

and their Executive Directors continue at pace with the ongoing piece of work aimed at fine-tuning and strengthening the BAF by ensuring that: -

- All actions which have breached their due dates are reviewed and closed accordingly.
- Consider how existing controls dovetail and align with ongoing pieces of work/project – Effectiveness of controls and assurance should be considered and aligned with ongoing work/projects.
- Consideration be given to triangulating the wider impacts of BAF risks from multiple perspectives and lenses e.g. Quality & Safety, Finance, People etc. These should be factored into the narrative, risk description and made much clearer. A consideration of how the interdependencies between these variables could be impacted upon were the risk to crystallise should be given some thought.
- Where applicable, the risk title and description should be reviewed to make it `much clearer` what the risk is, how it fits together and link to any existing strategy e.g. Estate Strategy, Quality Strategy, Clinical Strategy etc.
- The CRR should be developed to further align with and support the BAF.
- Members of the People Committee during a `deep dive` into the BAF at their February meeting further advised that the current holding position of the BAF be regularly reviewed whilst discussions are ongoing around overhauling and strengthening it. They recommended some work be done on reviewing the current BAF template to simplify, streamline and make it more user-friendly and advised risk aggregation i.e. for the following two BAF risks to be developed from the existing four risks on their BAF: -
    - Inability to recruit, retain or transform its workforce in response to the needs of our communities.
    - Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.

The plan is for the `new BAF` to be presented at its meeting in June with the view of presenting at a future Strategic Board Development session for further review, discussion, and adoption for wider use.

3. Significant movements in BAF Risks since the last iteration:

There hasn`t been any significant movements in the scores of BAF risks since the last iteration however, it is worth noting that members of Board Committees after reviewing the various reasons that were articulated, approved extension to the due dates to the following actions link to their BAF:

- *BAF05/QPES/002*
- *BAF05/QPES/004*
- *BAF06/QPES/001*
- *BAF06/QPES/002*
- *BAF02/FPP/002*
- *BAF05/FPP/004*

Members of the People Committee queried if it were realistic for most of the actions on the People Committee BAF to be achieved in April 2024 as they have been set and advised that these be reconsidered, and realistic completion dates set. People Committee BAF Leads have progressed this action as advised.

4. Key issues and risks:

The main issue to note with the BAF is the fact that it is a dynamic tool which is continuously reviewed, fine-tuned and strengthened as the Trust matures along its risk management journey.

1. Agenda item 8.2 – Details of updated Board Assurance Framework

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services		**Reducing pt death by suicide / safer and effective services**
People	✓	**Staff wellbeing and experience (impact of death by suicide)**
Quality		**Preventing harm / A pt safety culture**
Sustainability		**Inability to evidence and embed a culture of compliance with Good Governance Principles.**

Recommendation

The Board *is requested to:*

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE and ENDORSE*** *the content of the updated BAF (see agenda item 8.2 for details).*
3. ***GAIN ASSURANCE*** *that principal risks to the delivery of the Trust`s strategic objectives/goals are effectively mitigated and managed in line with best practice and the Trust`s Risk Management Policy.*

Enclosures

1. *Agenda item 8.2 – Details of updated Board Assurance Framework*

Updated Board Assurance Framework Report

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 March 2024

QUALITY AND CLINICAL SERVICES

Strategic Priority (Quality): *Delivering the highest quality services in a safe and inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve.*

Strategic Priority (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.*

Assurance Committee: Quality, Patient Experience and Safety Committee (QPES)

Table 1a: Updated Board Assurance Framework 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 inconsistency in the pace of implementing 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	Executive Director of Operations	QPES	Head of Strategy, Planning and Business	16	⟷

	transformation of mental health services across our systems			Development/ 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 evidence and embed a culture of compliance with Good Governance Principles.	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	12	
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	12	
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. Updated Board Assurance Framework Report showing Heat Map

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

Details of updated QPES Committee 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**	**18th Dec 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.	• Community transformation • The design of a Community engagement Framework being led by the ICB. • QI Programmes with our EBE`s. • Ongoing work around preventative needs and stigma. • The developing Participation and	• Changes in the Policy landscape and the creation of ICBs and system working. • Challenges around workforce as genuine engagement requires	• Quarterly reports on participation and engagement presented at Trust Clinical governance and QPES. • QI Reports • Executive oversight of the engagement activities.	• Lack of regular and frequent governance reporting and oversight. • Inability to integrate and effectively use data in reporting. • Lack of EBE Strategy • Patient safety partners are new to
	• Lack of a cultural shift required to capture the needs				

	of families and carers. • A stretched workforce that hasn`t always got the capacity to make these relationships. • Difficulties with sharing good practice and duplicating it. • The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services. • The diversity of our communities means Communities can find us hard to reach. • Lack of consistency and burnt-out workforce in some of the services. • High use of bank and agency staff can impact on our capacity to build relationships with families.	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	sufficient and consistent staff.		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	Completed	

	BAF01/ QPES/003	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.	February 2024	New action	
	BAF01/ QPES/004	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/ QPES/005	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.	February 2024	Change requested due to partial delay in recruitment and extended induction requirements.	
	BAF01/ QPES/006	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.
18/12/2023	**Progress** **Changes** Dates amended on the following actions; BAF01/003/QPES changed from 31st December 2023 to February 2024 **New Actions** No new actions added **Closed/Completed Actions** The following actions has been closed/completed; BAF01/002/QPES **Scoring** **The scoring is unchanged at 12**. Rationale is detailed below; **Likelihood: 4:** Limited progress has been made against the Patient Experience actions since original scoring was made meaning likelihood remains unchanged. **Consequence: 3:** Actions underway and complete ensure/mitigate against a higher consequence to end-user.

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**	**18th Dec 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 Group (PSAG). • patient satisfaction	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Learning from Deaths Reports. • Community Deaths Reports. • Medical Examiner	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. • Legal Quarterly Report • Never Events Reports • Commissioner and NED quality visits	Learning From Improvement Analysis and triangulation of data across different sources needs to be strengthened and made more consistent. Content, format, and flow. Embedding learning from Sis, complaints, and incidences.

		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 • Learning and Development Team • Internal Electronic Record System – Rio • ESR enables capture of Clinical Supervision and RMS <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 • Shared Care Platform	Reports. • NHS Digital Quarterly Data. • Commissioner and NED quality visits. • Gap in MHA Action Plan oversight arrangements from CQC inspections • Insufficient resource within the L&D Team to provide robust oversight of Quality and consistency of training delivery. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR is highlighted as being protracted and difficult and so	• Organisational Safety Bulletins. • Safety Summits • Trust Quality Strategy. • L&D Business Case submitted for CRAM Trainer to increase resource • ROAD Group (Rio delivery Group) provides trustwide oversight of changes to Rio • Clinical Systems Group • CCIO and 2 x Deputy CCIO's in place <u>Third level assurance</u>: • CQC planned and unannounced inspection reports. • Internal and External Audit reports.	Quality Strategy, Quality Management System and Quality priorities not fully aligned and lack of infrastructure to deliver. Currently no Trustwide Oversight Group for L&D Business Case for CRAM Trainer not yet approved. Clinical System strategic approach could be strengthened to maximize effectiveness

			compliance with use of ESR is low across most professional disciplines. • Perceived lack of training and support for supervision training at local level. • The action plan amnesty thematic review has highlighted a gap in staffs understanding of the importance of RMS/Clinical Supervision		
	• *lack of self-awareness of services that are not delivering.*	Clinical Governance meetings Directorate/Specialty governance meetings Improvement Programme.	Improvement Plans oversight Inconsistency in approach of local CGC arrangements	Standardized QPESC agenda item enabling escalation reporting to Trust CGC Triple A reporting to QPES from CGC Commenced CGC Local review-	Inconsistency in what type of information is reported/escalated to Trust CGC by local CGCs. This impacts what is then upward reported to QPESC and Board. Insufficient reporting

					from Board back to service areas.
	• *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	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 Reporting 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.	No consistent quality planning process Availability of data	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 Lack of upward reporting from PSAG to Trust CGC Committee structure between local CGC and Trust CGC needs strengthening and clarity regarding roles, responsibilities, and decision-making authorities.
	• *limited co-production with services users and their families.*	Patient Safety Advisory Group Patient Stories. Carer Strategy PEAR Group LEAR Group Service Area – Service User Forums EBE programme Recovery College Patient Safety Partners	PSAG do not send exception reporting to QPESC Reporting of associated forums/committees not consistent/lack of awareness-embedding of work	FFT Scores Exception reports: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports Internal inspection and	Poorly functioning complaints function disenabling learning/triangulation from complaints and patient feedback.

		EBE consultation and participation in specific trust-wide groups/forums		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 • Safer Staffing Committee Safety Huddles Professional Codes of Conduct NMC Code GMC Good Medical Practice Guide. HCPC Standards of Conduct, Performance and Ethics.	Poor adherence to Healthroster rules and management requirements Under use of ESR Insufficient resource within the L&D Team. Insufficient oversight of Quality and consistency of delivery.	Report on safer staffing levels to Safer Staffing Committee, TCGC, and QPESC. Safety Huddles review staffing on a daily basis Roster Clinics in place led by the Trust Safer Staffing Lead	Gaps in assurance: Safe staffing data for medical and nurse staffing. Currently no Trustwide Oversight Group for L&D Business Case for CRAM Trainer not yet approved. No corporate oversight for the quality of safety huddles.

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

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

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

target risk score.					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	Feb 2024	• Change requested due to agreed start date of February by DoF	
	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	May 2024	• Change requested due to change in ToR and consultation by Committees prior to agreement.	
	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. •	

		Action Plan amnesty has revealed 2 main themes from the MHA Inspections; • Rights being read • Associated documentation of mental capacity act MHL Team to identify group of bespoke actions to address thematic review.	MHL Team	March 2024	• Will support urgent action against 2 of the strongest themes of non-compliance.	
	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 Governance	January 2024	• Will enable QI resource to be allocated most usefully to the organisation alongside being a key function of the QMS. • Will assure the Board of QI approach and embedding QI culture into the organisation.	
	BAF02/QPES/007	Revised Safety Summit framework to be completed.	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	January 2024	• Change requested due to PSAG cancellation at the end of 2023.	
	BAF02/QPES/009	At start of the new financial year, to have a clear implementation plan linking the Quality Strategy, QMS, and	Executive Director of	April 2024	• Ensures a clear roadmap for the delivery of quality over the next	

		Quality priorities for 24/25 with approved dedicated resource	Nursing and Quality Executive Medical Director		12 months	
	BAF02/QPES/010	RMS and Clinical Supervision Workstream to be commenced with objectives to include; improvement in IT systems, compliance with policy requirements, and improved quality of supervision.	Associate Director of Clinical Governance	April 2024	• Will support engagement with RMS and Clinical Supervision enabling improved support mechanisms for staff.	
	BAF02/QPES/011	Customer Relations KPI Improvement Plan will be devised and reported to QPESC on a monthly basis	Head of Customer Relations	January 2024	• Will support QPES Oversight of improvements to KPI's	
	BAF02/QPES/012	Emerging Risk Group to be commenced to support triangulation of datasets and enable QI approach to emergent themes/concerns	Head of Patient Safety	February 2024	• To support triangulation and best use of intelligence reducing patient safety risk by maximising understanding.	

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.
18/012/23	**Progress** **Additions** Multiple additions made to controls, gaps in controls, assurance, and gaps in assurance. 3 further actions added to BAF action plan to support progress around current gaps **Changes** Dates amended on the following actions; BAF02/QPES /002 – Changed from October 2023 to February 2024. This is a new agreed implementation date from PDG. BAF02/QPES /003 – Changed from February 2024 – April 2024 – In line with approved TOR BAF02/QPES/008 – Changed from November 2023 – January 2024. This was due to PDMG being cancelled. Group will re-sit in January with 1st upward report presented then. **New Actions** BAF02/QPES/009, 010, 011 have been added to the BAF **Closed/Completed Actions** The following actions have been closed/completed; BAF02/QPES/005, BAF02/QPES/006, BAF02/QPES/007

	Scoring **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT.
Feb 2024	Updates on progress with mitigating and managing this BAF risk.

	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	**18th Dec 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 agendas to address learning activity. • Clinical service	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 and Board.		The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. The Safety Summits are in their early conception and may not be adopted well by	

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

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

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented	BAF03/QPES /001	Implementation of PSIRF by October 2023 strengthening the wholescale approach to understanding and sharing of excellence and organisational learning.	Deputy Director of IPC, Patient Safety, Clinical Quality and 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	

to achieve target risk score.					months detailed analysis. • Resultant outcomes from PSIRF implementation will be a Patient Safety Incident Response Plan and Policy.	
	BAF03/QPES/002	Options appraisal will be prepared for ET outlining options to support roll out of Patient safety Culture.	Deputy Director of IPC, Patient Safety, Clinical Quality and Governance	December 2023	• To support direction in how to successfully roll out Safety Culture Survey.	
	BAF03/QPES /003	Organisational Safety Culture Assessment will be completed, and Divisional led action plans put into place to address safety culture concerns.	Deputy Director of IPC, Patient Safety, Clinical Quality and Governance	June 2024	• Change requested to enable enaction of agreed options appraisal and subsequent survey requirements.	
	BAF03/QPES /004	PSAG Agenda and Cycle of Business will be reviewed and strengthened.	Deputy Director of IPC, Patient Safety, Clinical Quality and Governance Executive Medical Director	February 2024	• Change requested due to allowing transition to PSIRF supporting stronger view of this Groups new requirements.	

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.
18/12/2023	**Progress** **Additions**

	1 further actions added to BAF action plan to support progress around current gaps **Changes** Dates amended on the following actions; BAF03/QPES /003– Changed from October 2023 to June 2024. This is a new agreed implementation date as will require substantial roll out plan. BAF02/QPES /003 – Changed from July 2023 – February 2024 – PSIRF Implementation/transition was required before considering new TOR/Agenda for PSAG **New Actions** BAF03/QPES/002 has been added to the BAF **Closed/Completed Actions** The following actions has been closed/completed; BAF03/QPES/002 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to learn from previous incidents of harm to patients and staff. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. PSIRF transition has only just occurred and is in its early stages, new learning responses have not yet to be fully trialled to see if they bring about meaningful learning. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT
Feb 2024	Updates on progress with mitigating and managing this BAF risk.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential inconsistency with the pace of implementing 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**	**29th February 2024**

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 inconsistently implement a recovery focus model at a varied pace across our range of services.** This may be caused by: -				
	Lack of opportunities for service user participation. Lack of employment opportunities for those with lived experience. Lack of support for and involvement of families and careers. Lack of effective partnership working with Community agencies. Lack of effective understanding by staff of what the Recovery Model is about and its	• BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Implementation of Family and carer pathway. • BSOL peer support approaches.	Family and carers pathway not consistently applied or suitable for all services. Performance in these areas is not effectively measured.	• Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR) Group.	Having a strong service user/carer voice across all of our governance forums.

	expectations. Inconsistency of Pathways maturity and availability.	• 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.		• 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.
29/11/2023	Updates on progress made so far.
29th Feb 2024	Updated, title and risk description modified, and new controls added.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to be rooted in communities and tackle health inequalities.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date 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**	**29th February 2024**

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. Demand for community services	• 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	• Integrated performance dashboard. • BSOL system mental health performance dashboard. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering Group. • Reach Out governance structures. • Local FPP and CGC	• Inability to engage with all parts of the Trust. • Local meetings not feeding into higher level. • Relevant people not present at deep dives; includes consistency of how these are carried out and how KPIs are monitored.

	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	alongside day job. • Recruitment and retention	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. Above action modified to read as thus: - Work to address inequalities has commenced on certain parts (e.g. Secured Care & Perinatal Services) of the Trust and is progressing.	Head of Quality Improvement / Associate Directors of Operations	Ongoing process	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	Ongoing process	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.
29/11/2029	Updates on progress made so far.
29th Feb 2024	Updates on various works happening in other parts of the Trust have been considered. Actions reviewed and new one added.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date 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**	**29th February 2024.**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF06/QPES	**There is a risk that the Trust may fail to implement preventative and early intervention strategies which can help enhance mental health and wellbeing.** This may be caused by: -				

	Demand for services exceeding our capacity to deliver good quality, timely care.
	.
	Lack of admission alternatives, including full range of crisis support services.
	Waiting times to access Solar services in Solihull.
	Waiting times to access Birmingham Healthy Minds.
	Inadequate support for our service users with mental health co-morbidities e.g.,
		• System approaches to improving and developing services.
		• Solihull Children and Young People Transformation Programme including:
		  ○ Transition workers
		  ○ Mental health support in schools.
		• Talking therapies recovery plan.
		• Urgent care
			• Capacity within teams to deliver transformation and service developments alongside day job.
			• Not enough beds for population when compared nationally.
			• Recruitment
				• Integrated performance dashboard.
				• BSOL system mental health performance dashboard.
				• BSOL Talking Therapies Steering Group.
				• Solihull CYP Board.
				• Highlight and escalation reporting into Strategy and Transformation Board.
				• Performance Delivery Group “deep dives”.
					• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.

	substance misuse, learning disability, autism etc.	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.	and retention impacting delivery plans.	• Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Clinical Effectiveness and Assurance Group.	
	This may result in: -				
	• Service users being cared for in inappropriate environments when in crisis. • Increased pressure on A&E in acute hospitals. • Increased risk of incidents. • Individuals' mental health issues escalating leading to increased need for secondary care. • Negative impact on recovery and length of stay/time in service. • Increased local and national scrutiny. • Negative impact on service user access, experience and outcomes.				
	Linked risks on the CRR- 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	Ongoing process	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /002	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	Ongoing process	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. Completed in Jan 2024	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
02/06/2023	New risk which has just been added.
29/11/2023	Updates on progress made so far.
Feb 2024	Risk including actions reviewed and updated.

Details of FPP BAF

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
Title of risk	Failure to focus on and harness the wider benefits of digital improvements.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023
		Risk Appetite	**Open:** Systems / technology developments considered to enable improved delivery. Agile principles may be followed.			**Date reviewed**	**11th March 2024**

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,	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.	• Minutes show that last year 42 teams came to the system strategy group to discuss ideas and issues where digital, data and technology could offer a solution. • DOF chairs and attends SSG and reports to FPP with CIO.	

		• Estates, • 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.	• Communications around the offering.		
	• *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.	• Only new Business case projects go thorough the Capital Review Group, existing services are not considered unless	• Minutes • Reports to FPP committee • Business cases	• Does not apply to existing or service redesign if no funding is required

		• The DOF Chairs, CIO is included in the distribution of all new business cases.	capital investment is required.		
	• *Teams and services are not aware of digital solutions within the Trust.*	• System strategy group produces an annual update to the Trust (Digital newsletter). • The PMO ensures all digital projects have a case study and project on a page submitted to Connect and the staff briefing as they occur. Individual projects are discussed at FPP in the quarterly assurance update. • Strategy and Transformation Board receive a monthly update on all live projects.	• Articles, minutes, papers are predominantly digital media. • Those systems in place for a while no longer get entered into the papers or articles unless it is a significant change.	• Connect • Digital newsletters • Minutes of FPP • FPP Papers • System strategy minutes and papers. • Strategy and Transformation Board, minutes, and papers.	• Does not apply to existing products / systems.
	This may result in: -				

	• *Inability for services to innovate.* • *services do not engage with the digital first agenda.* • *Efficiencies and savings are not realised.* • *Quality improvements are not optimised.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	**N/A**

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	**BAF01/FPP/ 001**	Wider communication across the Trust regarding the Systems Strategy Group, including its role.	James Reed / Carl Beet	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	
	BAF01/FPP/ 002	Raise awareness of the ability for the Systems Strategy Group to help in service redesign and re-imagining service delivery. Start with Senior Leadership Team meeting and professional user groups	James Reed / Carl Beet / Shaun Kelly	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
12/06/2023	This is a new risk which has been recently added.
19/09/2023	Updates to FPP have taken place in line with the quarterly cycle, 9 comms articles have gone out in the last quarter lifting the profile of digital projects and services featured in the weekly brief. The Digital strategy is in draft and has been shared with FPP and circulated through wider meetings as part of a general digital awareness. We have dedicated snap comms for all things digital and have used the

	snap comms to promote campaigns on cyber awareness, general digital updates, and system upgrades. We have expanded the use of the virtual agent / chat bot “Ask Jake” which now covers the majority of password resets in the organisation and we are looking to expand that in to other departments such as HR and Estates.
14/12/2023	Members of the FPP and the various BAF leads at the BAF review meting queried if the lack of a Trust-wide transformation/continuous improvement piece or operational driver for digital shouldn`t be the focus of this risk considering the fact that digital is only an enabler with the aim of maximising the benefits of the transformation agenda. The Trust thus needs to demonstrate clarity around what it wishes to achieve through its clinical services transformation agenda with digital supporting as an enabler. Members agreed that this BAF risk is around failure to maximise the benefits from the investments in IT and that it should be widened to include cyber security and recommended the following new BAF risk for consideration: - • Potential failure to reap the added value of and embed a Trust-wide culture of continuous improvement and transformation. This underpins the risk of not delivering the outcomes linked to the transformation Strategy as reflected in our inability to define how things will look like in say 3years time.
11/03/2024	Digital, data and technology presentations have taken place with exec colleagues and a dedicated session at the senior leaders’ briefings. The System Strategy group continues to be the core group for all Digital, data and technology asks within the Trust, we have increased the areas represented and the diversity of the group to ensure greater collaboration and awareness takes place across the organisation. We are moving on to the national tenant for Office 365 to aid with the wider system collaboration piece across the ICS, this should aid with integration across our own organisational boundaries and help with accessing data from other organisations in the ICS. We have published our Microsoft roadmap on connect under the PMO and ICT pages, to aid the wider communications piece. The HR chatbot is under development to help with all Digital HR matters across our teams and we continue to automate the onboarding work for TRAC and ESR.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	3	3	9	Finance, Performance & Productivity Committee	
Title of risk	Potential failure in the Trust's care of the environment regarding implementation of the Green Plan.	**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**	**26th Feb 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF02/FPP	There is a risk that the Trust may fail to meet national and regional sustainability, net zero carbon and its green plan objectives. This may be caused by: -				
	• *Management of vacant properties.* • *Management of Owned, Retained, PFI and landlord facilities.*	• Shareholder, Liaison, Contractor and Operational Management Team Meetings and Committees are all in place to ensure communication, Service delivery, and physical aspects and priorities are delivered to meet all quality requirements. • Operational and Strategic Health and	• 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	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL,	• Risk of lack of ownership and prioritization. across the Trust • Risk of lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply.

		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.	Corporate Department delivery and Clinical/ Nursing service commitment making sustainability and net zero carbon part of our BAU.	Finance, Procurement, Clinical/ Nursing Teams, etc. • Trust Board Executive named responsible. • Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan. • Condition Surveys, review of premises statutory standards and compliance assessments / independent AE audits ensure standards are met and maintained. • Trust Green Plan signed off at Board level. With all National Returns completed on time and accurately.	• Risk of lack of leadership across the Trust to maintain momentum on the agenda and ensure it is sufficiently resourced and embed in core activities and behaviours. • External changes in legislation and mandates that lead to undue pressure on the organisation.

				• Trust Green Plan in line with ICS Green Plan.	
	• *Performance of owned/ PFI premises.* • *Achievement of the Action Plan set out in the Trust Green Plan across Trust multi-service suppliers.*	• Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme. • Revenue Programme. • Incident reviews and actions. • PFI Lifecycle Programme. • PPM, reactive and planned works • Delivery of the Trust Green Plan and the built in Action Plan	• Allocation of resource as necessary, but focused response to Audits and controls.	• Risks allocated inc mitigation, action and review. •	• Encourage - Clinical Management to liaise with Risk Management on all Sustainability issues. • Engage with Risk / Health and safety team; regular meetings.
	• *Service provision to premises both hard and soft FM. Examples; Waste Management, Cleanliness, Food Management, etc.*	• Trust Food Group- multi disciplinary team inc Clinical, Dietetic lead, SSL FM leads • Balanced menu provision designed by SSL and their Supply Chain. • Provision of food from Conventional	• 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.	

		in-house compliant facilities. • Operational and Strategic Water Management Groups. • Infection Control Committee.			
	This may result in: -				
	• The environment does not support delivery of first class Clinical services. • Service User safety, care and ability to receive the best therapeutic care is compromised. • Quality provision of the physical environment is challenging. • National Green Agenda targets not achieved				

	Linked risks on the CRR- Risk ID	**Brief risk description**
	85	Non-compliance with E and F statutory standards in external landlord-controlled buildings.
	97	Poor cleanliness standards leading to infection control risks.
	1459	Reaside- backlog condition and clinical functionality.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/FPP/ 001	Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	On-going	Full Action Plan schedule established, set against Regional and National objectives.	
	BAF02/FPP/ 002	Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust	August 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.
14/12/2023	Members at the BAF review meeting argued that this risk around the `Green Agenda` and should include the fact that it is driven by three things i.e. standards set by the quality improvement piece, the therapeutic environment and safety of patients. Members then recommended that this risk should be refined with clarity of purpose to include elements around transformation, compliance and the need to maximise benefits to patients and avoid harm.
26th Feb 2024	Risks and controls remain as this represents a long-term strategic approach needed by the NHS to manage its Sustainability and Net Zero challenges. It does not represent a short-term project or programme of works. Indeed, failure to deliver against the agenda in its entirety being a significant risk to all NHS organisations. In terms of long-term planning very significant financial resources will need to be made available to allow for fundament challenges such as Heat Decarbonisation. BSMHFT full Regional and National engagement. SSL/BSMHFT leading the ICB/ICS responses Nationally.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Failure to operate within its financial resources during financial year 2023/24.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16	**Date added**	09/06/2023
		Target Risk Score	4	2	8		
		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**	**12th Feb 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF03/FPP	*There is a risk that the Trust may fail to operate within the financial resources available to it.* *This may be caused by: -*				
	Poor financial management by budget holders	Governance controls (SFIs, SoD, Business case approval process) Financial Management supporting teams Reporting to FPP and Board on Trust performance. Continued review and utilisation of balance sheet flexibility.	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 and monthly reporting of financial position and any deviation from plans for 23/24.	Trust continues to be given assurance through audit reports. HFMA sustainability audit has identified a number of development areas that would improve controls and performance.
	Inadequate financial controls				
	Cost pressures are not managed effectively				
	Savings plans are not implemented	Savings Policy Sustainability Board review.	Attendance at Sustainability Board variable.	Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its	HFMA sustainability audit has identified a number of development areas that would

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

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

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

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

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
25/04/2023	25 actions confirmed closed through April Audit Committee for HFMA Sustainability Audit.

01/09/2023	Communications issued to whole Trust re financial position – number of initiatives implemented to increase controls including Vacancy Control Panel and Investment Oversight Group. Work ongoing to identify further opportunities for efficiencies and work by KPMG at system level now being finalised which offers some further options
14/12/2023	Members at the BAF review meeting argued that this risk is around compliance and the need to avoid financial failure and queried in the light of the previous discussions on digital and the green agenda if it has been appropriately framed? They also argued that this risk should specify which year it is referring to and how finance is enabling investments in clinical care and transformational change. Members also agreed that the Trust needs to generate financial efficiency in order to have the financial headroom to invest in the things that we want and to maximise benefits from the investments we make.
12/2/2024	BAF risk title amended to include reference to financial year 23/24 in light of discussions around when the risk relates to. Likely that the score will need to be amended to reflect the outcome of the planning round and certainty in income for 24/25 but position not yet confirmed. Additional element added within controls around utilisation of balance sheet flexibility as this is how the position is being managed in this financial year as reported and agreed by Board as part of the NHSE financial reset. Proposal for Risk Management Group to review how the risk is framed for 2024/25 financial position once there is more certainty around plan for next year.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	**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**	**8th March 2024**

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 not sufficiently evidence, demonstrate and embed a culture of compliance with the requirements of Good Governance such as CQC Regulatory provisions, standards and Notices, safety practices, the new NHS Provider Licence, the Nolan Principles, good corporate governance codes and principles 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.	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.	Poor learning from previous regulatory inspections. Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. Peer review not very regular.

	Excessive emphasis on compliance leading to a `tick-box` culture. *Poor perception of compliance leading compliance overload or fatigue.* *Human factors, poor attitudes, human behaviours and desire to circumvent due process.* *Weak internal systems, processes and procedures.* *Lack of awareness of the added value of regulatory compliance to the business.* *Requirement to meet the statutory duty to `breakeven`* *Staff circumventing due process or taking `shortcuts`.* *Managers making decisions above their competence or powers without due regards to the Scheme of Delegation.* *Lack of openness, fairness, transparency and non-*	Regular audits on 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. Savings Policy in place and implemented. Regular process audits e.g. Accounts or medication reconciliations. Awareness and Comms to be circulated. Populate the Scheme of Delegation and SFI. Awareness of the Nolan Principles	Controls have not been embedded.	Board Assurance Framework Report.	The culture of BAF not fully developed and embedded.

	adherence to the Nolan Principles. *Poor risk management arrangements.* *Inability to harness the benefits of good risk management in strengthening decision making.* *Lack awareness of the new NHS Provider Licence Conditions.*	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. Annual Self-certification to be published on Trust intranet. New NHS Provider Licence has been disseminated across the Trust. Conditions in the new licence mapped out for teams to consider evidencing compliance at a micro level. Annual compliance report provided to Board C`ttees and Board.	Still early days as the new NHS Provider Licence is sufficiently known across the Trust.	Annual Self-certifications. Local evidence at team and micro levels on compliance. Teams regularly discussing and evidencing how they are supporting the Trust meet relevant conditions. Annual Compliance Reports.	Culture of evidencing and demonstrating compliance not fully developed and embedded into business as usual.
	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 or Licence for the provision of some services.* • *Legal actions in some extreme cases.* • *Disciplinary actions for negligence or wilful failure to comply with key standards, Conditions of the Licence and other important aspects of Good Governance.*	
	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. *Picked up in the updated RM Policy.*	
	BAF04/FPP/002	Review of the Trust`s governance arrangements from `Ward to Board`.	David Tita & Lisa Pim	31/05/2024	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	31/05/2024	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.
14/12/2023	Risk description strengthened to focus on the lack of a culture around compliance and other aspects of compliance. Some fresh causes, controls and assurance have also been added especially around the requirements which underpin the new NHS Provider Licence. Request change of due date for action BAF04/FPP/ 003 to enable aligning its implementation to the ongoing review of the Trust`s governance arrangements.
8th March 2024	A CQC Steering Committee that regularly meets has now been created to monitor and oversee ongoing pieces of work around compliance with CQC regulatory provisions, standards and Notices and safety practices.

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	**13th March 2024**

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

		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.	*decommissioning.* • *Newly relationships take time to nurture, grow and mature.* • *Changes to the translation of the Procurement, Patient Choice and Competition Regs 2013.*		
	• *Poor Commissioning Committee decision-taking.*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance architecture. • Partnership Agreement • Memorandum of Understanding.	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out Commissioning Sub-Committee • Escalation and assurance reporting	• Delays in getting signed agreements.

				• from Executive Steering Group • 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 target risk score.	BAF05/FPP/001	*MHPC Governance architecture governance meeting 23/6/23 to review accountabilities and ownership of risks.*	JW	June 2023	This action will create awareness and help reduce the likelihood were the risk to crystallise.	
	BAF05/FPP/002	Attendance at the VCFSE Collective and Panel Meetings which take place monthly	JW	Dec 2023	This action will create awareness and help reduce the likelihood were the risk to crystallise.	
	BAF05/FPP/003	Multi-agency engagement in decision forming groups for MHPC.	All Chairs Monthly	Dec 2023	This action will create awareness and help reduce the likelihood and impact were the risk to crystallise.	
	BAF05/FPP/004	Ownership of new and emerging risks and reporting within the Collaborative	JW	09/05/2024	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.
14/12/2023	Members at the BAF review meeting recognised that partnership working is a means to an end and argued that the risk here is around the inability to land a system-wide strategy for BSOL, with enablers such as the BSOL MHPC, effective commissioning and working across the system and co-producing solutions while delivering health services to our populations in a much more impactful way.

Feb 2024	Updates on progress with mitigating and managing this BAF risk. • All Age MH HNA has been commissioned from the Centre for Mental Health which will be delivered in August 2024. • Experience of Care campaign led by Rethink Mental Illness will underway and due to be completed May 2024. • Interim Strategy for BSOL MHPC to be available in draft end of March 2024. • Co-produced All Age MH Strategy to be developed by end of March 2025. • Ongoing engagement with VCFSE Panel and Collective. • MHPC attendance at Birmingham City Councils Strategic Commissioning Group. • MHPC attendance at Solihull Commissioning Group meetings – monthly. • Review of governance arrangements for the inclusion of Learning Disabilities & Autism. • Determining new arrangements surrounding introduction of Procurement Selection Regime 1/1/24.

Details of the People Committee BAF

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	3	12		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Cautious:** We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.			**Date reviewed**	**6 March 2024**

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	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	• Despite our value-based recruitment approach, some recruiting managers aren't reflecting these yet. • Feedback form, new guidance re

		Leavers surveys (exit questionnaires) Health & Wellbeing offer Model Employer	Recruiting but not retaining colleagues Turnover rate is below KPI, and staff in post is significantly increasing. Still losing staff within first 2 years, some staff groups i.e psychology and pharmacy are above turnover KPI.	recommendation of the organisation. • Staff Survey results improving to top quartile performance.	makeup of panel, and values-based questions – will be reported on a quarterly basis – possible conflict of interest as person filling in form is the chair of the interview panel, also feedback is reviewed possibly 3 months after the event • Staff survey results still reflect some gaps.
	• *Less attractive pay for some staff groups.*	Management of the workforce market: ICS workforce programme to manage demand and competition in the system in collaboration with partners.		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population	• Falling to reassurance rather than assurance

		• 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		• 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. • Now part of a number of ICS working groups that have links to pay i.e. agency rates • Working with NHSP to look at directly engaging with agency workers.	
	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	March 25	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.		Dec 24		
	BAF01/PC/003	Support delivery of service specific recruitment and retention plans.		Ongoing		
	BAF01/PC/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		March 25		
	BAF01/PC/005	Develop and roll out a package of First Line Management (B5-7) training that supports all aspects of the role and is supported by an action learning set infrastructure	Head of People & Culture	June 24	Training has now launched although not all modules are up and running, this is being monitored via Shaping Our Future Workforce Committee.	

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.
12/12/2023	The likelihood score has reduced to a 3 bringing the overall risk score down to a 12, International recruitment is continuing at a steady pace. A full onboarding review has taken place with improvements identified. Work is continuing to move bank workers onto substantive contracts. Working with the ICS on areas of priority such as agency pay. Directly engaging with agency workers.

	A request for an extension of the deadline for risk BAF01/PC/005 is sought due to the delay in finalising some of the modules, therefore this is being rolled out on a phased approach with a final launch date of March 2024.
7/03/2024	A revised launch date for the first line management training programme has been identified for Apr 24. This will be monitored through Shaping the Future Workforce Committee. There have been significant numbers of Internationally educated nurses arriving who have completed or currently completing their OSCE training and are being inducted into the organisation. The workforce planning round has commenced for 24/25. Staff in post continues its upward trajectory and turnover continues to improve. Head of Workforce Transformation has started in post and will lead on this BAF risk.

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	3	12		
		Target Risk Score	4	2	8	**Date added**	**02nd June 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**6th March 2024**

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. • HR Toolkit now launched, number of key policies revised, and language changed to reflect values.	• Falling to reassurance rather than assurance.

				• Social media policy ratified. • Reframed values in practice process • Pulling together EDI and OD in relation to restorative learning and Just Culture. • Development of the corporate psychology offer.	
	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
	BAF02/PC/ 001	Provide continuous support to operational divisions in improving the experience of our workforce.	AD OF EDI and OD	June 24	Periodic set of actions to identify and address barriers in a timely manner with escalation	

Actions being implemented to achieve target risk score.					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	Sept 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	Dec 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
12/12/2023	Likelihood risk score has been reduced due to a number of activities that have taken place over the last quarter, The HR Toolkit now launched with a number of key policies revised, and language changed to reflect values. Social media policy has been ratified and due to launch shortly. We have reframed values in practice process. Pulling together EDI and OD in relation to restorative learning and Just Culture and there has been the development of the corporate psychology offer.
March 2024	BAF02/PC/002 BAF02/PC/003 timelines may need to be extended as although underway resource to develop the infrastructure for delivery has only been fulfilled in the last 8 weeks.

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	3	12		
		Target Risk Score	3	3	9	**Date added**	**2nd June 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**6th March 2024**

Reference / Risk ID or Number	Risk Description	**Controls** *Things in place to address the cause*	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance What are the weaknesses in the assurance?**
BAF03/PC	There is a risk that the Trust may fail to modernise its people practice in ensuring the achievement of its operational objectives. This may be caused by: -				
	• *Inability to deliver digital solutions.* • *Inability to foster a psychologically safe environment.*	• Staff survey • Pulse check • Reflective HR casework • Transforming culture sub-committee • Systems strategy board • A range of digital platforms through which colleagues can escalate and feed in centrally. • QI Projects to address some of the	• Colleagues not completing surveys. • Capacity to undertake this work. • Low trust and confidence. • Lack of digital infrastructure.	• 360-degree feedback for senior leaders • FTSU quarterly reports to committees • HR casework tracker • Staff survey results are improving in some areas. • Improved HR KPI reports. • Audit reports • Digital Staff management system.	• Falling to reassurance rather than assurance. • Lack of engagement and buy-in from staff. • Built in evaluations to every large-scale project

		concerns raised by staff. • Research and benchmarking against what good looks like. • Working with ICS partners to identify shared digital solutions. • Use of integrated digital solutions e.g. Digital passports.	• Lack of sufficient funding. • Lack of digital competence. • Lack of digital expertise within existing workforce resources to deliver training. • Digital solutions haven`t been embedded.	• New workforce digital group, project tracker on people goals • Trust wide audits are conducted in line with a forward planner learning lessons which will be considered for future activities.	• Audits are not systematic as they are adhoc at the moment. • local audits are more sporadic.
	This may result in: -				
	• Poor employer brand limiting recruitment. • Staff feeling vulnerable and unable to speak up resulting in missed opportunities to improve practice. • Increased retention of a valuable workforce. • Compensation costs. • Increased regulatory scrutiny, intervention, and enforcement action.				
	Linked risks on the CRR- Risk ID	Brief risk description			
	N/A	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
	BAF03/PC/	Develop a range of digital solutions to streamline or automate people processes	Head of People & Culture	March 25	Periodic set of actions to identify and address barriers in a timely manner with	

Actions being implemented to achieve target risk score.	001				escalation opportunities available, locally and systemically.	
	BAF03/PC/002	Ensuring that ESR holds accurate and credible workforce data	Head of Workforce Transformation	Dec 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.
12/12/2023	Risk score remains the same as this is the area with least progress. A new workforce digital group has been set up, and trust wide audits are in place for any large-scale changes so lessons can be learned, however as this work has only just started we are not able to assess the impact to reduce the risk scoring.
07/03/2024	Risk score has reduced slightly, due to the work that has been completed since the last update to increase the accuracy of data and demographics of F/W requests, leavers and honorary contract status. We have received a small amount of funding from NHSE to improve ESR data quality and currently reviewing options. Work is underway on a People chat box similar to Ask Jake which will provide automated responses and sign posting for HR related queries, which is due to launch the end of March 24. Other suggested areas of improvement are now being presented and reviewed regularly by internal groups.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Current Risk Rating**	4	4	16		
		Target Risk Score	2	4	8	**Date added**	**6th July 2023**
		Risk Appetite	**Significant:** We seek to lead the way in terms of workforce innovation and actively challenge racism and discrimination in everything we do. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positive change.			**Date reviewed**	**6th March 2024**

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

				• Staff Survey results improving to top quartile performance. • EDI Improvement plan • Triangulating data in transforming culture reporting.	to health inequalities. • Falling to reassurance rather than assurance.
	This may result in: - • *Sickness and recruitment challenges.* • *Lack of engagement.* • *Loss of trust and confidence with communities.* • Services that do not reflect the needs of service users and carers. • Inequality across patient population. • Workforce that is not culturally competent to support populations and colleagues.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	BAF04/PC/ 001	Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU	AD OF EDI	31/07/2024	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	30/09/2024	Action will mitigate potential likelihood of risk materialising.	

target risk score.	BAF04/PC/003	Take PCREF from pilot to full implementation	AD OF EDI	31/03/2025	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
12/12/2023	PCREF is currently only understood fully in our pilot areas of secure care, talking therapies and perinatal. Further work is required to socialise to the rest of the organisation by way of communications plan, launch event and EDI team site visits.
March 2024	BAF04/PC/001 Delays with engagement have resulted in a timelapse with projected end date of May 2024 BAF04/PC/002 Anti Racist infrastructure being socialised via the behavioural framework, 1st element has been released, with roll out being spread across the year. BAF04/PC/003 Some delays experienced with the co-production, full implementation will be realised by April 2025

8.1. Corporate Risk Register

Report to the Board of Directors							
Agenda item:	**8.1**						
Date	3rd April 2024						
Title	Trust Corporate Risk Register & Cover Sheet						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

Alert		**Advise**		**Assure**	✓

Purpose: This report provides a position of activity for the Corporate Risk Register since the last RMG and its review at Board Committees in February and March 2024. The CRR comprises high operational risks to the delivery of local Directorate, Service and Divisional operational objectives which score ≥15 that have been escalated via the Divisional CGC and approved by the RMG for inclusion onto the CRR.

Introduction: In reviewing risks for approval and inclusion onto the CRR members of the RMG at its last meeting noted with satisfaction the ongoing piece of work around reviewing risks on Directorate and Divisional risk registers and advised that high `red` risks be escalated via the relevant governance meetings for consideration and approval at the RMG. Members also noted that some of the risks which have been escalated stretched far back to more than 3 years ago and advised CRR risk leads/owners to consider redefining and reassessing such risks to align with current challenges, performance and/or to demonstrate how these have been mitigated and scores reduced over time.

A review of the CRR will enable Board Committees and the Board to fulfil their key governance function of risk oversight and scrutiny while gaining assurance that the Trust has effective and comprehensive systems and processes in place to identify, understand, monitor and address current and future risks deemed high enough to negatively impact on the delivery of its operational objectives. The plan going forward is for Board Committees and the Board to regularly receive, review and scrutinise both the BAF and the CRR at the same sitting so as to: -

- underscore the symbiotic relationship between these two key instruments of assurance.
- foster triangulation, joined-up learning, and any read across while creating the space for both instruments to inform and feed off each other.

Ownerships of risks on the CRR are in the process of reviewing and updating their risks to incorporate the feedback from Board Committees and these will be reflected in the next CRR Report to the Board in June 2024

Appendix 1 below sets out the structure and content of the Trust CRR.

Key Issues and Risks:

1. The review and design of the Trust CRR is a dynamic ongoing piece of work which will be strengthened as the Trust`s risk management arrangements mature and embed into business as usual.

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services		**Reducing pt death by suicide / safer and effective services**
People	✓	**Staff wellbeing and experience (impact of death by suicide)**
Quality		**Preventing harm / A pt safety culture**
Sustainability		**Inability to evidence and embed a culture of compliance with Good Governance Principles.**

Recommendation

The Board is requested to:

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE and ENDORSE*** *the content of its CRR.*
3. ***GAIN ASSURANCE*** *that high level operational risks to the delivery of the Trust`s operational objectives are appropriately mitigated and managed in lined with best practice and the Trust`s Risk Management Policy.*

Enclosures

1. Appendix 1 – Details of the Trust Corporate Risk Register.

Appendix 1 – Details of the Trust Corporate Risk Register.

TRUST CORPORATE RISK REGISTER

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.

Table 1a: Updated Trust Corporate Risk Register summary showing movements in risks:

CRR Risk ID	Title of Risk	Executive Lead	CRR Risk Lead or Doer	Oversight Committee	Current risk score	Movements in risk score
QPES CRR						
CRR01 /272	Inability to recruit and retain RMNs and psychology staff.	Executive Director of Nursing	Tariro Nyarumbu	QPES	16	⟷
CRR02 /276	Potential insufficient capacity across Acute Care pathway to manage patient demand.	Executive Director of Nursing	Tariro Nyarumbu	QPES	16	⟷
CRR03 /888	Potential harm to patients due to using the top of doors as a ligature point.	Executive Director of Nursing	Sophia Fletcher	QPES	15	⟷
CRR04 /453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.	Executive Director of Nursing	Ritchie Balan	QPES	20	⟷
CRR05 /868	Potential delays in undertaking timely mental health assessments due to lack of AMHP.	Executive Director of Nursing	Jessica Asson	QPES	15	⟷
CRR06 /1641	Patient care may be undermined by the increased use of section 136's by the police.	Executive Director of Nursing	Shrikaanth Krishnamurthy	QPES	15	⟷
CRR07 /1736	Potential harm to patients arising from the new Kingsway anti-ligature anti-barricade doors are having issues with false alarm activation.	Executive Director of Nursing	Sophia Fletcher	QPES	15	⟷
CRR08 /1763	Inability to receive timely assessments and input from the psychology service	Executive Director of Nursing	Jacqueline Kelly	QPES	20	⟷
People Committee CRR						
CRR09 /1058	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	Executive Director of Strategy, People & Partnerships	Mandy Fletcher, Head of Programmes - Strategy, People & Partnerships	People Committee	16	⟷

FPP CRR						
CRR10 /108	Potential inability to deliver savings.	Executive Director of Finance	Richard Sollars, Deputy Director of Finance	FPP	16	⟺

1b. <u>Updated Trust CRR Heat Map</u>

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic			CRR03/888 CRR07/1736	CRR04/453	
4 Major				CRR01/272 CRR02/276 CRR10/108 CRR09/1058	CRR08/1763
3 Moderate					CRR05/868 CRR06/1641
2 Minor					
1 Insignificant					

Details of QPES Corporate Risk Register (CRR)

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Inability to recruit and retain RMNs and psychology staff.	**Inherent Risk Rating**	5 Major	4 Likely	20	QPES	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	**05/11/2013**
Risk ID on Ulysses	**272**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR01/272**						

Risk description

There is a risk that the Trust may be unable to recruit and retain particularly for Band 5 RMNs and psychology staff.

This may be caused by a diminishing labour market for RMNs and psychology staff, difficulties with sourcing trained and qualified staff in these areas and demand exceeding capacity.

This may impact on bank shifts not always being filled, the quality of care service users receive, positive patient experience, may also lead to delays in treatment or the provision of care, fatigue and stress of existing staff in these areas, rising agency cost to fill vacancies, reputational damage and potential financial cost in the case of claims arising from poor care.

Controls in place	Assurances
• Ward Managers to plan their off duties 7 weeks in advance, therefore planned shortages can be covered. • Team managers and nurse in charge to utilise the on call and site link system to raise immediate concerns if shifts are not filled. • Creative management of E-Rosters to allocate shifts over a three-month period which could enable staff to plan. • TSS within the Trust. • Moving staff around between wards to cover shortfalls.	• Business meeting • Monitoring of the financial impact on teams • Eclipse reporting • SARSA • Monitoring E-Rostering

• Increase in the staffing on the inpatient wards from 3 band 6 nurses to 4 to hopefully improve retention within the trust and recruitment of staff from other hospitals. • Managers have a number of staff bank they repeatedly use to improve continuity of care for patients. • Band 6 link workers dedicated per shift on each site to improve leadership and support especially out of hours. • CNM's have gone to Ireland and London to recruit staff and continue to discuss further recruitment drives. • Managers completing the online system to improve the speed and efficiency of recruiting staff. • Further recruitment to band 7 positions in HTT. • Non-medical prescribing discussed with Nigel Barnes. • Ward skill mix review underway.	

Gaps/weaknesses in Controls/mitigations
• Timeliness of recruiting to TSS is an issue due to delays. • Team managers are regularly covering shifts so unable to undertake their own role. • Current policy does not support the training of all temp staff in Medical emergencies, placing on additional pressure on patient safety. • Demand for shifts is outweighing capacity and staff establishments. This is more evident in core working hours. • TSS are not open after the nights shift staff commence their shifts, so if bank staff don't turn up they have no one to contact to ask where they are or to book another person. • The recruitment drives in Ireland and London has identified a small number of new employees but they are not in post yet. • Not everybody is reporting on Eclipse.

Link to other risks on Ulysses		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1763	Inadequate psychology staffing levels at the Oleaster	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.

1058	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	BAF01/PC	Potential failure to shape our future workforce.

Actions to mitigate risk and attain target score:						
Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	5769	The trust has undertaken a safe staffing review to support appropriate levels of cover and support across acute care. A report will be completed by the chief nursing officer which is expected by the end of September 2021. Mitigation in the form of daily AD & executive level meetings commenced July 2021 to allow for additional resources to be moved across the trust to ensure wards are staffed appropriately.	Tariro Nyarumbu	11/04/2024		
	5071	Meeting arranged with HR re acute and urgent workforce planning workshop. 25 -30 people from all disciplines to look at workforce transformation planning, to consider creative ways going forward to deliver clinical care, using new and different roles- for example physician associates, nursing associates, mind workers and peer support workers. This is part of wider engagement work around workforce planning.	Tariro Nyarumbu	11/04/2024		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: ***(Please enter any progress that has been attained)***

12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential insufficient capacity across Acute Care pathway to manage patient demand.	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	QPES	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	**01/02/2015**
Risk ID on Ulysses	**276**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR02/276**						

Risk description

There is a risk of potential insufficient capacity across Acute Care pathway to manage patient demand.

This is caused by demand outsripping supply and difficulties to recruit and retain staff in some roles.

This may result in higher level of risk being managed in our community teams, Service Users being placed out of area, potentially meaning that patient are not being given the required levels of care or safety, rising financial cost with Out of Area placements and poor patient experience.

Controls in place	Assurances
• 12pm MDT and multi-agency bed management meetings on weekdays. • 10am weekend conference call for on-call managers, on-call consultant and director. • Bed Management Policy in place and being implemented. • Discharge Policy in place and being implemented. • Access to out of area beds • Creative management of E-Rosters to allocate shifts over a three-month period which could enable staff to plan. • HTT are contacted on a daily basis to see if patient still requires an inpatient admission • Daily review by Clinical Directors who will initiate additional reviews where necessary.	• National benchmarking • Insight reporting • Performance report to the trust board • NHSI submission • Report submitted to weekly Senior operational forum (Chaired by COO) which details ward round compliance to enhance flow. • A fully comprehensive set of reports and updates go to the Trustwide bed

• Respite services are being re-tendered, to provide an improved level of access for our client group. • Bed utilisation managers posts are operational. • 3 x band 7 HTT clinicians now in post. • Opened 4 new additional beds on Acute wards. • Third middle grade Dr recruited to in South HTT taking team over-capacity.	management meeting, chaired weekly by the COO, this includes delays on ward, reviews of the bed reports and length of stay on PDU.

Gaps/weaknesses in Controls/mitigations

- The system is unable to flex capacity in periods of extreme or unexpected demand. (physical environment, physical workforce).
- Lack of electronic bed board to oversee patient flow.
- Timeliness of social and CCG panels/assessments to agree needs of patients - often delays out of our control.
- Inability to flex capacity within our community services (CMHT/HTTs) to respond to patient demands which can result in unexpected admissions of individuals to Acute beds.
- Patients being admitted without a plan of care for their admission, and patients on the ward not having a clear discharge plan resulting in an extended stay.
- Newtown report 2017 identifies that investment is required in the end to end processes (patient entry to exit of care).
- Newton Report 2017 identifies the need for transition of some care into the primary and secondary care setting.
- DTOC impacting on timely discharge.
- Lack of control the bed management has over the flow of discharge from wards.
- The reliance on the referrer to be able to articulate all risks of patient to ensure referral is appropriate and sound - although the daily review provides an added level of assurance and scrutiny daily.
- Control over external factors - such as reliance on progress from partners such as social care and CCG.
- National shortage of mental health beds means that there are frequent occasions when out of area beds are not readily available.
- Patients declining out of area when informal / out of area placements not accepting patient who are informal due to risk profile.
- PDU is not an inpatient facility, therefore cannot reside there after 24 hours.
- Bed occupancy levels are consistently above 95%.

Link to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.
1058	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	3972	Current strategy and implementation group in place to oversee the development and creation of new wards at the Highcroft Hospital site.	Tariro Nyarumbu	31/05/2025	This is intended to provided improved quality wards but also a chance to seek funding for additional bed capacity and increased flexibility of bed stock.	
	4769	Ongoing scoping work is underway in respect of reprovision of inpatient facilities in the north of the city , this is coupled with external support in reviewing capacity and demand.	Tariro Nyarumbu	31/05/2025		

	6177	The community transformation programme will be appointing a number of roles within the community that will impact future inpatient demand. It is expected that the PCN roll out coupled with large investment in community services will reduce the demand in inpatient provision- Jason Nash as the transformation lead for A&U will work with the transformation lead for ICCR (Renu).	Tariro Nyarumbu	01/04/2024		
	6974	Actions and plans will be put into place addressing the flow of DTOCs. A deep dive into DTOC will take place in order for us to work on discharge projects and understand the issues with patient flow.	Tariro Nyarumbu	01/04/2024	To understand the issues with patient flow.	
	6975	Initiatives to look at enhancing capacity to be undertaken. These include: - Gatekeeping workshops with Grant Thornton - Looking at the fidelity of the locality model to ensure patients are placed close to home in order to enable follow up care	Tariro Nyarumbu	01/04/2024		
	7212	A new East pilot will be conducted by Dr Vincent and Dr Sadira Teeluckdharry to see outcome in controlling patient demand.	Tariro Nyarumbu	01/04/2024		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential harm to patients due to using the top of doors as a ligature point.	**Inherent Risk Rating**	5 Catastrophic	4 Likely	20	QPES	
		Current Risk Rating	5 Catastrophic	3 Possible	15		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	**23/03/2018**
Risk ID on Ulysses	**888**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR03/888**						

Risk description

There is a risk that patients may come to harm from using the top of doors as a ligature point.

This may be caused to patient`s medical conditions, inability to observe all patients all the time, access to the top of doors as ligature points as different doors are installed in different wards in Acute Care, with some doors not yet fitted/ not working properly and hence staff may be in danger of complacency and uncertainty about the area they are working in, as it is not uniform. Due to the nature of observation bathroom doors are considered a higher risk than bedroom doors, though both viable ligature points.

This may result in death by strangulation, increasing potential of serious incidents, harm to patients, reputational damage and negative medial attention for the Trust and poor patient experience.

Controls in place	Assurances
• Adherence to the therapeutic observation policy. • Individual dynamic risk assessment. • Communication to all ward staff, conveying this specific risk. • There is a current action plan in place of the roll out for anti-ligature doors (PMO, H&S lead and estates support). • Focus on MDT and care plans review. There is a MDT and care plan audit taking place weekly which is carried out by the matrons.	• Signed practice alert for all substantive staff. • Patients will have a therapeutic observation care plan. • Incident reports. • Ward induction. • A trust anti-ligature door strategy and programme. • To be included in a local ward induction sheet for bank staff.

Gaps/weaknesses in Controls/mitigations
• High percentage of bank and agency staff on inpatients unit that will not have awareness of the practice alert. • The roll out of anti-ligature door programme will take around 12-18 months. • Practice alerts not completed. • Therapeutic care plans not completed. • incident reports not being completed.

Link to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk IDs	**Risk Titles**	**BAF Number**	**BAF Risk Title**
1736	Potential harm to patients arising from the new Kingsway anti-ligature anti-barricade doors are having issues with false alarm activation.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.
		BAF03/ QPES	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	5454	Rollout of door alarms fitted to ensuite bedrooms has commenced. there is a work schedule in place with all acute IPU's scheduled in	Sophia Fletcher	31/03/2024		
	7088	Email sent to Neil Hathaway regarding update on progress from on the slow rollout for anti-ligature door fitting.	Sophia Fletcher	01/02/2024		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.	**Inherent Risk Rating**	5 Catastrophic	4 Likely	20	QPES	
		Current Risk Rating	5 Catastrophic	4 Likely	20		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	**01/03/2016**
Risk ID on Ulysses	**453**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR04/453**						

Risk description

There is a risk that patients will not be able to be admitted to an Acute inpatient bed within a timely manner, from both A&E and general wards.

This is caused by the lack of bed availability.

This may result in an impact on the quality of care and can exacerbate mental health due to a delay in treatment. It can also place a strain on capacity for PL staff who are trying to manage patients as well as new referrals. For the general hospital it limits the availability of A&E beds and impacts on general staff capacity. It can increase the risk for the patient as they are staying in an environment which doesn't have the same environmental controls in place as a psychiatric ward. It increases worry and distress for patients and their families.

Controls in place

- National target is being introduced to state that patients are; 'not to wait longer than 4 hours to be in a bed' (for urgent patients ONLY: 136/ RAID) which will impact on timeframes.
- Daily report which details ward round compliance to enhance flow.
- CNM's are contacted on a daily basis to see if patient under home treatment still requires an inpatient admission.
- Bed Management Policy are reviewed, and a multi-agency capacity meeting is held daily.
- Additional wards have been opened with further discussions of increases in future capacity.

Assurances

- Bed management issues discussed daily with the executive director of operations and weekly at OMT performance management, Urgent Care Forum and Acute Care Forum.
- Daily bed management meetings which are multi agency provide robust monitoring of situation

Gaps/weaknesses in Controls/mitigations
• Bed management and flow is a Trustwide issues and responsibility and therefore difficult to manage all the nuances involved within Urgent Care programme. • Due to the demobilisation of under 25 services there is a need to close inpatient wards which impacts on resources. • Timeliness of social and CCG panels/assessments to agree needs of patients - often delays out of our control. • The reliance on the referrer to be able to articulate all risks of patient to ensure referral is appropriate and sound - although the daily review provides an added level of assurance and scrutiny daily. • Control over external factors - such as reliance on progress from partners such as social care and CCG. • National shortage of beds means that there are occasions when out of area beds are not readily available. • Patients declining out of area when informal/ out of area placements not accepting patient who are informal due to risk profile. • PDU is not an inpatient facility, therefore cannot reside there after 24 hours.

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
276	Potential insufficient capacity across Acute Care pathway to manage patient demand.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.
		BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	4452	Ongoing discussions about increasing HTT/Crisis/Acute capacity and reviewing the model of care.	Sophia Fletcher	31/03/2024		

	5071	The 10am conference call to review patients and the current work on creating a live bed state to help with quicker allocation of beds. Efficacy of this to be reviewed.	Ritchie Balan	31/12/2023		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential delays in undertaking timely mental health assessments due to lack of AMHP.	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	QPES	
		Current Risk Rating	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	**15/01/2018**
Risk ID on Ulysses	**868**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR05/868**						

Risk description

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.

This is caused by the lack of AMHP availability, particularly out of hours.

This may result in individuals waiting longer than 12 hours for a mental health act assessment as the request has to be resubmitted and processed again after 9am the following morning due to lack of AMHPs at night within the system. This also affects the assessments under Section 135 (1) applications, may lead to delays in commencing treatment, reputational damage and poor patient experience.

Controls in place	Assurances
• At present discussions take place regularly with the Local Authority AMHP help desk to prioritise allocation of AMHP. With winter pressure initiative we did employ two additional Nurse AMHP through the trust which alleviated the risk at the time. • Agreed timescales for reporting, Incidents to be captured after a four hour delay. • Ongoing review of the AMHP services are taking place through Multiagency involvement.	• There is monitoring system in place to check the compliance with national standard of timely assessment and best practice. • Not all staff report incidents when happen. • Some are categorised incorrectly, therefore not captured. • Discussed/ monitored through UC CGC

Gaps/weaknesses in Controls/mitigations
• The LA has limited resource specially at the transition hours of early evening and again in the early hours of the morning when often there is only one AMHP on duty but the demand is high.

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Titles**	**BAF Number**	**BAF Risk Title**
276	Potential insufficient capacity across Acute Care pathway to manage patient demand.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.
1058	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	5789	Explore the issue of the lack of Emergency Department Team handovers to the AMHP day team which has also been noted as impacting the delays to mental health act assessments.	Jessica Asson	01/03/2024		
	5790	There will be a system wide review with involvement of the CCG and A&E delivery board in September. There will be a deep dive into the	Tariro Nyarumbu	30/11/2023		

		data to further understand the issues compounding the 'AMHP crisis' impacting AMHP availability. An action is likely to be created which will inform the next steps of BSMHFT and the wider system.				

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Patient care may be undermined by the increased use of section 136's by the police.	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	Urgent Care CGC	
		Current Risk Rating	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	**12/01/2022**
Risk ID on Ulysses	**1641**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR06/1641**						

Risk description

There is a risk that patient care may be undermined by the increase use of section 136's by the police.

This is caused by many patients needing S136s.

This results in increased clinical workload on top of an already busy service and pressure on AMHP and bed availability. This increases the length of stay in A&E, pressure on A&E and LP staff managing the patient and prevents admissions from ambulances bay while the bay is in use. This wait also delays the outcome for the patient whether this is discharge, treatment or admission.

Controls in place	Assurances
• Monthly liaison meeting with police and senior managers	• Discussed/ monitored through UC CGC

Gaps/weaknesses in Controls/mitigations

- Reliance on Police and hospital staff- out of our control

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk IDs	**Risk Titles**	**BAF Number**	**BAF Risk Title**
		BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.

		BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	6781	Monthly liaison meeting with police and senior managers to discuss issues	Jean Hammond	31/12/2023		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
12/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential harm to patients arising from the new Kingsway anti-ligature anti-barricade doors are having issues with false alarm activation.	**Inherent Risk Rating**	5 Catastrophic	4 Likely	20	QPES	
		Current Risk Rating	5 Catastrophic	3 Possible	15		
		Target Risk Score	2 Minor	2 Unlikely	4	**Date opened**	**18/11/2022**
Risk ID on Ulysses	**1736**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR07/1736**						

Risk description

There is a risk of potential harm to patients arising from the new Kingsway anti-ligature anti-barricade doors.

This is caused by the fact that these new doors are having issues with false alarm activation, variation in the threshold for door alarms activation, cumbersome door system on some of them which creates difficulty for staff to open them despite training and inconsistency in operating these doors.

This could lead to poor quality and safety of patients, inability for staff to timely access such doors in times of emergency, potential loss of life, poor patient experience, complaints, financial impact and reputational damage.

Controls in place	Assurances
• The transition strip between flooring between the ensuite and bedroom floors has been causing the false alarms, so this has been replaced. • Training of staff on use of doors. • Regular checks and observations.	• Regular checks and observations. • Feedback through Acute Care CGC.

Gaps/weaknesses in Controls/mitigations

- Staff may still be unable to open doors, even after training.
- Staff may respond inappropriately to alarm activation.

Link to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
888	Potential harm to patients due to using the top of doors as a ligature point.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	7044	Escalation to the director of nursing by head of nursing and clinical director, meeting to be arranged to discuss the concerns highlighted and actions required.	Sophia Fletcher	14/03/2024		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: ***(Please enter any progress that has been attained)***
15/02/2024	Risk newly added onto the CRR.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Inability to receive timely assessments and input from the psychology service.	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	QPES	
		Current Risk Rating	4 Major	5 Almost Certain	20		
		Target Risk Score	2 Minor	2 Unlikely	4	**Date opened**	**07/02/2023**
Risk ID on Ulysses	**1763**	**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. **Target risk score range 6-8.**				
CRR ID	**CRR08/1763**						

Risk description

There is a risk that patients across acute care inpatient wards may not receive timely assessments and input from the psychology service.

This is caused by inadequate psychology staffing levels in the inpatient service, high vacancies in the psychology service and demand exceeding capacity.

This may impact on the quality of care and safety of patients, positive patient experience, delays in treatment or the provision of care, rising agency cost to fill vacancies and potential financial cost in the case of claims arising from poor care.

Controls in place	Assurances
• Agreed with the service manager to prioritise female acute clients (Melissa and Japonica) and people on Caffra, over other wards. Other cases on the male wards will be prioritised depending on risk and need. • The assistant psychologists provide weekly lower-level interventions to the wholly acute wards (Tazetta, Melissa, Caffra) and are starting to provide some input to acute patients on the mixed wards (Magnolia and Japonica). • A record of referrals is kept in the triage meeting every week and then prioritised as previously indicated.	• Discussion / review at FPP. • Feedback through Acute Care CGC.

Gaps/weaknesses in Controls/mitigations

- No consultations are taking place remotely - all face to face. Previous remote agency cover was provided but did not meet the needs of the inpatient service.

Link to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
272	Inability to recruit and retain RMNs and psychology staff.	BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.
		BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems
		BAF01/PC	Potential failure to shape our future workforce.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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	7462	An outline psychology service business case proposal to be developed by lead psychologist to explore and recommend options to address the psychology clinical provision	Gary Roberts	February 2024		
	7463	For acute care SLT to agree the recommendations of the proposal and submit to sustainability board for consideration to fund the model .	AD / CD	1st April 2024		

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: *(Please enter any progress that has been attained)*
15/02/2024	Risk newly added onto the CRR.

Details of People Committee Corporate Risk Register (CRR)

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	People Committee	
Title of risk	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	**Current Risk Rating**	4	4	16		
		Target Risk Score	4	2	8	**Date opened**	**16/8/2019**
		Risk Appetite	**Cautious:** We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. **Target risk score range 6-8.**				
Risk ID on Ulysses	**1058**						
CRR ID	**CRR09/1058**						

Risk description

There is a potential risk of a shrinking supply of mental health nurse nationally coupled with 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.

This is caused by a shrinking market for mental nurses, demand outstripping supply, a third of all leavers being band 5 nurses and band 3 HCAs from inpatient settings (including secure services) and the lack of bursary for those wanting to train as nurses in particular Mental Health Nursing which historically attracted a mature workforce (e.g. the potential impact on living standards).

This may impact on the quality of care provided to patients, positive patient experience, reputational damage and overstretched nursing workforce.

Controls in place	Assurances
• Workforce Transformation Corporate Implementation Action Plan - Nursing Supply Workstream.	• Workforce recruitment and retention KPI's are monitored and reported monthly through the HR KPI

• Workforce Transformation Corporate Implementation Action Plan - Retention Workstream. • The Trust is part of Cohort 1 of the NHSI Retention Support Programme - as part of this the Trust has an NHSI-approved action plan.	Dashboard - these KPI figures are taken to WFSC and IQC quarterly.

Gaps/weaknesses in Controls/mitigations

- National skill shortages impact our ability to recruit to workforce gaps.
- The actions on the NHSI Retention Action plan are mostly complete and a few are no longer suitable due to the plan having been developed in September 2017.
- Recruitment KPIs - accurate vacancy date is reliant on the accuracy of the establishment data in ESR; there are known issues with the ESR establishment accurately reflecting the finance system or what's happening in reality within services.
- ESR Leaving Reasons are restrictive in choice and often not completed accurately resulting in a large proportion of 'other/not known' which impacts data analysis.

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
272	Inability to recruit and retain RMNs and psychology staff.	BAF01/PC	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. Potential failure to shape our future workforce.
276	Potential insufficient capacity across Acute Care pathway to manage patient demand.		
868	Potential delays in undertaking timely mental health assessments due to lack of AMHP.		

Actions to mitigate risk and attain target score:

Risk Response Plan	Action ID	Action	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	CRR09/1058/001	Deliver our workforce plan through: Increasing workforce supply to address workforce gaps across the organisation.	Head of Workforce Transformation	March 25	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	CRR09/1058/002	Progressing the retention activities and improve our turnover rate.		Dec 24		
	CRR09/1058/003	Support delivery of service specific recruitment and retention plans.		Ongoing		
	CRR09/1058/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		March 25		
	CRR09/1058/005	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	June 24	Training has now launched although not all modules are up and running, this is being monitored via Shaping Our Future Workforce Committee.	

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: ***(Please enter any progress that has been attained)***
12/02/2024	Risk newly added onto the CRR.

Details of the FPP Corporate Risk Register (CRR)

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential inability to deliver savings.	**Inherent Risk Rating**	5	4	20	FPP	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	3	12	**Date opened**	**16/4/2015**
Risk ID on Ulysses	**108**	**Risk Appetite**	**Open:** We are willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward. ***Target risk score 12.***				
CRR ID	**CRR10/108**						

Risk description
There is a risk that savings schemes may not be delivered in full by the Trust. This may be caused by the Trust failing to meet its financial plans. This may lead to a deficit in year, a fall in financial risk rating or inability to fund capital programme.

Controls in place	**Assurances**
• Sustainability Board in place to monitor overall financial position, including performance against savings. • Internal Audit includes performance against CIP, and associated process in their annual plan. • Reporting into ICB includes savings and financial performance – expectation around delivering financial balance, including offsetting savings.	• 23/24 financial performance forecasting break even – including shortfall on recurrent delivery against savings programme. • Planning for 24/25 financial plans already includes expectations around 1% recurrent plans.

Gaps/weaknesses in Controls/mitigations
• Consequences of poor financial performance, or non-delivery of savings do not attract any further review. • Attendance at Sustainability Board variable. • Trust has not been able to develop a pipeline for delivery of savings.

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk IDs	**Risk Titles**	**BAF Number**	**BAF Risk Title**
		BAF03/FPP	Sustainability – Balancing the Books Failure to operate within its financial resources

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**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/FPP01	HFMA Sustainability Audit identified over 50 actions, that would lead to improvement in financial controls and delivery of financial savings targets.	Richard Sollars, Deputy Director of Finance.	Different dates for each action but all to be completed by 31/3/24.	These actions have been developed nationally by the NHS finance profession and aim to support the principal requirements in delivering financial balance and savings.	

Progress since last Committee review/scrutiny of risk:

Date	Progress made since last Committee review/scrutiny of risk: ***(Please enter any progress that has been attained)***
12/02/2024	Risk newly added onto the CRR.

Key:

	On track to delivery on time
	Completed
	Outstanding or delayed

Quality

9. Quality, Patient Experience and Safety Committee Report

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 April 2024**
Date(s) of Committee Meeting(s) reported	**21 February 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Review of the Trust Corporate Risk Register • CQC Update and Action Plan Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control Team Report • Medicine Management • Integrated Performance Report • NHS Impact Report/ Quality Management System • Learning from Deaths Report/ Annual Thematic Review • Community Treatment Orders • Clinical Governance Committee Report • Strategy update – Quality Priority • Strategy update – Clinical Services Priority • Action Plan from Internal Audit Review of the Clinical Governance
Alert:	The Committee were appraised there are currently 9 serious incidents under review under the old serious incident framework, including a suspected homicide and a severe incident involving a service user. Staffing: Whilst recruitment strategies have shown positive outcomes, staffing levels across the Trust have been highlighted as a cause for concern and are recorded on the risk register. Work streams are in place to mitigate against all risks. The Trust is continuing to use the MHOST tool that is defining a clear picture of workforce requirements to support acuity across inpatients areas. The Trust has successfully filled a number of vacancies as a result of international recruitment and recruitment programmes with further events scheduled. Transport Issues: A number of concerns have been identified across the system regarding the safe and appropriate transfer of service users. Contracts and policies are currently under review with work being undertaken with system partners. The Audit Review of Corporate Clinical Governance Committee highlighted a number of areas for improvement. An action plan has been developed but wider work to address the underlying issues will be scheduled.
Assure:	The Committee was assured on the following key areas:

	• The Committee was assured the Board Assurance Framework continues to develop on track and reviews are ongoing to demonstrate rationale and will include RAG rating. • The Risk Management Group has been re-established with local divisions taking management. The Committee were assured the risk register reaffirms the Board Assurance Framework. • The Committee were assured that following regular updates provided to the CQC a further inspection took place between 17-19 October 2023 and it has been confirmed that the trust has delivered against all actions following the receipt of the Section 31 notice in December 2020, therefore the Trust has been served with a Notice of Proposal to remove the conditions imposed. • Notable decrease in PALS cases, consistent numbers of formal complaints. • The Committee were assured the Infection Prevention Control audit dashboard has been implemented with data being collated by an Infection Prevention Control administrator with a Community & Infection Prevention Control audit tool being implemented from September 2023. • The Committee noted the improvements made with pharmacy staffing and the improvement this has had on the Pharmacy service during 2023 with further improvements anticipated during 2024. • NHS Impact development sessions are planned and key areas of focus for the next 3-6 months are being implemented. • The Committee were assured that the Learning from Deaths group have developed links with safeguarding and have scheduled a deep dive in line with PCREF. • The Committee noted there are 16 goals in total for Quality, with 15 goals prioritised as Level 1 or Level 2. At the end of quarter 3, 9 goals (60%) of these goals are rated 'Green' which means they are where we expected them to be in relation to their milestone plans at this point in the year. Three goals (20%) are rated 'Amber' which reflects moderate issues impacting delivery that are being managed. Three goals are rated 'Red' i.e. they aren't where we want them to be against the milestones set at the beginning of the year. This is up from two at the end of Q2. • There are 38 goals in total for Clinical Services, with 27 goals prioritised as Level 1 or Level 2. Of these 27 goals, 85% are rated 'Green' or 'Amber' which means they are where we expected them to be at this point in the year, or have only moderate issues impacting delivery that are being managed. It should however be noted that the number of amber goals has increased from 9 to 12 and the number of green goals has decreased from 12 to 11 which suggests that there are more issues impacting progress that need to be managed than last quarter.
Advise:	• The Committee heard the service user story and noted the concerns in relation to the falls policy not being adhered too and the long term impact of this for both staff and service users. The incident highlighted the need for further clarity for locum doctors, their responsibilities and their accountability. There have been a number of lessons learnt and the Committee were advised that further training has been implemented in line with PSIRF. It was agreed that an induction package for locum doctors would be developed. • The Committee noted the CQC has also reviewed progress following the S29a warning notice issued on 3rd January 2023 in relation to core services. This required the trust to make significant improvements regarding the

	deployment of enough staff to work on the wards and that those staff receive the right training, professional development and have access to supervision and appraisal. Whilst CQC note improvements have been undertaken in this area they were not sufficient to step down the notice at this time. • Changes to the "Bare below the elbow" policy has been approved and will be implemented into the relevant policies. • Concerns regarding increase of cases of Measles in the Midlands. Pharmacy are leading on the changes that are currently being considered. • In the year to September 2023, overall annual prescribing costs across BSMHFT were £7,516,510 including supplies through trust pharmacy's and FP10 prescription, up from £6,601,475 in September 2022, a rise of 14%. • Integrated Performance Report will continue to be developed to include the narrative and assurances. • The Community Transformation project report will be bought to Committee in April 2024.	
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. It was agreed the Board Assurance Framework will be received and reviewed monthly.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Linda Cullen, Non-Executive Director	**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	**3 April 2024**
Date(s) of Committee Meeting(s) reported	**20 March 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Review of the Trust Corporate Risk Register • CQC Update and Action Plan Report • Healthwatch Community Survey • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control Team Report • Learning From Measles • Integrated Performance Report • Clinical Governance Committee Report • Action Plan from Internal Audit Review of the Clinical Governance • Capital Programme 2024/25 • Committee Effectiveness Self-Assessment
Alert:	The Committee were appraised there are currently seven serious incidents under active review. This includes a case of suspected homicide and an incident where a service user absconded from an inpatient ward and was later found deceased. Capital Programme 2024/25: The first draft plan for BSMHFT comprises a £14.5m savings target. This includes 1.1% national requirement, 1.9% locally agreed BSOL requirement and £5m out of area reduction target carried forward from 2023/24. There is a risk that further efficiency requirement will need to be applied in order to reduce the system financial gap. £12.7m cost pressure funding requests were submitted as part of the BSMHFT planning process. It was only possible to fund £861k of these requests given the challenging financial position. The capital plan to be submitted in the first full plan submission on 21.3.24 is £6.6m. This includes a notional allocation of £0.4m relating to the system capital investment fund (SCIF), against which spend is to be prioritised across the system. To date, £5.3m capital pre-commitments have been identified for 2024/25. Risks noted the funding could fluctuate. Any system overspend will impact the capital spend, there is a continued focus and aim across BSoL to meet the agreed target. Infection Prevention & Control Team Report: The IPC team note there are significant levels of noncompliance from clinical teams to submit their monthly audits. A meeting has been held with the Head of Nursing to seek support to address issues of non-compliance within their areas. This has been escalated to the Deputy DIPC.

	Concerns raised in assurance regarding staff vaccination before starting job with the Trust regarding both Hep B and MMR. Healthwatch survey: The Committee noted the significant increase in referrals and the ongoing impact from COVID whilst services continue to develop and improve whilst managing the increase in demands of over 10,000 cases. There was a detailed discussion in relation to the issues with the report that has been published and lack of understanding of mental health and the divisions and services associated. The Committee were assured communications are ongoing with Healthwatch to strengthen mental health understanding and partnership arrangements. CQC Update and Action Plan Report: There are 9 'must do' overdue actions from the core inspection and 3 'should do' overdue actions from the core inspection. Based on recent queries received from the CQC, there is focus on Reaside, Cilantro and the Acute inpatient wards in the North. All queries have been sent to the senior leaders for the services to enable full responses to the CQC. Enquiries relate to staffing levels, clinical and nursing care provision, management support, and management of serious incidents. Transport Issues: A number of concerns have been identified across the system regarding the safe and appropriate transfer of service users. Contracts and policies are currently under review with work being undertaken with system partners. The Audit Review of Corporate Clinical Governance Committee highlighted a number of areas for improvement. An action plan has been developed but wider work to address the underlying issues will be scheduled.
Assure:	The Committee was assured on the following key areas: • The Committee were informed there was a confirmed measles case on January 9th, following a rash detected on 7 January 2024. There was an immediate isolation, contact tracing, and deployment of PPE. Staff with unknown immunization status were temporarily restricted from work. Early detection and isolation, proactive staff engagement, and rapid deployment of protective measures highlighted the positive response from staff. The Committee noted the excellent response from staff. • FFP3 mask fitting program started.
Advise:	• The Committee acknowledged the need for the Board Assurance Framework to be simplified at pace using the intelligence from the Risk Management Group. The group are leading on the changes to review the current ratings and recommendations for closure of risks. • The number of associated red risks for the Committee were noted as a concern and it was agreed the dates for the risks would be reviewed and adjusted with the rationale for extension.
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. It was agreed the Board Assurance Framework will be received and reviewed monthly.

	New risks identified: no additional risks were identified.	
Report compiled by:	Linda Cullen, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Governance and Membership Manager

People

10. People Committee Report

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 April 2024**
Date(s) of Committee Meeting(s) reported	**20 March 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • People Dashboard • People Strategy Update • Workforce Plan • LGBTQ+ Staff Network Report • Staff Survey Results • Medical Revalidation and Job Planning Report • Safer Staffing Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • A 3% increase in whole-time equivalents had been expected however a 6.8% had been reported. Considering the growth plan for the new financial year would be a significant challenge, however the ambition for 2023/24 had been achieved. • The target of 60 **internationally recruited nurses** had not yet been reached; currently the Trust had welcomed 32 nurses to the organisation. Plans continued to develop to achieve the target. • New data sets continued to be collated on **flexible working**; an increase in requests and approvals had been reported, and work continued to understand the reasons why some flexible working requests were rejected. A thematic analysis would be considered at Committee when the data was available. • Challenges remained in relation to spend on bank and agency staff, although significant improvements had been made in the medical workforce. • Sickness remained a key challenge for the Trust; some improvements had been seen however proactive work continued to support managers in areas of particularly high short-term sickness. • Turnover had reduced in January, and exit interview data was analysed to identify areas for improvement.
Assure:	• A positive staff story on fasting during the month of Ramadan was received. • The Committee heard from the LGBTQ+ Staff Network Chair and commended the network for the positive activities that had taken place over the last few months. • The Committee was assured by the medical revalidation and job planning processes, noting that appraisal compliance for doctors was very high. • The Safer Staffing Report continued to highlight positive progress with MHOST and e-rostering plans.

Advise:	The Staff Survey results highlighted an overall improved position, with increases shown in all nine People Promise elements and employee experience. No questions were "significantly worse" than the previous year, and 63 were "significantly better". The Committee was encouraged by the results, and assured by the plans in place to focus on areas that required additional improvement.	
Board Assurance Framework	The Committee had considered the Board Assurance Framework risks during a development session in February and the following risks had been identified: • Inability to attract, retain or transform our workforce in response to the needs of our communities. • Failure to create a positive working culture that is anti-racist and anti-discriminatory. The risks were currently in development and would be reviewed by the Committee in May in preparation for recommendation to the Board. A Board Strategy Session had also been planned for later in the year to review and approve the revised Board Assurance Framework.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Bal Claire, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

11. Staff Survey Results

Report to Quality, Patient Experience and Safety Committee						
Agenda item:	**11**					
Date	Wednesday 3 April 2024					
Title	National Staff Survey					
Author/Presenter	Patrick Nyarumbu, Executive Director of People, Strategy and Partnerships					
Executive Director	Patrick Nyarumbu, Executive Director of People, Strategy and Partnerships					

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report *(executive summary, key risks)*

To provide an overview of the National Staff Survey 2023 results, the journey of cultural improvement as an organisation and the next steps and support available to improve areas of focus

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People	✓	
Quality		
Sustainability		

Recommendation

Enclosures

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

BSMHFT Journey

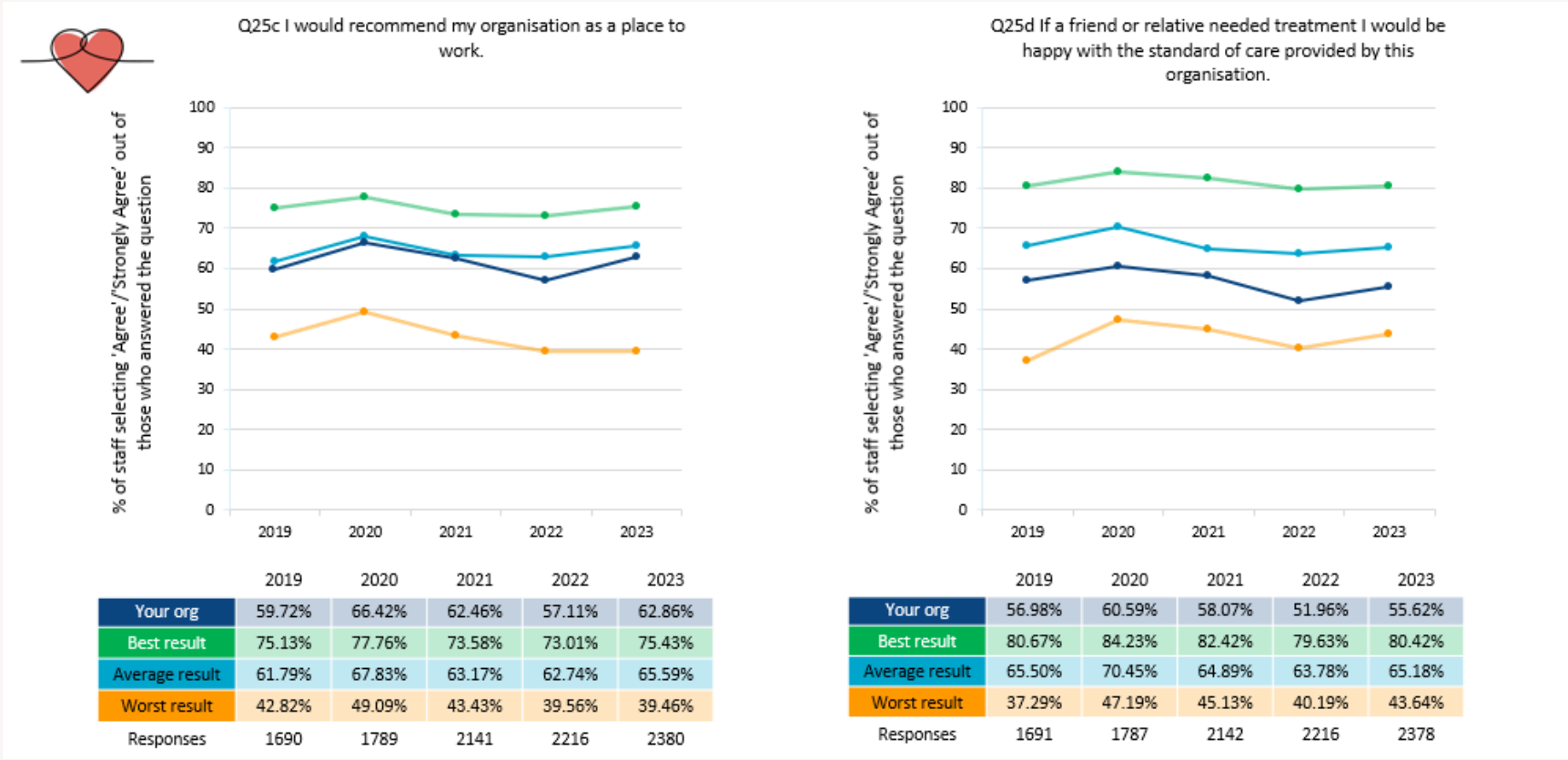
Organisational Development National Staff Survey 2023 results

Overview

- Survey ran between September – November
- 55% 2393 respondents in 2023 vs 55% 2230 respondents in 2022 *
- Bank Only Colleagues - 33.64% 253 respondents
- 112 teams received localised reports (92 teams in 2022)
- No questions are “significantly worse” in comparison to 2022 and 63 are “significantly better”
- Employee experience has improved for both White colleagues and Black and Asian colleagues.
- Increase in all 9 People Promise elements and themes scores largest increase in ‘we are compassionate and inclusive’ and ‘we work flexibly’
- We are above the average on learning and morale and seven of the nine themes are below average. The only theme which remains significantly below the average is We are compassionate and inclusive.

Local and National position

- We are 31st out of 51 Mental Health Trusts, 6th nationally improved
- 62.9% of staff would recommend BSMHFT as a place to work. We have seen a 5.8% increase from 57.1% in 2022 and we are 2nd in the region
- 55% of staff would recommend BSMHFT as a place for care. This is a 4% increase from 51%



	2019	2020	2021	2022	2023
Your org	59.72%	66.42%	62.46%	57.11%	62.86%
Best result	75.13%	77.76%	73.58%	73.01%	75.43%
Average result	61.79%	67.83%	63.17%	62.74%	65.59%
Worst result	42.82%	49.09%	43.43%	39.56%	39.46%
Responses	1690	1789	2141	2216	2380

	2019	2020	2021	2022	2023
Your org	56.98%	60.59%	58.07%	51.96%	55.62%
Best result	80.67%	84.23%	82.42%	79.63%	80.42%
Average result	65.50%	70.45%	64.89%	63.78%	65.18%
Worst result	37.29%	47.19%	45.13%	40.19%	43.64%
Responses	1691	1787	2142	2216	2378

Snapshot of 2023 results

Birmingham and Solihull Mental Health NHS Foundation Trust

Organisation details

Survey Coordination Centre NHS

Birmingham and Solihull Mental Health NHS Foundation Trust

2023 NHS Staff Survey

Organisation details

Completed questionnaires	2393
2023 response rate	55%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

2023 benchmarking group details

Organisations in group: 51

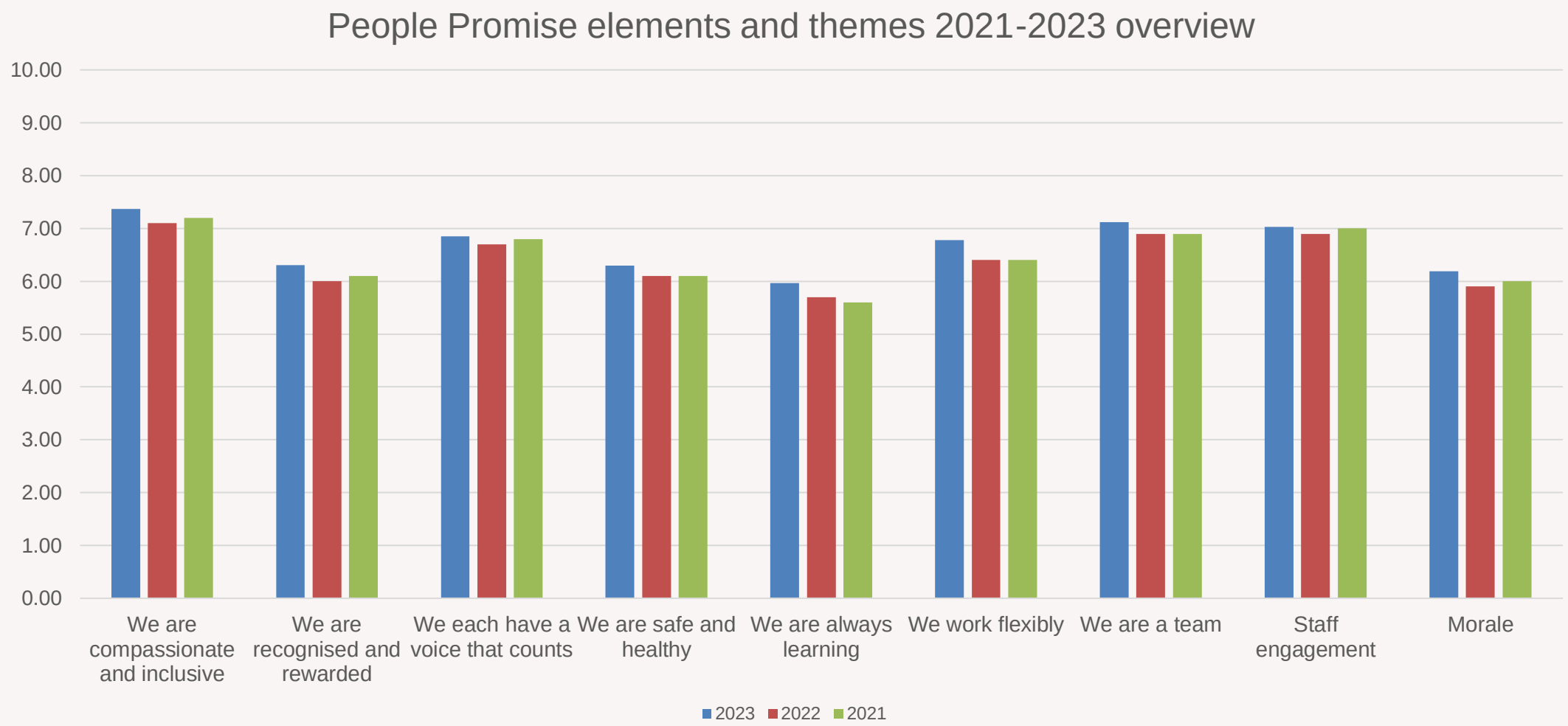
Median response rate: 52%

No. of completed questionnaires: 127293

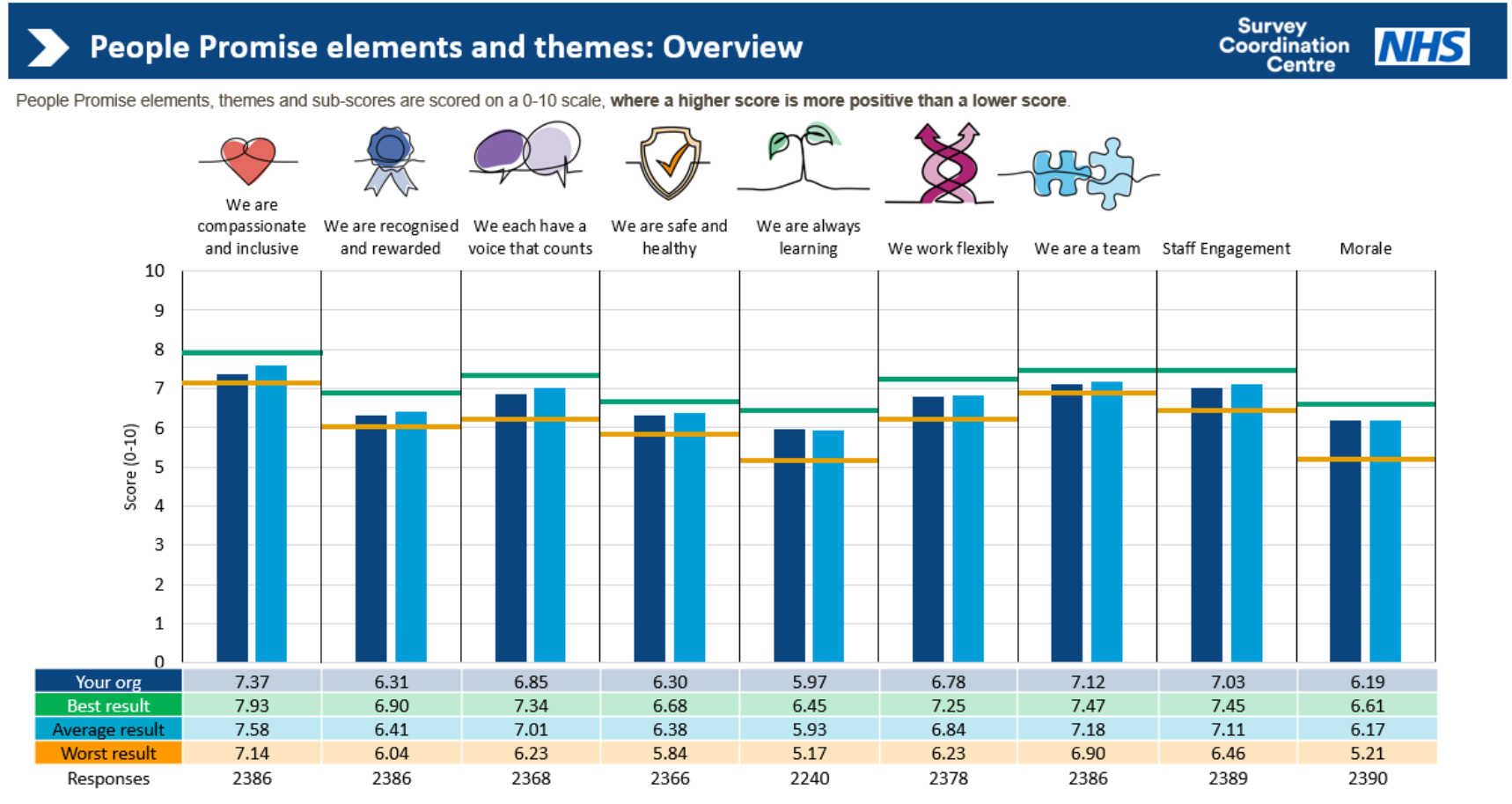
For more information on benchmarking group definitions please see the Technical document.

BSMHFT Improvement Journey

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



Theme scores



2023	7.37	6.31	6.85	6.3	5.97	6.78	7.12	7.03	6.19
2022	7.1	6	6.7	6.1	5.7	6.4	6.9	6.9	5.9
Improvement score	0.27	0.31	0.15	0.2	0.27	0.38	0.22	0.13	0.29

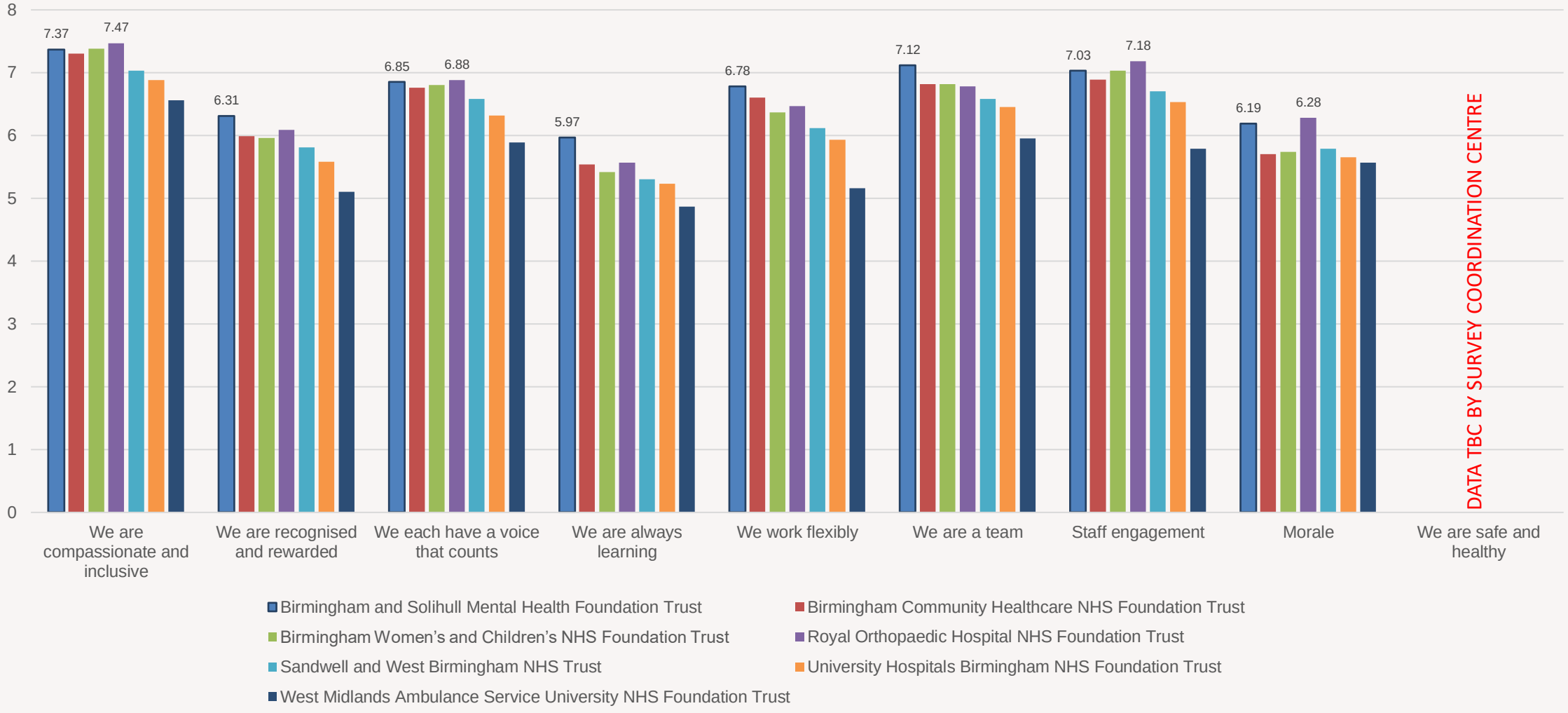
Comparison Against System Partners

Birmingham and Solihull Mental Health NHS Foundation Trust

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	We are safe and healthy
Birmingham and Solihull Mental Health Foundation Trust	7.37	6.31	6.85	5.97	6.78	7.12	7.03	6.19	-
Birmingham Community Healthcare NHS Foundation Trust	7.3	5.99	6.76	5.54	6.6	6.82	6.89	5.7	-
Birmingham Women's and Children's NHS Foundation Trust	7.38	5.96	6.8	5.42	6.37	6.82	7.03	5.74	-
Royal Orthopaedic Hospital NHS Foundation Trust	7.47	6.09	6.88	5.57	6.47	6.78	7.18	6.28	-
Sandwell and West Birmingham NHS Trust	7.03	5.81	6.58	5.3	6.12	6.58	6.7	5.79	-
University Hospitals Birmingham NHS Foundation Trust	6.88	5.58	6.32	5.23	5.93	6.45	6.53	5.65	-
West Midlands Ambulance Service University NHS Foundation Trust	6.56	5.1	5.89	4.87	5.16	5.95	5.79	5.57	-

BSMHFT Position Against System Partners

Birmingham and Solihull Mental Health NHS Foundation Trust



compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

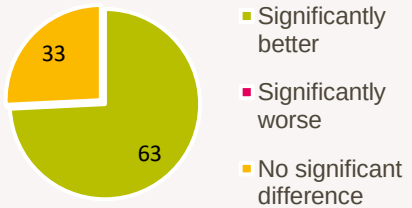
Question level comparison

4390	4339	**55%**	52%	55%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (2393)	Median response rate for similar organisations	Your previous response rate

None of the questions are “significantly worse” in comparison to 2022 and 63 are “significantly better”

63%	q25c. Would recommend organisation as place to work
56%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
75%	q25a. Care of patients/service users is organisation's top priority

Comparison to 2022**



Comparison with average**

- 3 ‘significantly better’ scores relate to; career Development, whether your appraisal has helped you improve how you do the job and colleagues here work fewer hours unpaid than at other MHTs.
- We are the sixth most-improved mental health trust on ‘recommend as a place to work’ measure
- We are 31st out of 51 in absolute terms as a MHT.

Improvements

Top 5 scores vs Organisation Average	Org	MHT Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46%	43%
q24b. There are opportunities for me to develop my career in this organisation	60%	57%
q23b. Appraisal helped me improve how I do my job	28%	25%
q3g. Able to meet conflicting demands on my time at work	51%	49%
q23c. Appraisal helped me agree clear objectives for my work	39%	37%

Most improved scores	Org 2023	Org 2022	Increase
q3i. Enough staff at organisation to do my job properly	36%	28%	+8%
q4c. Satisfied with level of pay	34%	27%	+7%
q6b. Organisation is committed to helping balance work and home life	56%	49%	+7%
q24d. Feel supported to develop my potential	65%	58%	+7%
q24e. Able to access the right learning and development opportunities when I need to	66%	60%	+6%

Improvements made

- Initiatives that were based on 2022 results to ensure career development and interview practices are more inclusive has proven effective, as 54% of colleagues believe the ‘Organisation acts fairly in relation to career progression’ with an increase of almost 5%
- Another 5% of colleagues feel satisfied with the recognition they get for their work, 54% of colleagues feel career progression is fair (was 46% in 2019).
- 56% (7% increase) of colleagues think the Trust is committed to helping people balance work and home life - that equates to 350 colleagues having a different experience
- 39% (4% increase) of colleagues say their appraisal has helped them improve how they do their job.
- 99% of colleagues know our trust values. More people are demonstrating our values more than ever before with the percentage of managers (69%) (7% increase) and colleagues 65% (6% increase) demonstrating our values.
- All nine measures of managers improved significantly year on year with all at or within one percent of the average either way. Return of manager training – more focus.
- Teamwork – improvement across the Board
- Employee experience has improved overall for Gay, Lesbian, Bisexual or ‘other’ colleagues, including a consistent pattern of improvement in questions that relate to the likelihood of raising concerns.

Achievements

Flexible Working

'We work flexibly' is one of our highest improved scores reported, there was a great deal of work carried out to review the current flexible working policy and as a result a revised policy was created and disseminated. Toolkits, template letters and lunch and learns were created and held to educate employees and managers of the changes. There was a sharp rise in flexible working requests in January 2023 reinforcing the communication of the revised policy and toolkits alongside the lunch and learns resulted in an increase in flexible working requests

Appraisal

'We are always learning' sub theme 'Appraisals' (5.17) is above national average (5.13). When asked In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review, 86.45% staff answered yes. The benefits of the introduction of values-based appraisal meant that 99% of staff are aware of our values with and increased percentage of managers (69%) and colleagues (65%) demonstrating our values always or often

ICCR

The most improved directorate year on year is ICCR they adopted a team level approach which has been built over the past two years. Whereby, local managers have been responsive to local issues, and increased visibility, SLT have been responsive to adverse events recorded via eclipse and have been taking an active values-based approach.

Areas of focus

Bottom 5 scores vs Organisation Average	Org	MHT Avg
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	66%	75%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	70%	76%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	56%	65%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	85%	93%
q19c. Organisation takes positive action on health and wellbeing	58%	65%

Most declined scores	Org 2023	Org 2022	Decrease
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	68%	70%	-2%
q3a. Always know what work responsibilities are	85.8%	86.2%	-0.4%
q2c. Time often/always passes quickly when I am working	72%	73%	-1%
Q25a Care of patients/service users is organisation's top priority	75.2%	75.3%	-0.1%
Q9b Immediate manager gives clear feedback on my work	74%	76%	-2%

Areas to improve

- 34% of staff work additional paid hours per week for this organisation, over and above contracted hours, potentially linked to the 65.8% of staff feeling burnt out or 39.6% of staff planning
- Bullying by service users, carers relatives and the public remains one of our worst relative scores overall and is becoming a relative area of concern 15% of staff suggest that they have experienced discrimination from patients/service users, their relatives or other members of the public. 30% of staff have experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
- Experience as employees for staff with a disability or long-term health condition
- 42% of staff believe the organisation takes positive action on health and wellbeing
- 5.29% of staff have experienced unwanted behaviour of a sexual nature from other colleagues

Birmingham and Solihull Mental Trust

Participation and topics analysis for the organisation

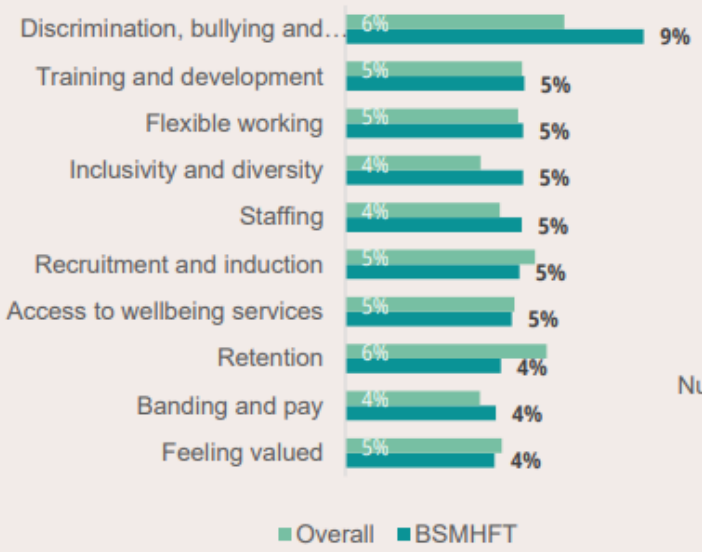
- BSMHFT staff saw the second highest number of participants (291), making up nearly a fifth (18%) of all those that joined the online engagement. Overall, 5% of invited BSMHFT staff engaged with the conversation, the second highest among all partners.
- BSMHFT contributed a third of all ***Add Prof Scientific and Technical*** staff to join the engagement, the highest of any organisation, along with the second highest share of *Nursing and Midwifery* and *Additional Clinical Services* colleagues.
- The topic of ***Discrimination, bullying, and harassment*** ranked much higher for this organisation compared to others, alongside a slightly higher focus on ***Inclusivity and Diversity*** issues.
- Responding to gateway survey questions (1) most (53%) BSMHFT staff were in somewhat undecided when it came to their satisfaction with the workplace, quality of care being delivered, or being able to affect change. The remaining participants **were evenly split between *enthusiasts* and *sceptics***, indicating both pockets of excellence at the organisation, as well as those where culture needs attention.

By the numbers

291 number of participants	206 | 18% written contributions
18% share of participants	1,840 | 19% votes contributed
5% of invited staff engaged	19% of total contributions*

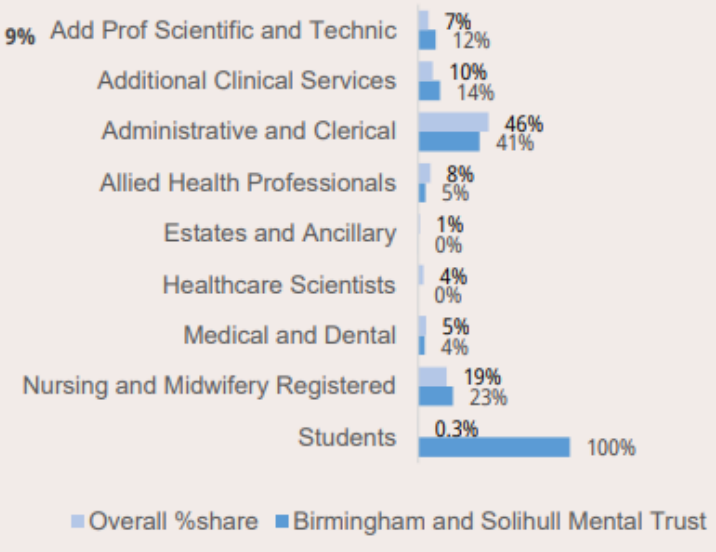
Most prominent topics

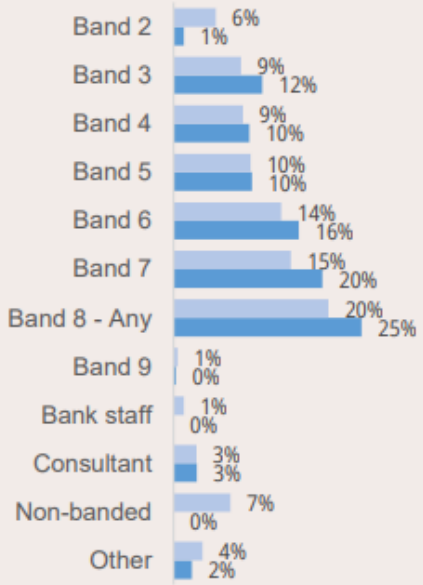
ranked by total contributions from BSMHFT staff

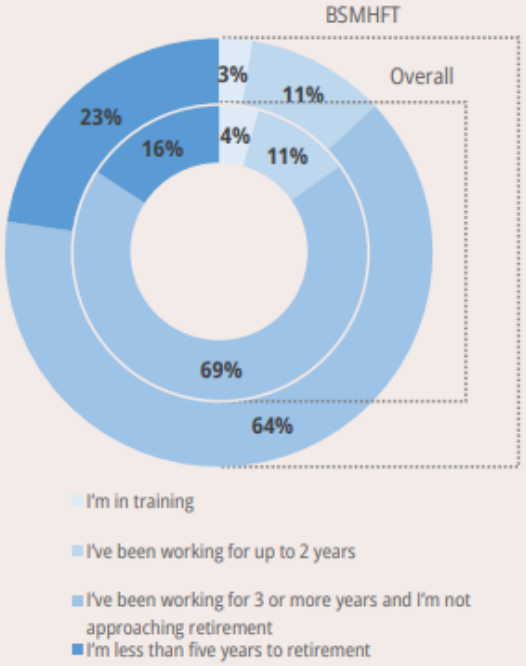


Participation by staff group, band, and career progression

share of BSMHFT participants within the conversation, compared to all participants







Next steps

As part of the Organisation Development team the National staff Survey results help inform initiatives that are required to promote a change in behaviour for the better and are in line with our values and encourages a shift in culture that encourages and increases an appreciative enquiry approach to reduce bullying and harassment, victimisation and discrimination.

- Launch Values in practice initiative March 24 to ensure accountability for leading and managing informal claims of bullying, harassment and discrimination to further support those who need to raise issues around bullying. It is a reflective tool process to support individual development in line with our Trust values.
- Developed and rolling out March 24 an anti-racist, anti-discrimination behavioural framework, to enable the right ingredients for an Inclusive culture which is anti-racist and anti-discriminatory for all to improve access, experience and outcomes for our people.
- Highlight and communicate via anti-discrimination campaigns how valued colleagues with a disability or long-term health condition are, perhaps with an educational element about different conditions.
- Signing up to Sexual safety in healthcare – organisational charter. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this

next steps continued…

- Developed a team-based approach supported by a manager's toolkit which guides managers to understand and analyse their own results locally and how to start a conversation about the results and how to explore what they mean, positives and strengths and weaknesses and areas to improve within their teams
- Specific work on building trust in speaking up safely for medical colleagues with the Freedom to Speak Up Lead. Specific work to look at building more trust for medical colleagues so they are more likely to speak up earlier about concerns around care.
- We are committed to developing new more aligned communications and engagement strategies and will consider how we can reconnect with “hard to reach” areas in the trust and improve overall engagement score.
- Embed a restorative just and learning culture.
- Developing a Leadership Development Framework.
- Specific work to refresh and communicate our approach to tackling assaults, abuse and discrimination against staff potentially modelled on a modified “no excuse for abuse” approach.
- Positioning the work on building a safety culture as part of a staff survey response related to better care.

Support available

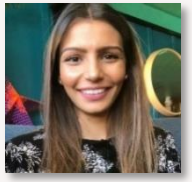
- Business partnering model across the EDI and OD team to ensure we can support our employees locally (see appendix 1)
- Online tool for self-help ‘Staff Survey Managers Toolkit’ - improving local engagement with results
- Corporate support offer (see appendix 2)
- Anti-Racist Framework
- Restorative Just and Learning Culture
- Mediation
- Values in Practice

Appendix 1 - EDI/OD Business Partnering Model

Birmingham and Solihull Mental Health NHS Foundation Trust

DIRECTORATE	Organisational Development Business Partner	Equality, Diversity & Inclusion Business Partner
ACUTE & URGENT CARE	Sonia Orr Organisational Development Business Partner sonia.orr@nhs.net	Lynn Phung Senior Equality Diversity and Inclusion Lead lynn.phung@nhs.net
SPECIALTIES	Sonia Orr Organisational Development Business Partner sonia.orr@nhs.net	Manisha Panesar Senior Equality Diversity and Inclusion Lead manisha.panesar1@nhs.net
SECURE CARE & OFFENDER HEALTH	James Hart Organisational Development Business Partner james.hart4@nhs.net	Manisha Panesar Senior Equality Diversity and Inclusion Lead manisha.panesar1@nhs.net
INTEGRATED COMMUNITY CARE & RECOVERY SERVICES	James Hart Organisational Development Business Partner james.hart4@nhs.net	Lynn Phung Senior Equality Diversity and Inclusion Lead lynn.phung@nhs.net
CORPORATE	Nageeta Paul Senior Organisational Development Business Partner nageeta.paul2@nhs.net	Jas Kaur Associate Director of Equality, Diversity, Inclusion and Organisational Development jaskiern.kaur@nhs.net


Jas Kaur


Nageeta Paul


Sonia Orr


James Hart


Lynn Phung


Manisha Panesar

compassionate inclusive committed

Appendix 2 - Corporate Support Offer

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

1. Leader/manager identifies need for support request. i.e. team effectiveness, change management, performance management/development etc

2. Leader/manager to complete Microsoft Form - connect EDI/OD intranet page

3. Completed forms will be downloaded by Head of Programmes and collated in an excel spreadsheet In preparation for weekly triage meeting and for tracking and intel purposes

4. Programmes Lead to review request and ensure we have required information. If not, will further consult in preparation for triage meeting

5. Triage meeting; Programmes, OD and L&D leads required to discuss support requests

6. Diagnosis - A meeting with the senior team; OD, L&D, HRBPs, QI, EDI, Psychological professional leads will take place to triangulate data - deep dive into data; staff survey results, sickness rates, PSIRF data, ECLIPSE data, FTSU cases, environment, historical information etc to then determine the support required

7. Oversight meeting - Manager and relevant leads to meet and discuss proposed support, agree and provide confirmation to proceed. Workshop, away day, coaching etc

8. Determine which lead/s will help support and manage the request. Set up relevant meetings

9. Support request to be raised at FPP for awareness

10. Create action plans, strategies and techniques

Plan is to be owned by service, oversight through the division, to be supported by lead/s

11. Support from areas of expertise OD, L&D, QI etc. Use of 30, 60, 90 day cycles to track progress.

12. Update on progress at FPP to provide assurance of work and ensure continuous feedback between all involved

13. Update Programmes Lead of work carried out to update information held locally

14. Evaluation, outcome, impact on 30, 60, 90 day cycle

Close the loop through sharing good practice

Sustainability

12. Finance, Performance and Productivity Committee Report

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	**3 April 2024**
Date(s) of Committee Meeting(s) reported	**21 February 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Integrated Performance Report • Finance Report • Sustainability Strategy Update • Clinical Services Strategy Update
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Month 10 financial position showed a **surplus** of £1.4m year-to-date. • Challenges remained with significant spend related to **Out of Area placements;** current expenditure of £15m was reported, which was a £9m overspend. A reduction had been highlighted during quarter 3, however an increase in non-Trust bed usage had been seen in January. • A year-to-date **bank and agency spend** of £37m was reported, with the Trust in breach of all but one of NHSE agency rules. Positive progress was reported on all agency usage KPIs, although medical over cap agency remained a key issue. • There was a year-to-date **savings** delivery of £11.9m which was a shortfall against the plan of £0.4m. The full savings delivery of £14.7m was forecast, and was mainly driven by non-recurrent delivery. A **challenging 3% savings** target had been agreed as a system planning assumption for the first high level draft of the plan for 2024/25. • **National planning guidance** had not yet been received, however the local planning process had developed a high level draft of the 2024/25 plan, with a deficit of £18.1m.
Assure:	Updates on the Sustainability and Clinical Services strategy areas were received, noting the work that was taking place to measure the impact of the strategies and alignment with the performance framework, Quality Management System, and quality improvement approach. The Committee endorsed the Trust as a going concern.

Advise:	A review of the performance metrics in the Integrated Performance Report was underway to enhance triangulation of data. Further refinements would be made to ensure operational metrics were fully reflective of the key areas. The Committee would receive the initial approach in March.	
Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. A Board session would take place during 2024 to consider the entire Board Assurance Framework.	
	New risks identified: The Committee reviewed the corporate risk register and was assured by the ongoing work to align operational risks to the BAF. No additional risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**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	**3 April 2024**
Date(s) of Committee Meeting(s) reported	**20 March 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Corporate Risk Register • Integrated Performance Report • Finance Report • Planning and Budget Setting 2024/25 • Reach Out Commissioning Business Case • Emergency Preparedness, Resilience and Response Report • Declarations of Interest Policy • Committee Effectiveness Self-Assessment
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • 24/25 capital planning risks remain a concern and the lack of guidance received from NHS England continues to be impacting on the ability to plan robustly for capital spend and savings plans. • The capital spend envelope for 24/25 remains a challenge with £6.6m available. This includes a national allocation of £0.4m relating to the system capital investment fund, against which spend is to be prioritised across the system.
Assure:	• Performance reports are highlighting the emerging trends and triangulating across Board Committees. The Committee were assured the improvements with the report are allowing for focused discussions. • Financial trajectory remain on track for the agreed end of year forecast and submission. • The Committee approved the Reach Out Commissioning Business Case and noted the positive good news stories within the report including the 70% reduction of out of areas, increase in quality of services for inpatients, reduction in health inequalities and positive example of collaborative working.

Advise:	• Positive meeting with ample time to review and consider the reports received. • The Committee approved the process for the Effectiveness Self-Assessment survey. • The Committee approved the Declarations of Interest Policy.	
Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. A Board session would take place during 2024 to consider the entire Board Assurance Framework.	
	New risks identified: The Committee reviewed the corporate risk register and was assured by the ongoing work to align operational risks to the BAF. No additional risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

13. Integrated Performance Report

Report to All Committees and Board							
Agenda item:							
Date	21 March 2024						
Title	Integrated Performance Report						
Author/Presenter	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 Director	Dave Tomlinson, Director of Resources						

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

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

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

FPPC is asked to note that the performance report has been shared at the Performance Delivery Group meetings and relevant metrics also discussed at service area deep dive meetings on an ongoing basis.

FPPC is asked to note that from March 2024, a revised framework is being implemented with service areas as part of the deep dive meetings. A service line review process has commenced to ensure that all services within the operational portfolios are covered. The process remains developmental and learning from the first round of meetings will be utilised to shape future meetings. As part of this framework, a service line RAG rating assessment is planned to cover each of the domain areas.

Regarding the performance metrics, at the 22 November 2023 FPPC meeting, it was agreed that a RAG rating position on the metrics be included in the Executive Summary of the report for an accessible view on performance trends. This has been added below. This approach was supported by members at the January FPPC meeting.

Members are reminded that at the February 2023 FPPC meeting, a specific request was made for the provision of action plans and improvement trajectories related to 11 of the metrics. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is a possible concern or a deteriorating trend.

Relevant Leads have provided an update on each area. The detailed summary of progress against action plans is included as Appendix I. Further details are provided in Appendices II and IIa which provide an outline of discussions and progress at PDG and Deep Dives.

FPP talked about Incidents resulting in harm, noting that while this should have been raised at QPES, numbers have increased significantly in ICCR and Specialties on previous six months, not just the overall position, and this might not have been noted by QPES.

Table 1: Improvement Metrics identified by FPPC at February 2023 meeting

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
CPA 7 DFU			Below 95% standard. Previous months consistently below standard with exception of December 2023.	11-12, Appx I
Talking Therapies – service users seen within 18 weeks			Slight deterioration in trend (83.6%), below 95% standard and improvement trajectory of 90.2%.	3, 16-18, Appx I
Talking Therapies – service users seen within 6 weeks			Improving trend (70.04%) and above trajectory but below 75% standard.	3, 16-18, Appx I
Inappropriate out of area bed days			Improving trend in February but remains above trajectory	1-2, 19-21, Appx I
Referrals over 3 months with no contact			Small deterioration in trend for last month. Long waits reduced.	3, 22-24, Appx I
CPA 12-month reviews			Maintained - Improved trend in last 2 months and above target of 95%.	4, Appx I
People				
Vacancies			Stable trend for last 3 months February data not available.	4, 25-26, Appx I
Sickness			Improving trend in last 3 months.	4, 27-28 Appx I
Appraisals			Small improvement in last month months to 76.7% and remains below the 90% standard.	4, 29-30, Appx I
Bank and Agency fill rate			Improvement in last month at 91.6% and above improvement trajectory of 86%.	4, Appx I
Sustainability				
Monthly Agency costs			Down in month, but remains above NHSE ceiling	5, 33 Appx I

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Service users moving to recovery			Deteriorating trend in month (46.5%) below 50% target	

Delayed Transfers of care: percentage of bed days			Deteriorating trend.	4, 14-15, Appx 1
Delayed transfers of care: Number of delayed days			Deteriorating trend.	4, 14-15, Appx 1

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Small deterioration in month. Remains below target. A plan has not been provided for inclusion in this report	31-32

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Absconsions from inpatient units			Increase in last month	4, 33, Appx I
Incident resulting in harm (patients)			Increasing trend in last 7 months. A plan has not been provided for inclusion in this report	4, 34, Appx I

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

Recommendation

The Board is asked to receive assurance on performance

Enclosures

- Performance Report and Data March 2024
- Appendix I FPPC March 24 Performance Metric Trajectories
- Appendix II FPPC March 24 Performance Framework Update
- Appendix IIa Specialties deep dive presentation – 7th March 2024
- Appendix IIb Specialties deep dive (CHP) presentation – 7th March 2024

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 February 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 (** improving trends for 6 weeks**)
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months (** now significantly improved and reaching target**)
- 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 improvement plans and these are outlined in Appendix 1.

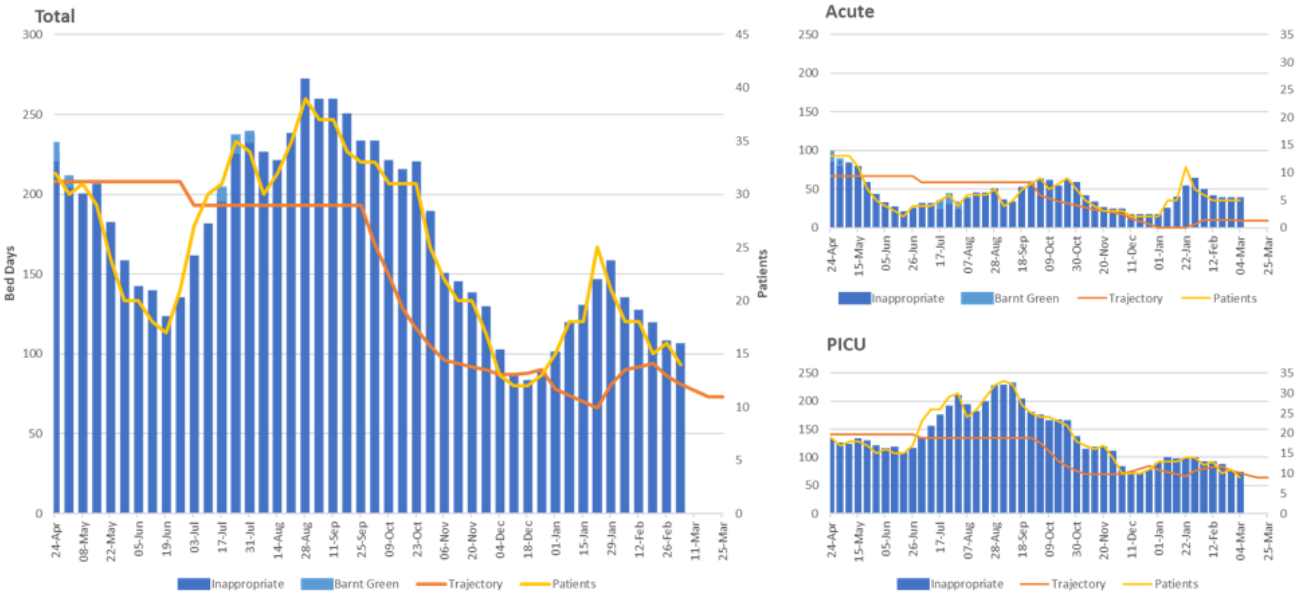
Due to the level of detail within the overall performance report, at the October 2023 FPPC meeting, members asked that the report below provides greater summarised detail on the key issues. The report content below has therefore been revised to address this feedback.

Performance in February 2024

The key performance issues facing us as a Trust have changed little over the last 2 years, although there have been some improvements against some of the metrics in recent months:

Inappropriate Out of Area Bed Use – process improvements being implemented as part of the Productivity action plan are helping to 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. Up until the end of December, significant progress was achieved with December levels in line with the monthly trajectory. Post Christmas and New Year, the service has seen an increase in demand for acute and PICU beds leading to use of inappropriate placements during January, which has started to drop in February. The granular level weekly data, see chart below for February 2024 shows that there only 5 remaining inappropriate placements for acute beds and PICU usage has started to fall and is under trajectory. February 2024 was at 519 bed days above the monthly trajectory of 378

and a total of 27 inappropriate out of area placements, which is a reduction of 7 compared to January.



In summary, the action plans continue to be taken forward to mitigate and reduce the need for inappropriate out of area placements with updates as follows:

- **Admissions Decision MDT /escalation process –** now embedded.
- **Joined up 18+ bed management process** – options appraisal exercise in process – due end of November 2024.
- **Contract procurement exercise** – in progress, with view to extending Priory capacity and procuring additional capacity.
- **Demand Management/Gatekeeping -** Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered.
- **Confirm and challenge for referral process** – assurance over referrals going to all providers in the quickest possible timeframe – now embedded.
- **Reducing LOS/DTOCs** - weekly internal bed management, ICB deep dive weekly, EDD Confirm and challenge process (more proactive approach for patients with longer LoS) – senior ICS support required
- **Optimising Capacity** - daily bed states shared to ensure contracted beds are used first, then KN before only PICU OOA are considered – now business as usual
- **Locality Model** – ensuring that teams work within locality across the patient pathway – 50% embedded and roll-out continuing. FTB aligning with model where possible.
- **Clinical Oversight Team -** senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients – informal processes in place. Formal SOP to be signed off this week

Talking Therapies waits – Trust performance remains below the national waiting time standards for 6 weeks (75%) and 18 weeks (95%). Good progress has been made on the 6-week standard and is on target to reach 75% by January 2025, with February 2024 position at 70%. The 18-week standard is planned to be met by end of June 2024 and this remains challenging with February 2024 position at 83.64%. 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. Recruitment plans have been taken forward and new staff are beginning to embed and positively impact on the improving trends.

Staff vacancy challenges: Staff vacancies continue to remain a significant challenge impacting on ability to carry out activity levels. Current vacancies include 21 vacancies at step 3 level and 7 vacancies at step 2. A rolling programme of recruitment is in place and the managers are working hard to promote staff wellbeing with initiatives to foster retention within the service.

New referrals not seen within 3 months – Both Adult and older Adult CMHTs have made progress against their improvement plans focusing on reducing long waits. Challenges in both services remain in particular around managing high caseload levels and staffing levels.

ICCR Adult CMHTs – Progress against the improvement trajectory to achieve a 20% reduction in new referrals not seen within 3 months by the end of January 2024 has been slower than anticipated and the trajectory has not been reached. February 2024 at 732 service users waiting for an appointment. An action plan is in place based on the following:

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 teams (NMHT) is now the front door to CMHTs to triage and refer appropriate patients to CMHTs. There has been a focus on the 52+ week waiters and these have reduced by 70% from 94 in November to 19 in February 2024.

Medium Term plan – Achieve full staffing 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 and reducing DNA rates for first appointments to 20% by May 2024. A small reduction for DNA rates has been noted in February 2024

Older Adult CMHTs – the action plan focuses 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. Good progress continues to be made and February 2024 position is at 179 service users waiting over 18 weeks, below the trajectory of 203.

There has been a focus on the 52+ week waiters and these have reduced from 86 in November 2023 to 61 in February 2024. The recovery plan is focused on staffing and increasing capacity and leadership within existing teams.

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, the trust performance standard of 95% was met in January 2024 and maintained with February at 96.24%. Older adult CMHTs achieved 95.9% and adult CMHTs 95.2%.

Delayed transfers of care (DTOC) - bed days lost to DTOC have been on an increasing trend, with the latest position at 9.64%. The main drivers for this are the delays in both adult and older adult acute services. DTOCs in Adult Acute & Urgent Care is at 8.8% (23 patients) and in Older Adult Services at 19.7% (16 patients) The number of delays in Acute and urgent care have reduced this month and the delays in Older Adults have increased. The main reasons for the delays in adult acute are lack of public funding and service users awaiting a care package in their own home and in older adults is due to waits for nursing home placements.

Quality the detailed position on these metric areas is discussed at QPES committee. A summary of the metric outliers is outlined below.

- Absconsions from inpatient units have increased from 1 to 9 this month.
- Incidents resulting in harm (patients) has increased from 26% to 27.1%

People Workforce measures – There is an adverse variance against most of the set performance standards although there have been improving trends in reducing sickness absence and increasing bank and agency fill rates. Improvement plans are being taken forward for these areas and the detail of the plans are outlined in Appendix 1.

- Staff sickness levels have decreased to 5% in February 2024 below the improvement trajectory of 5.4%.

- Bank and Agency fill rate Bank and agency fill rate improved to 91.7% and above the trajectory of 86% for February 2024.

- Staff Appraisals at 76.7% as at February 2024 and remains below the 90% Trust standard.

  - A task and finish group in place to review and address any emerging themes or barriers within services.
  - Additional support for operational areas has been offered to outlier areas to include, VBA demonstration, ESR support and SMART card access.
  - A QI project has commenced and is currently identifying the areas for focus.

- Staff vacancy levels Vacancy data for February 2024 is not yet available.

Sustainability (detail in finance report). Summary below:

- Capital expenditure for 11 months to February is ahead of plan, reflecting work that was in hand as we moved into 2023/24
- Cash remains above £80m for eight months in succession
- CIP YTD efficiencies are £13.4m against £13.52m plan, improved trend, but insufficient pipeline of potential savings.

- Agency YTD expenditure remains well above NHSE ceiling of 3.7% of pay bill, though February 2024 spend at £763k is lowest since March 2023. Key issues - level of medical staff expenditure (£6.3m), particularly in ICCR on key staff vacancies.
- Operating Surplus - YTD surplus of £2m against plan of breakeven. Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

NHS
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

February 2024

Performance

CPA 7 day FU	92.7%
CPA with Formal Review last 12 mths	96.2% ↑
Data Quality Maturity Index (DQMI)	97.8% ↑
Delayed Transfer Bed Days	1471 ↓
Delayed Transfer, percent of bed days	9.6% ↓
Eating disorders routine	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	46.5%
IAPT seen in 18 weeks	83.6% ↓
IAPT seen in 6 weeks	70.0% ↓
Out of Area Bed Days	519 ↑
Referrals over 3 mths with no contact	3420 ↓

People

Bank & Agency Fill Rate	91.7%
Fundamental Training	92.3% ↓
Rolling 12m Turnover	7.2% ↑
Staff Appraisals	76.7% ↓
Staff Sickness	5.0% ↓

Quality

Absconsions from inpatient units	9
Commissioner reportable incidents	0
Community confirmed suicides	0
Community suspected suicides	0
Failure to return	10 ↑
Incidents of self harm	160
Incidents resulting in harm (other)	10.4% ↑
Incidents resulting in harm (patients)	27.1% ↓
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	10 ↗
Ligature with anchor point	0
Patient assaults	27
Patient ssaults / 1000 OBD	1.5
Physical restraints	214 ↑
Physical restraints/ 1000 OBD	11.9 ↑
Prone restraints	44 ↑
Prone restraints/ 1000 OBD	2.4 ↑
Reported incidents	2056 ↑
Staff assaults	99
Staff assaults / 1000 OBD	5.5

Sustainability

CAP Ex	£704k
Cash	£92,306k ↑
CIP	£1,518k ↑
Info Governance	94.5%
Monthly Agency	£763k ↓
Operating Surplus	-£616k ↓
SOF rating	3 ↑

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

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Integrated Performance Dashboard

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division
A: All

A: All

Measure	Latest Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	
CPA 7 day FU	95.00	88.0%	83.8%	90.3%	95.8%	89.8%	92.7%	
CPA with Formal Review last 12 mths	95.00	94.3%	95.3%	95.3%	94.8%	96.2%	96.2%	↑
Data Quality Maturity Index (DQMI)	95.00	97.8%	97.1%	97.9%	97.8%	97.8%	97.8%	↑
Delayed Transfer Bed Days		1163	1412	1391	1349	1491	1471	↓
Delayed Transfer, percent of bed days		7.6%	8.9%	9.0%	8.5%	9.1%	9.6%	↓
Eating disorders routine	95.00	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	
Eating disorders urgent	95.00	100.0%	100.0%	100.0%		100.0%		
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↑
IAPT into recovery	50.00	43.5%	47.5%	47.7%	52.4%	45.0%	46.5%	
IAPT seen in 18 weeks	95.00	80.5%	74.9%	78.4%	84.3%	85.3%	83.6%	↓
IAPT seen in 6 weeks	75.00	43.0%	46.9%	48.0%	66.6%	67.2%	70.0%	↓
Out of Area Bed Days		1071	1006	604	402	561	519	↑
Referrals over 3 mths with no contact		3474	3568	3412	3484	3310	3420	↓

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

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Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division: A: All

A: All

Measure	Latest Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Staff Vacancies		11.7%	11.0%	11.1%	11.0%	10.2%	
Staff Sickness	4.28	5.5%	6.0%	5.6%	5.7%	5.6%	5.0% ↓
Staff Appraisals	90.00	77.6%	78.9%	78.8%	78.2%	75.8%	76.7% ↓
Rolling 12m Turnover		8.4%	8.2%	8.0%	7.7%	7.4%	7.2% ↑
Fundamental Training	95.00	92.6%	92.5%	92.3%	92.8%	92.5%	92.3% ↓
Bank & Agency Fill Rate		85.2%	88.9%	88.5%	90.3%	90.3%	91.7%

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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	
Absconsions from inpatient units		2	4	3	6	1	9	
Commissioner reportable incidents		2	0	0	0	0	0	
Community confirmed suicides		0	0	0	0	0	0	
Community suspected suicides		0	0	0	0	0	0	
Failure to return		10	16	19	19	17	10	↑
Incidents of self harm		182	186	187	150	160	160	
Incidents resulting in harm (other)		14.3%	9.9%	10.0%	9.8%	10.2%	10.4%	↑
Incidents resulting in harm (patients)		19.0%	23.4%	23.4%	28.6%	26.1%	27.1%	↓
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		1	0	0	0	0	0	
Ligature no anchor point		27	37	47	25	21	10	↗
Ligature with anchor point		0	0	1	1	0	0	
Patient assaults		27	41	42	52	44	27	
Patient ssaults / 1000 OBD		1.5	2.2	2.3	2.7	2.3	1.5	
Physical restraints		217	190	221	224	213	214	↑
Physical restraints/ 1000 OBD		11.9	10.0	12.1	11.8	11.0	11.9	↑
Prone restraints		63	52	47	56	50	44	↑
Prone restraints/ 1000 OBD		3.4	2.7	2.6	3.0	2.6	2.4	↑
Reported incidents		2310	2623	2334	2181	2309	2056	↑
Staff assaults		109	91	118	113	97	99	
Staff assaults / 1000 OBD		6.0	4.8	6.4	6.0	5.0	5.5	

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	
CAP Ex		£346k	£384k	£515k	£672k	£394k	£704k	
Cash		£83,895k	£88,356k	£88,274k	£86,507k	£86,186k	£92,306k	↑
CIP		£1,670k	£1,525k	£1,666k	£962k	£2,049k	£1,518k	↑
Info Governance		94.8%	94.4%	87.0%	88.6%	95.8%	94.5%	
Monthly Agency		£846k	£819k	£824k	£857k	£765k	£763k	↓
Operating Surplus		-£32k	-£75k	-£614k	-£580k	-£606k	-£616k	↓
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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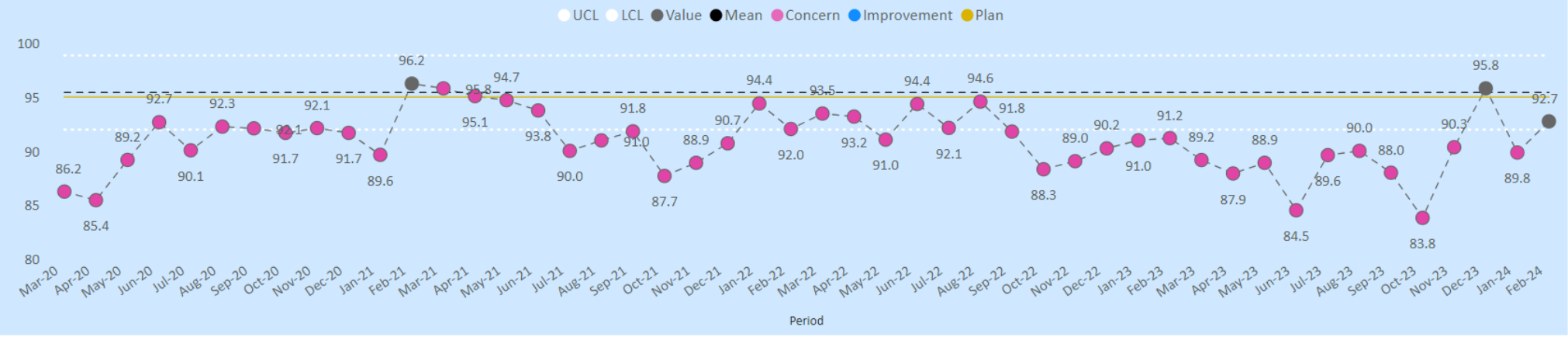
Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	88.0%	83.8%	90.3%	95.8%	89.8%	92.7%
B: Acute and Urgent Care	87.6%	83.2%	95.6%	95.4%	92.7%	91.9%
C: ICCR	66.7%	82.4%	86.4%	100.0%	91.7%	80.0%
D: Secure Serv & Offender Health	87.5%	83.3%	66.7%	100.0%	25.0%	100.0%
E: Specialties	100.0%	87.0%	92.0%	94.7%	93.3%	100.0%

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 with the exception of December 2023 which was above the 95% target. February 2024 performance remains below target at 93.5%. This relates to 9 outstanding follow ups from 123 discharges in February of which, attempts were made to see 3 patients but were unsuccessful, 1 patient was seen outside 7 days, 1 patient was discharged to another mental health service, 1 patient was discharged back to the care of the GP, 1 patient returned to Scotland but did not arrive at destination, 1 patient was followed up on the same date as discharge and 1 will be a pass when data entry is completed. Of the 9 exceptions 8 were adult acute and 1 in ICCR.

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

February 2024

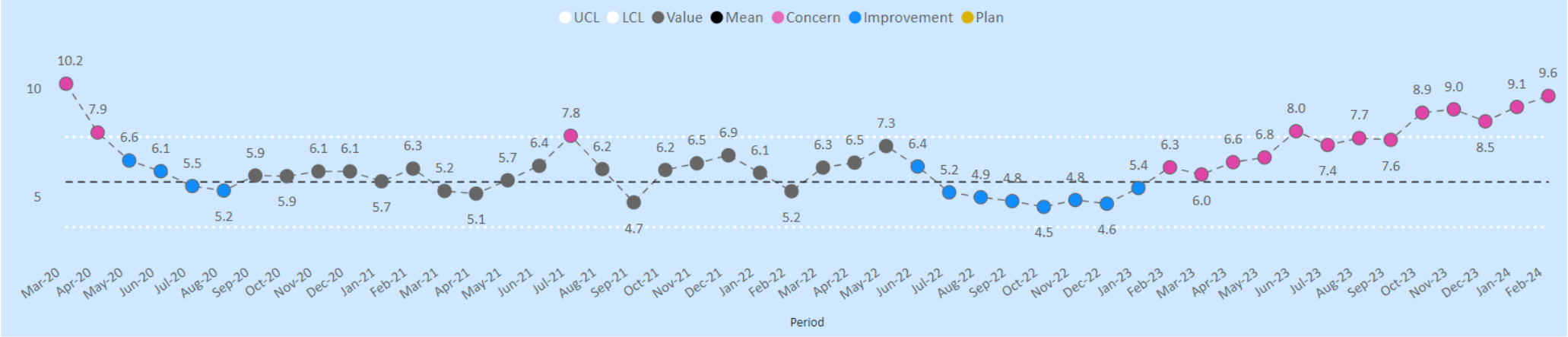
Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2023, performance has been below 95% and below the lower control limits with the exception of December 2023 which was above the 95% target. February 2024 performance remains below target at 93.5%. This relates to 9 outstanding follow ups from 123 discharges in February of which, attempts were made to see 3 patients but were unsuccessful, 1 patient was seen outside 7 days, 1 patient was discharged to another mental health service, 1 patient was discharged back to the care of the GP, 1 patient returned to Scotland but did not arrive at destination, 1 patient was followed up on the same date as discharge and 1 will be a pass when data entry is completed. Of the 9 exceptions 8 were adult acute and 1 in ICCR.
B: Why has it happened?	1 patient was discharged to other trusts which requires the staff to check to see whether they have been seen. 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. There is 1 case where data entry is outstanding for February.
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 there is a lower threshold of 80%, which has been met this month but 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

Delayed Transfer, percent of bed days

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	7.6%	8.9%	9.0%	8.5%	9.1%	9.6%
B: Acute and Urgent Care	10.6%	12.1%	10.3%	9.5%	8.1%	8.9%
D: Secure Serv & Offender Health	1.8%	2.8%	6.9%	7.2%	7.5%	7.0%
E: Specialties	13.5%	14.6%	10.9%	9.0%	15.7%	17.6%

Commentary

Since the beginning of January 2023, bed days lost to DTOC were at 5.4% and have been on an increasing trend, with the latest position at 9.64% remaining outside control limits. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this. DTOCs in the acute and urgent care service from January 2023 rose from 4.8% to a peak of 12.1% in October 2023. Since November there has been a gradual reduction with February at 8.8%. This represents 23 patients and the main reasons for the delays are public funding and awaiting a care package in their own home. Older Adult services at the beginning of January 2023 were at 9%, reaching a peak in June at 19.7% and are now at the same level in February 2024% following a rise in January and February. This represents 16 patients currently experiencing a delay to their discharge and the main reason for the delay is awaiting nursing home placements.

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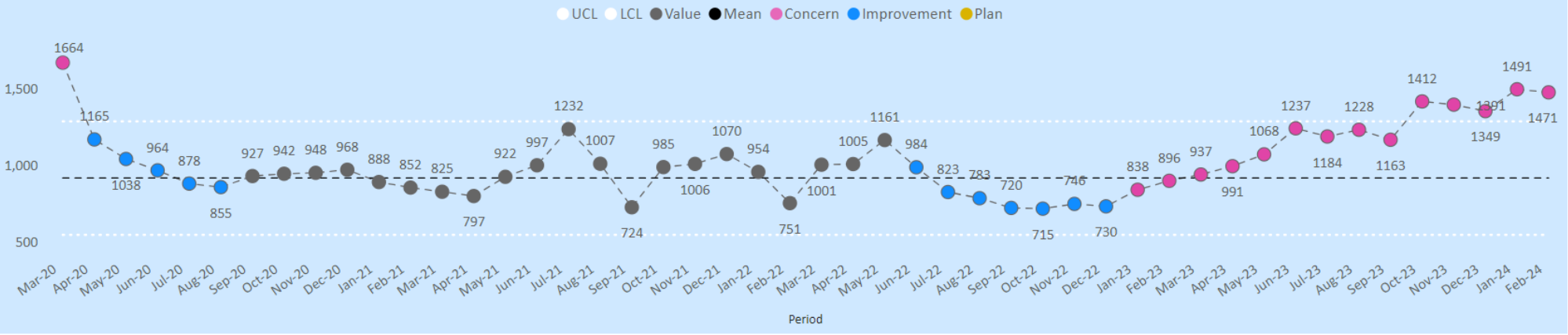
Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer Bed Days

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	1163	1412	1391	1349	1491	1471
B: Acute and Urgent Care	698	821	678	633	546	557
D: Secure Serv & Offender Health	112	177	423	479	504	439
E: Specialties	353	414	293	237	441	475

Commentary

At the beginning of January 2023, bed days lost to DTOC were at 954 bed days and have been on an increasing trend, with the latest position at 1471 bed days which is above the upper control limit. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this increase. Acute and urgent care service have increased from 106 bed days in January 2023 to a peak of 821 in October 2023. The last 4 months have shown a decrease with February 2024 at 557. This represents 23 patients and the main reasons for the delay is are public funding and awaiting a care package in their own home. Older Adult services at the beginning of January 2023 were at 72 bed days, rising to a peak of 416 in June 2023. There has been a gradual reduction until December, followed by a sharp increase in january and February to 388 bed days. This represents 16 patients currently experiencing a delay to their discharge and the main reason for the delays are awaiting nursing home placements.

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Delayed Transfer Bed Days

February 2024

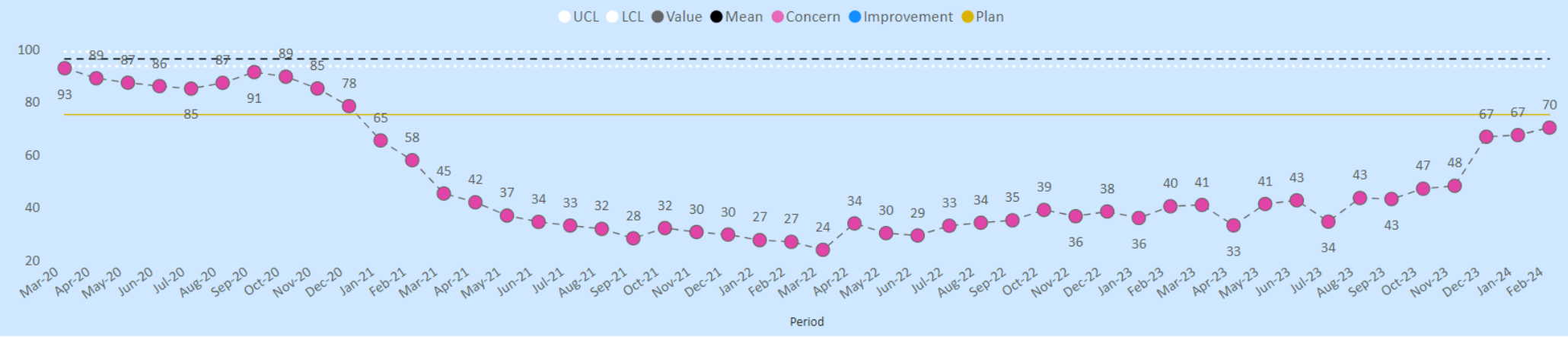
Question	Answers
A: What has happened?	At the beginning of January 2023, bed days lost to DTOC were at 954 bed days and have been on an increasing trend, with the latest position at 1471 bed days which is above the upper control limit. DTOCs in Acute & Urgent Care and Older Adult Services are the main drivers for this increase. Acute and urgent care service have increased from 106 bed days in January 2023 to a peak of 821 in October 2023. The last 4 months have shown a decrease with February 2024 at 557. This represents 23 patients and the main reasons for the delay is are public funding and awaiting a care package in their own home. Older Adult services at the beginning of January 2023 were at 72 bed days, rising to a peak of 416 in June 2023. There has been a gradual reduction until December, followed by a sharp increase in january and February to 388 bed days. This represents 16 patients currently experiencing a delay to their discharge and the main reason for the delays 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 or awaiting public funding which 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. Social care have access to a fund to recruit social workers and the outcome of this is awaited.
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 seen in 6 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	43.0%	46.9%	48.0%	66.6%	67.2%	70.0%
E: Specialties	43.0%	46.9%	48.0%	66.6%	67.2%	70.0%

Commentary

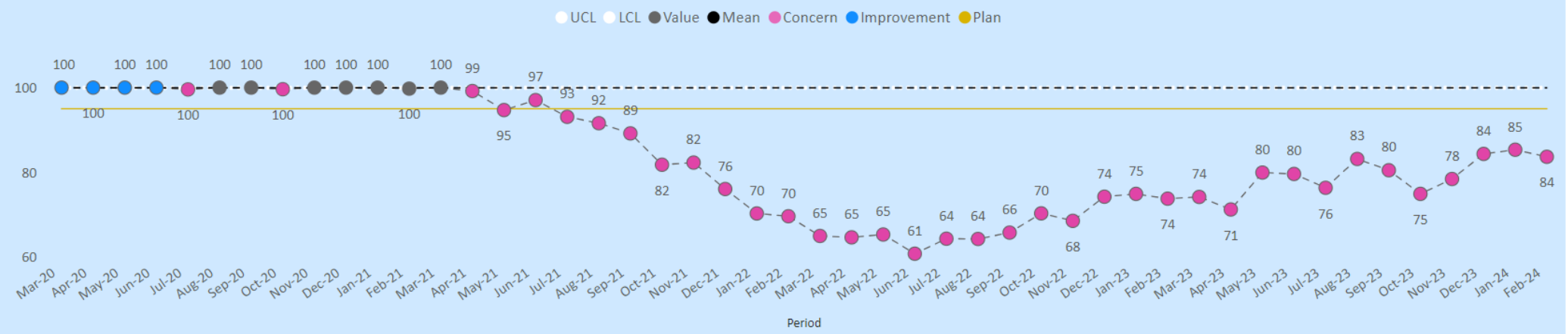
Performance has been on a gradual increasing trend for the last 12 months but remains below the 75% target. February 2024 position has increased to 70.04%, which is above the recovery plan trajectory for February.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 18 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	80.5%	74.9%	78.4%	84.3%	85.3%	83.6%
E: Specialties	80.5%	74.9%	78.4%	84.3%	85.3%	83.6%

Commentary

Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. February 2024 has decreased to 83.64%.

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

February 2024

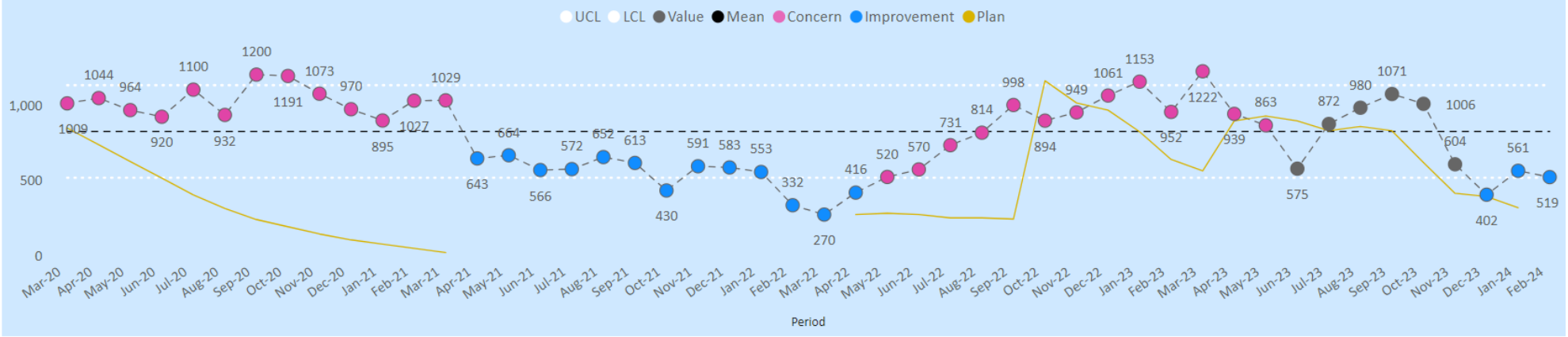
Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months but remains below the 75% target. February 2024 position has increased to 70.04%, which is above the recovery plan trajectory for February.
B: Why has it happened?	The Talking Therapies model 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. The impact of new staff in post can be seen with an increase in contact levels being achieved, however it will take time for staff to build up their full caseload numbers.
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 commenced in October (including the trainees for the year), 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. The increase in staff has had a positive impace on the waiting times for 6 weeks with an increase in February 2024 which has placed them ahead of the trajectory. 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, new staff commencing in October and November, and this has been reflected in an increased number of contacts being recorded, however it will take time for the staff to build up their caseloads and as the waiting times are measured when therapy finishes it will take time for this to come through into the data. There still remain challenges in staffing with a large number of vacancies which is impacting the level of activity which can be undertaken. A rolling programme of recruitment is in place and the managers are working hard to promote staff wellbeing with initiatives to foster retention within the service. 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 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 was initially affected, falling to 42% in August, below the 50% national standard, however, however, this improved with December at 52.31% but has fallen again in Februaryto 46%. 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 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.

Out of Area Bed Days

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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	1071	1006	604	402	561	519
B: Acute and Urgent Care	1071	1006	604	402	561	519

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. November 2023 has seen a significant reduction to 604 beds, and this was continued in December further reducing to 402. January rose to 561 bed days and has fallen to 519 days in February, above the trajectory with continued demand for PICU beds.

There 6 admissions to PICU beds and none to an acute bed bringing the full months number to 27 placements and 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 February 2024 is 378 OOA bed days and the actual position is 519 bed days. By the end of the month there remained just 5 pateints in inappropriate placements and PICU pateints moved to below trajectory.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

February 2024

Out of Area Bed Days

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. November 2023 has seen a significant reduction to 604 beds, and this was continued in December further reducing to 402. January rose to 561 bed days and has fallen to 519 days in February, above the trajectory with continued demand for PICU beds. There 6 admissions to PICU beds and none to an acute bed bringing the full months number to 27 placements and 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 February 2024 is 378 OOA bed days and the actual position is 519 bed days. By the end of the month there remained just 5 pateints in inappropriate placements and PICU pateints moved to below trajectory. 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 overall in January, which was driven by increases in older adults, however adult decreased to 546 lost bed days, which is the lowest level 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 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.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

February 2024

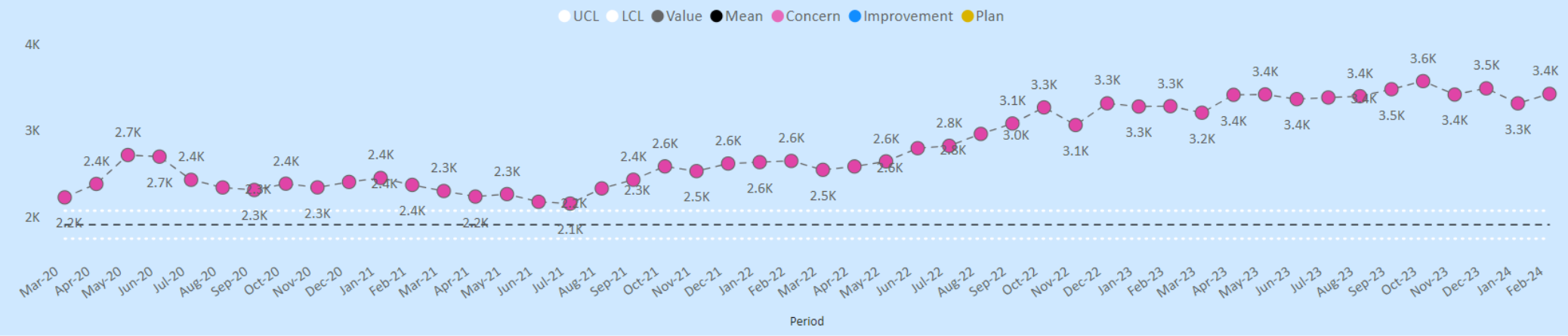
Question	Answers
D: What are we doing about it?	An update on the project plan was shared at the Performance Delivery group in November 2023 outlining progress within the 3 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 3 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. 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. The locality model has now been rolled out to all other localities. New bed management function to support the locality model being developed nd it is anticipated that they will . 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 has been established, and 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. The Clinical Oversight Group will be reviewed in the future to ensure that it is effective. 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. Work is being undertaken to review the current contracts for appropriate placements with the number of beds available increasing for 2024/45, this should help reduce the number our of area placements in the future
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	3474	3568	3412	3484	3310	3420
C: ICCR	1268	1391	1262	1272	1245	1297
D: Secure Serv & Offender Health	154	160	164	168	79	77
E: Specialties	1898	1893	1866	1925	1951	2012

Commentary

The number of patients who have not been seen after 3 months of referral has fluctuated over the last 5 months and has shown a small increase in February to 3420. The number of referrals not seen within 3 months of referral has decreased in CAMHS Primary Mental health in Schools and Solar primary care and Neuropsychiatry but has increased in SOLAR and Adult CMHTs.

Neuropsychiatry service accounts for 23% and Adult CMHTs 21% of referrals open for over 3 months without a contact.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

February 2024

Question	Answers
A: What has happened?	The number of patients who have not been seen after 3 months of referral has fluctuated over the last 5 months and has shown a small increase in February to 3420. The number of referrals not seen within 3 months of referral has decreased in CAMHS Primary Mental health in Schools and Solar primary care and Neuropsychiatry but has increased in SOLAR and Adult CMHTs. Neuropsychiatry service accounts for 23% and Adult CMHTs 21% 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. 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. progress has been slower than expected and a revised trajectory will be put in place as the original trajectory to meet the 20% reduction at the end of January has not been achieved. February 2024 at 676. 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. 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. January 2023 at 200 below the trajectory of 211.There are long waiting times within neuropsychiatry with the longest waits for the Epilepsy service at 33 weeks and the shortest waits are for Huntington's at 10 weeks. The average therapy times are between 4-6 months.
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

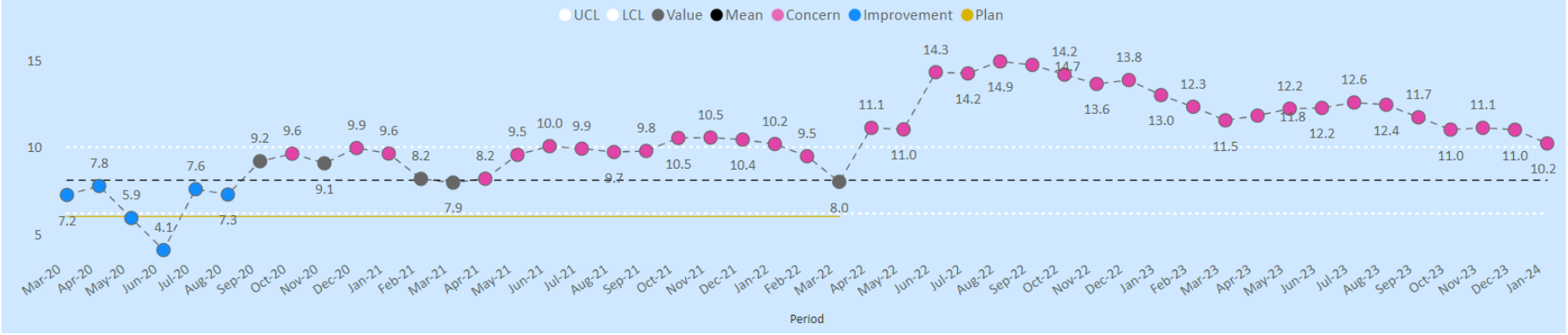
Question	Answers
D: What are we doing about it?	ICCR: Are continuing to review CMHT activity via twice monthly waiting list & KPI oversight meeting. Clinical service managers review the numbers waiting and how many appointment slots are being offered and take away actions for their teams. These actions including cleansing the data, discharging, or prioritising appointments for service users who need an appointment with community mental health services. There has been a focus on those waiting over 52 weeks and these have now been reduced and will now allow a focus on those waiting for more than 26 weeks. 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. They are planning a circuit breaker In April to help improve waiting times and are going to undertake a QI project to look at their processes. 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. Within Memory Assessment service, triage is takeing place with those on the waiting list and if any risks are identified they will be referred to an appropriate toeam or signposted to toher services.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Vacancies

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
A: All	11.7%	11.0%	11.1%	11.0%	10.2%
B: Acute and Urgent Care	15.1%	12.8%	12.8%	13.0%	12.5%
C: ICCR	10.7%	11.2%	11.0%	10.7%	10.3%
D: Secure Serv & Offender Health	14.3%	13.7%	14.9%	15.0%	14.2%
E: Specialties	16.4%	15.7%	15.5%	15.4%	14.1%
F: Corporate	-2.3%	-2.7%	-2.5%	-3.2%	-4.3%

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Commentary

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Vacancies

February 2024

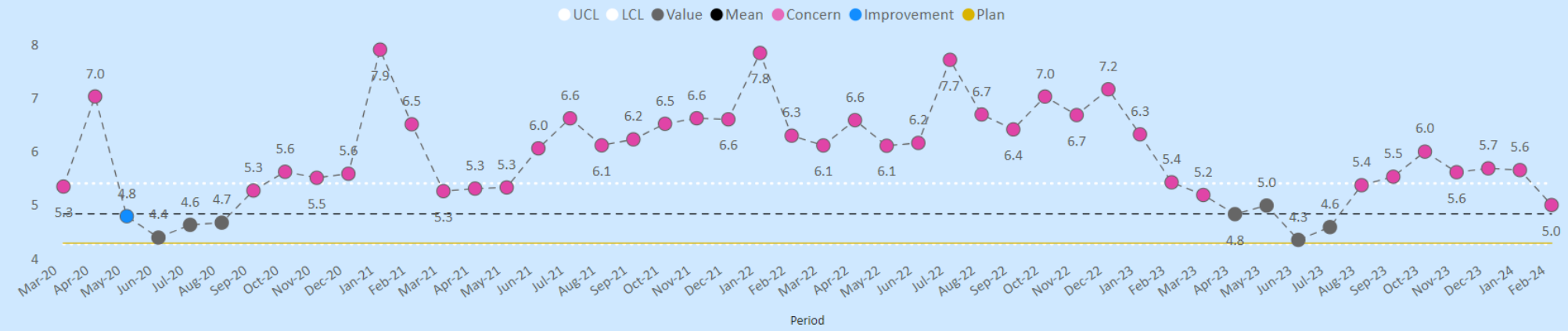
Question	Answers
A: What has happened?	We are awaiting February data but the vacancy rate in January was 10.02% and was above the KPI target of 6.0%. The HCA vacancy rate was 0.0% and the band 5 vacancy rate was 39.8% - down from 47% between June and September in 2023.
B: Why has it happened?	The national shortage of registered nurses particularly band 5 has not changed and this is reflected in our local data, despite some progress with the reduced vacancy rate.
C: What are the implications and consequences?	Unsafe staffing levels continue to pose the risk to both service users and our workforce alike.
D: What are we doing about it?	BSMHFT's People Partner for Resourcing and Temporary Staffing met and presented to Nursing Students at the University of Birmingham and hosted a stand at both the Birmingham City University and University of Wolverhampton Nursing Careers Recruitment Events. Approximately 40 students in their final year were spoken to in detail at both recruitment events and their names and contact details were collected, with a view to being able to facilitate making offers to them upon completion of their studies and them acquiring their PIN's. BSMHFT will be hosting a stand at the RCNI Recruitment event on the 11th March with up to 500 Nurses in attendance, with a proportion of those being Mental Health Nurses. Interviews will be held of the day with a view to makings offers to those successful. The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel (now in its 6th full month) 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. 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. A sixth 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.
E: What do we expect to happen?	There are national supply issues in relation to registered nursing staffing groups meaning we do need to recognise that this will limit the improvements that can be made in relation to vacancy rates. We are competing with private hospitals in the BSol area who are prepared to offer significant financial attraction packages which we currently are not able to match. However targeted work ongoing across the Trust, including recruitment events and bank and agency reduction programmes, will hopefully mean that we see a reduction in vacancy rates over time.
F: How will we know when we have addressed issues?	When the vacancy rate is at or below the 6% Trust target.

Staff Sickness

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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	5.5%	6.0%	5.6%	5.7%	5.6%	5.0%
B: Acute and Urgent Care	5.0%	6.6%	7.1%	7.0%	7.1%	6.2%
C: ICCR	5.3%	6.2%	5.5%	5.4%	5.2%	5.5%
D: Secure Serv & Offender Health	6.9%	7.4%	6.5%	6.8%	7.7%	6.2%
E: Specialties	6.4%	6.3%	5.2%	5.5%	5.1%	3.8%
F: Corporate	3.8%	3.2%	3.6%	3.5%	2.9%	3.1%

Commentary

Sickness absence has reduced from 5.7% to 5% over the past five months there has been consistent reduction in overall sickness absence of 0.98%. Although marginal reduction the trajectory is on the right way. Return to work contact has increased from 66.5% to 67%. Having these increase contacts is positive in supporting the health and wellbeing of staff.

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Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

February 2024

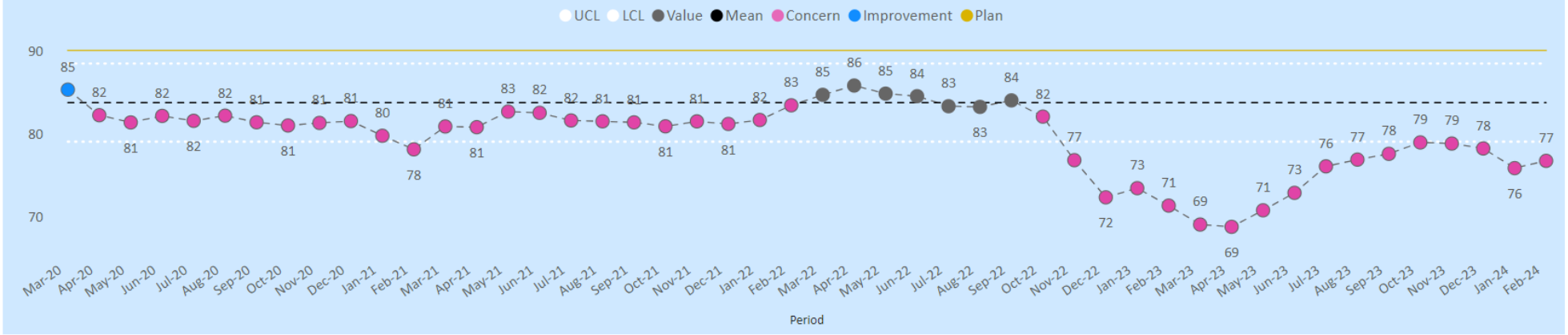
Question	Answers
A: What has happened?	Sickness absence has reduced from 5.7% to 5% over the past five months there has been consistent reduction in overall sickness absence of 0.98%. Although marginal reduction the trajectory is on the right way. Return to work contact has increased from 66.5% to 67%. Having these increase contacts is positive in supporting the health and wellbeing of staff.
C: What are the implications and consequences?	The implication of the above is that sickness absence continue to be managed and the impact of staff returning to work helps the Trust reduce cost in bank costs. Also improves staff morale of staff who cover work for colleagues who are off sick.
D: What are we doing about it?	People team continue to work with managers to manage sickness cases. HR clinics to support managers in managing sickness absence also have continued.
E: What do we expect to happen?	To work towards reducing sickness to the Trust target and improving the health and wellbeing of our staff.
F: How will we know when we have addressed issues?	Reduced sickness absence levels, and more staff working feeling healthy and well to do their work.

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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	77.6%	78.9%	78.8%	78.2%	75.8%	76.7%
B: Acute and Urgent Care	67.2%	67.1%	68.1%	66.7%	65.8%	67.7%
C: ICCR	84.7%	85.1%	84.9%	85.5%	81.6%	80.3%
D: Secure Serv & Offender Health	82.5%	86.0%	85.6%	83.5%	80.7%	82.3%
E: Specialties	82.4%	82.7%	82.0%	82.4%	79.9%	81.3%
F: Corporate	67.6%	69.7%	68.3%	68.5%	67.9%	68.3%

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Commentary

The trust's Appraisal compliance for February is 76%. The trust remains below the Trust target of 90% and commissioner's target of 85%.
The teams within the Trust that are below the compliance trajectory of 75% are:
Acute And Urgent Care Services 67%
Exec Dir - Medical 72%
Exec Dir - Nursing 62%
Exec Dir - Resources 71%

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals

February 2024

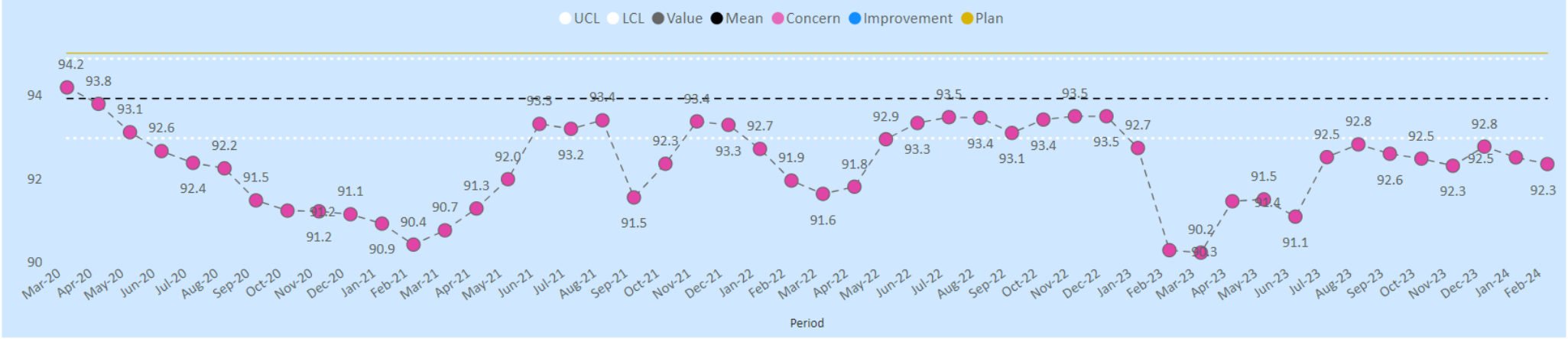
Question	Answers
A: What has happened?	The trust's Appraisal compliance for February is 76%. The trust remains below the Trust target of 90% and commissioner's target of 85%. The teams within the Trust that are below the compliance trajectory of 75% are: Acute And Urgent Care Services 67% Exec Dir - Medical 72% Exec Dir - Nursing 62% Exec Dir - Resources 71%
B: Why has it happened?	The appraisal compliance figure has been maintained from January and we recognise that the drop from December has occured due to staff reaching their 12 month expiry of appraisal, therefore a need to refresh their understanding/skill set to completed appraisal.
C: What are the implications and consequences?	We are not meeting our commissioner target of 85% and the Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and represent the ommunities served by the Trust.
D: What are we doing about it?	We are actively targeting hot spot areas, for example targeted face-to-face sessions with New Care Models, Oleaster site. Additional examples include providing support to Healthy Minds (Shenley Fields). We are working with the Comms team to step up the comms plan in acknowledgement that staff will need to renew appraisal as year post launch and staff need to be redirect to appraisal resources. The QI project work continues and we are currently in the process of arranging workshops with the working group to support the development of a driver diagram.
E: What do we expect to happen?	Increase in comms for Appraisal in supporting staff to available resources and potentially an increase in queries as Appraisal expiry's increase.
F: How will we know when we have addressed issues?	The overall aim will be aligned to the appraisal process in achieving an improvement in the quality of values-based appraisal converstions, enabling the development of an inclusive, compassionate culture.

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	92.6%	92.5%	92.3%	92.8%	92.5%	92.3%
B: Acute and Urgent Care	92.5%	91.8%	91.6%	91.8%	91.6%	91.8%
C: ICCR	93.5%	93.1%	92.3%	92.9%	92.6%	92.7%
D: Secure Serv & Offender Health	93.0%	92.6%	92.5%	93.2%	92.8%	92.2%
E: Specialties	93.3%	93.0%	93.2%	93.6%	93.3%	92.7%
F: Corporate	89.6%	91.5%	91.7%	91.9%	91.9%	92.1%

Commentary

The overall Fundamental Training compliance decreased slightly from 92.5% in January to 92.3% in February 2024. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. With the exception of Executive Director-Resources, every area is still below the 95% Trust target. Temporary Staffing Compliance has decreased from 84% in January to 83.4% which remains above the Trust Target of 75%

- Chief Executive Locality – 75.4%,
- Exec Director - Medical Locality –94.4%,
- Exec Director - Nursing Locality – 92.3%,
- Exec Director – Operations
  - Acute and Urgent Care –92.2%,
  - ICCR – 92.4%,

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

February 2024

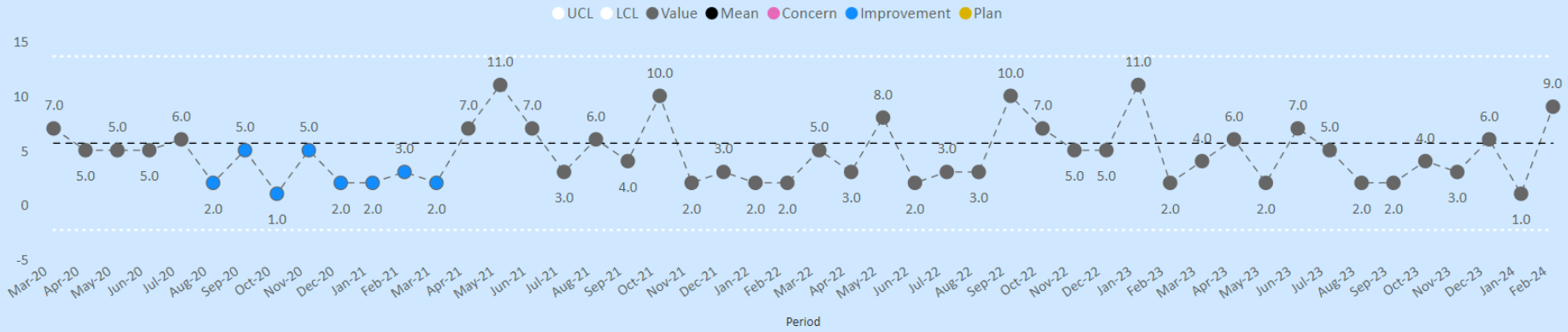
Question	Answers
A: What has happened?	The overall Fundamental Training compliance decreased slightly from 92.5% in January to 92.3% in February 2024. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. With the exception of Executive Director-Resources, every area is still below the 95% Trust target. Temporary Staffing Compliance has decreased from 84% in January to 83.4% which remains above the Trust Target of 75% • Chief Executive Locality – 75.4%, • Exec Director - Medical Locality –94.4%, • Exec Director - Nursing Locality – 92.3%, • Exec Director – Operations o Acute and Urgent Care –92.2%, o ICCR – 92.4%, o Secure Services and Offender Health – 92.4% o Specialties – 92.9% • Exec Director - Resources Locality – 96.8%, • Exec Director - Strategy People and Partnerships Locality – 90%
B: Why has it happened?	Since the trust hired 201 staff in September and 153 in October—much more than the average of 110—face-to-face and webinar courses have reduced in compliance and put more pressure on the spaces for training that are availble within the trust. Temporary Staffing turnover is at 71.2% within a 12 month period it means that compliance will struggle to keep up as staff become compliant they then leave the trust.
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?	• Updated trajectories have been made to accommodate for increased recruitment levels. • For Fundamental Subjects with less than 90% compliance, a recovery plan with monthly trajectories is in place. • External ELS, ILS, and DMI (AVERTS) training is purchased in order to meet compliance requirements. • To accommodate the surge of new hires, CRAM has added more training in place. • Regular business operations, with L&D persistently chasing staff to fill spaces in order to maintain compliance at the necessary percentages. The L&D staff is always working on this
	• Rapid Tranquillisation training is now available via webinar once a month in addition to in person multiple times a month • Extra notifications about upcoming training are being sent out by the Fundamental Training staff.
E: What do we expect to happen?	• By the end of March 2024 we expect all courses except for ILS and ELS to reach 90% • We 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 Reporting System

Birmingham and Solihull Mental Health NHS Foundation Trust

Absconsions from inpatient units

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	2	4	3	6	1	9
B: Acute and Urgent Care	1	2	2	6	1	7
C: ICCR	1	1	1	0	0	1
D: Secure Serv & Offender Health	0	0	0	0	0	0
E: Specialties	0	1	0	0	0	1

Commentary

(Blank)

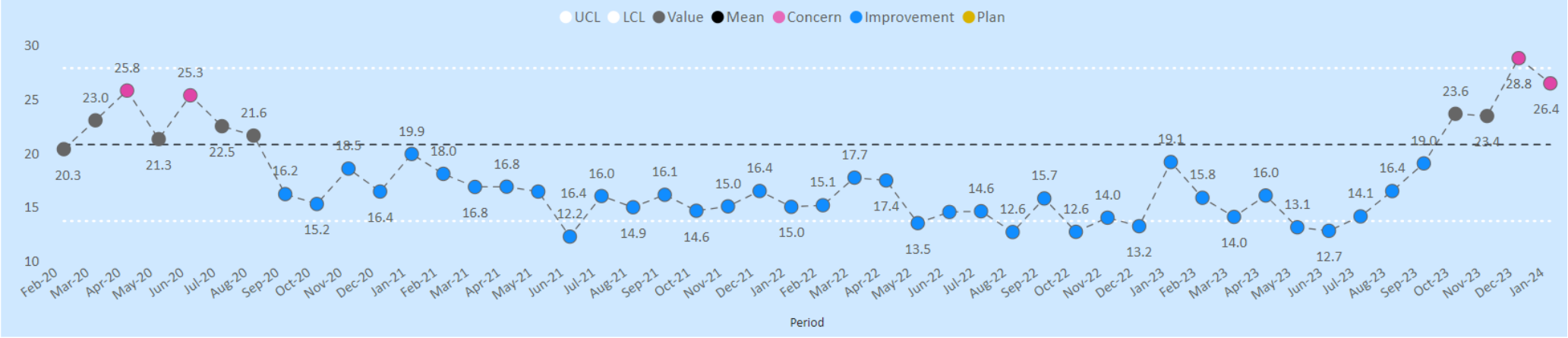
compassionate inclusive committed

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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
A: All	16.4%	19.0%	23.6%	23.4%	28.8%	26.4%
B: Acute and Urgent Care	15.2%	18.7%	24.6%	25.9%	29.1%	28.7%
C: ICCR	28.7%	28.6%	29.4%	21.0%	25.7%	34.4%
D: Secure Serv & Offender Health	14.8%	13.2%	18.9%	21.2%	35.0%	24.0%
E: Specialties	16.6%	27.8%	30.6%	25.1%	25.6%	31.3%

Commentary

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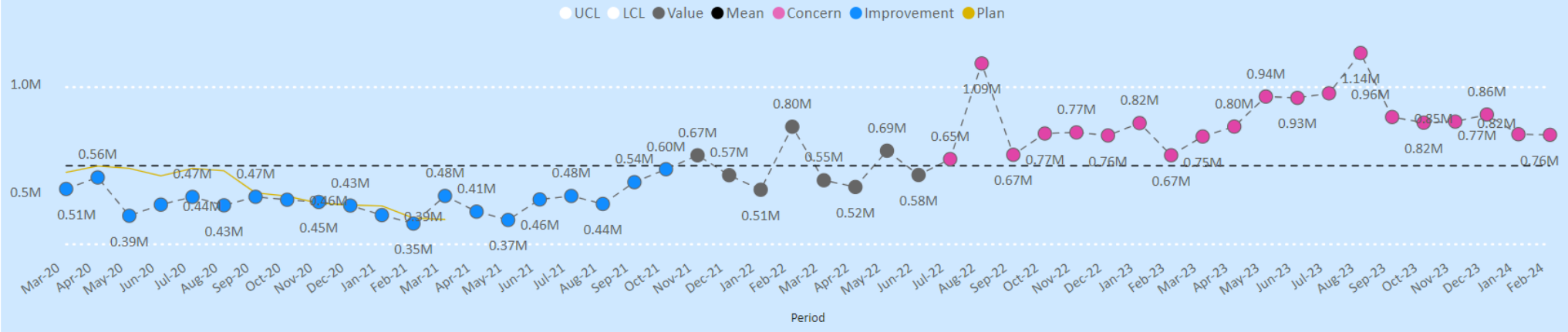
compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

Monthly Agency

Divisions

Statistical Process Control (SPC)



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

Division	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
A: All	£846k	£819k	£824k	£857k	£765k	£763k

Commentary

YTD agency expenditure remains above NHSE ceiling of 3.7% of pay bill at 3.9%

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 21st March 2024

Performance metric trajectory updates

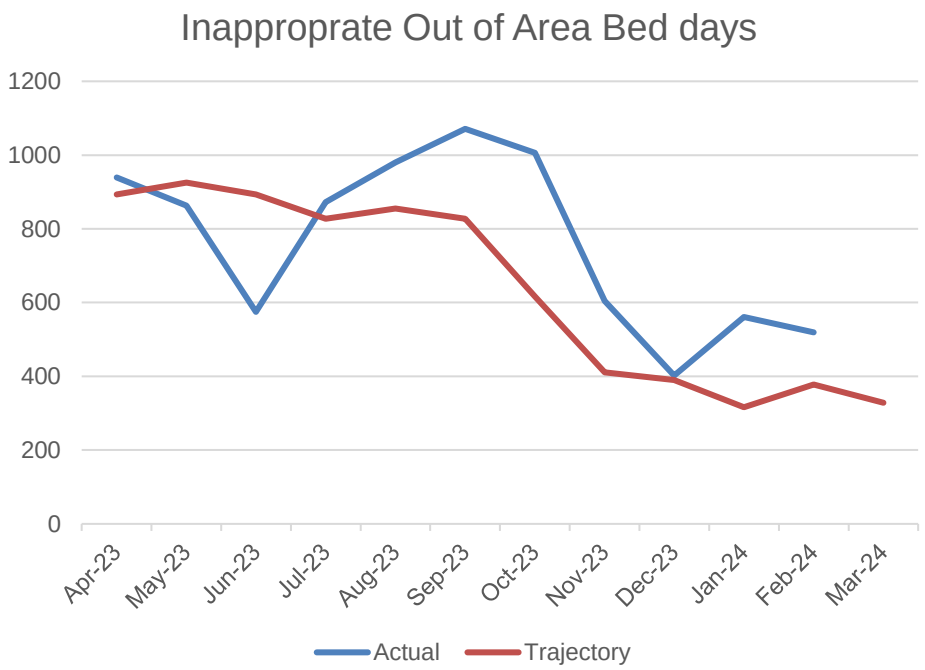
Trust Performance Metrics

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 have been discussed in the deep dives with services and a summary of these discussions is provided to FPPC. 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

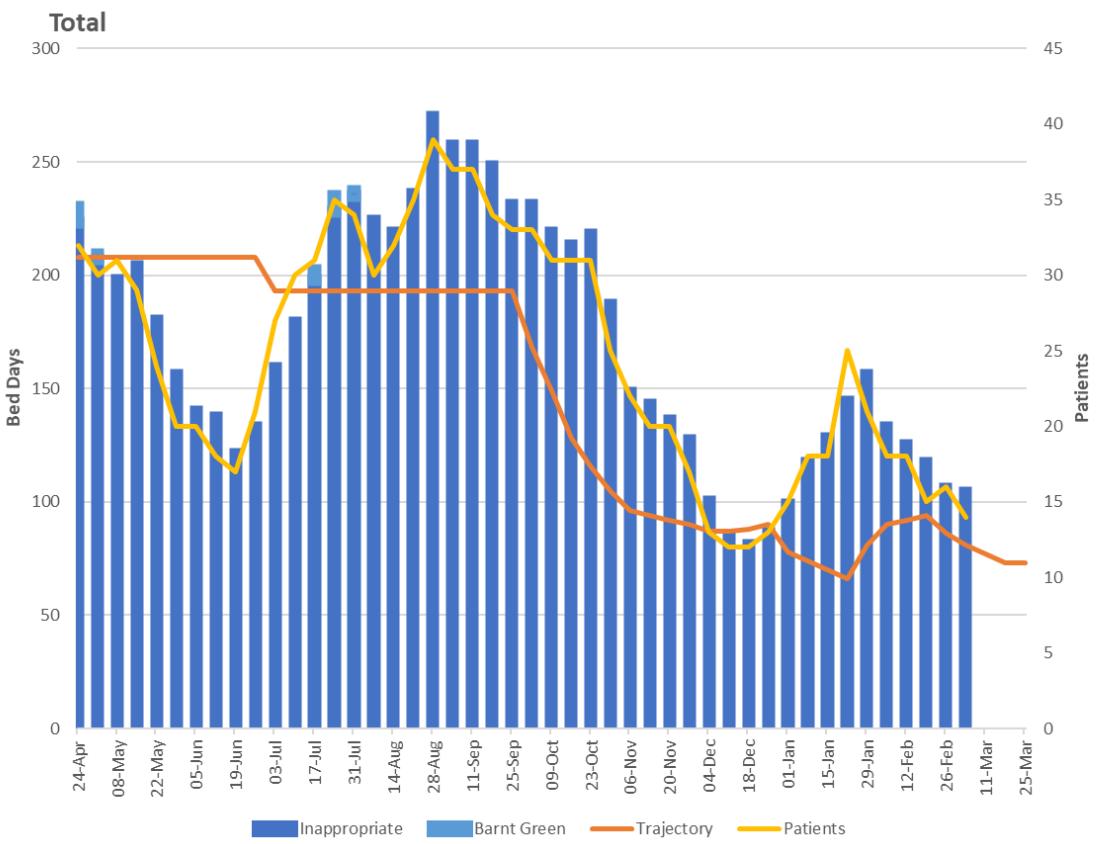


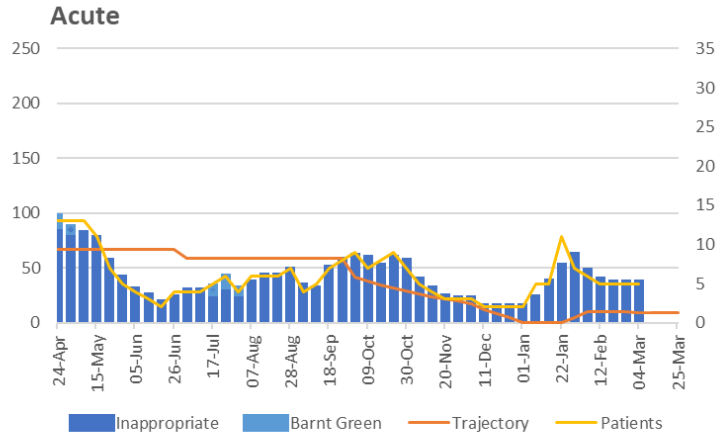
Inappropriate Out of Area trajectories have been agreed as part of the national planning round for 2023/24. The aim is to reach 328 bed days in March 2024. February 2024 decreased to 519 days above the trajectory of 378 days.
The productivity action plan is focussing on 3 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. An update on progress is outlined below.

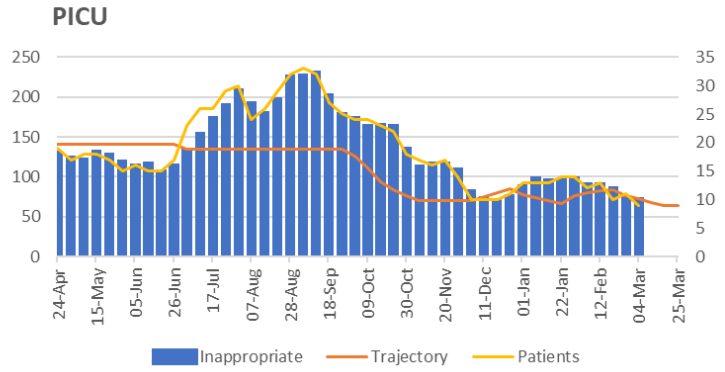
Current Progress:

Post Christmas and New Year, the service saw an increase in demand for acute and PICU beds leading to use of inappropriate placements during January. February has started to show an improved position with no new acute inappropriate placements and a reduced number of PICU placements. Slide 4 below highlights the weekly progress being achieved, monitored via the out of area steering group. A key pressure point remains the impact of delayed transfers of care that are not within Trust control, particularly social care impacting on reducing available Trust capacity to support repatriation. A dedicated workstream has been established to focus on addressing system and partnership wide barriers related to reducing delayed transfers of care. Slides 5 & 6 outline progress in each of the above workstreams.

2. Inappropriate Out of Area Bed Usage - BSMHFT





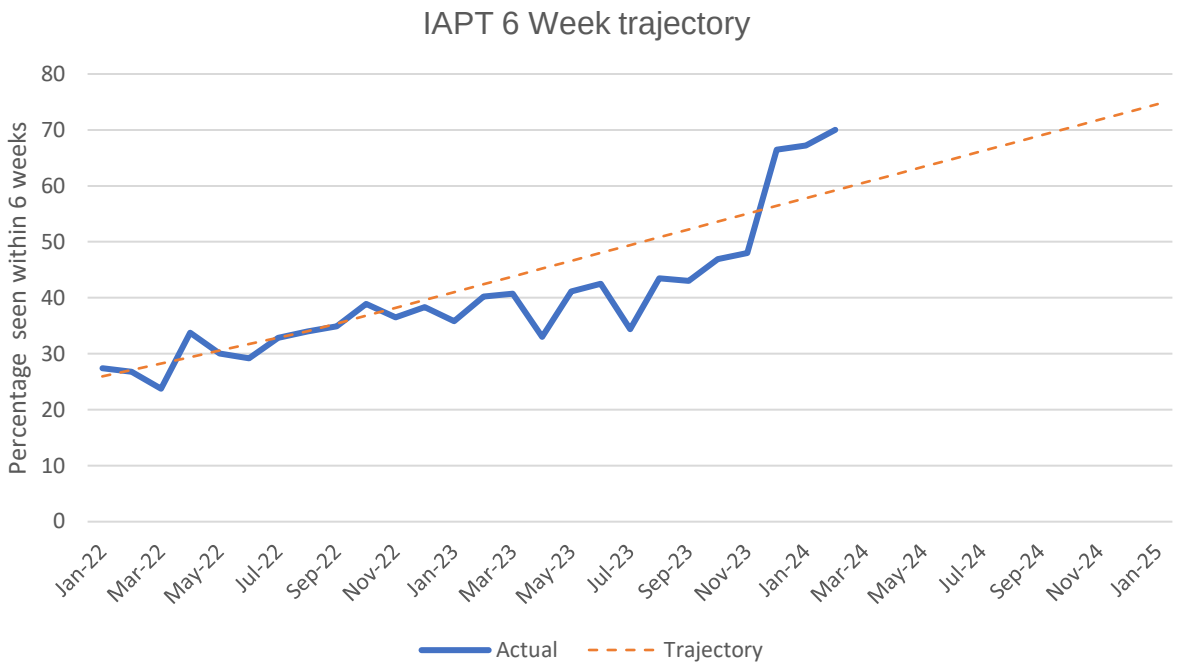


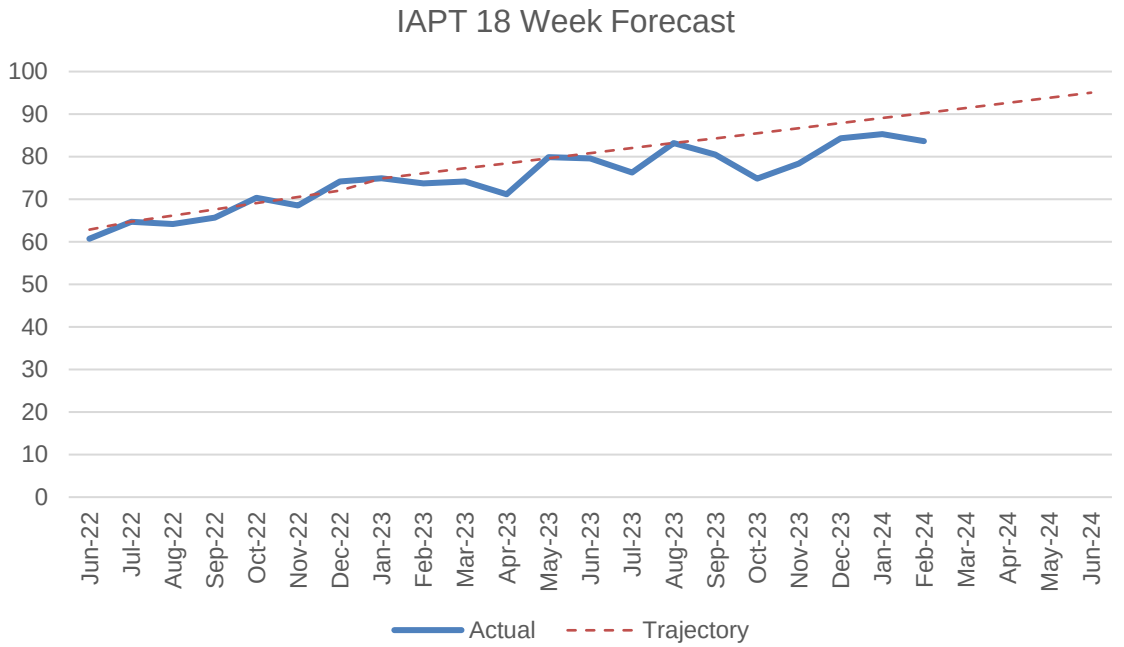
- Acute bed usage has 5 patients in inappropriate placements.
- PICU bed usage reduced this week and remains below a trajectory position for the third consecutive week.

Action Plan - update

- **Admissions Decision MDT /escalation process –** now embedded
- **Joined up 18+ bed management process** – options appraisal exercise in process – due end of November
- **Contract procurement exercise** – in progress, with view to extending Priory capacity and procuring additional capacity
- **Demand Management/Gatekeeping -** Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered.
- **Confirm and challenge for referral process** – assurance over referrals going to all providers in the quickest possible timeframe – now embedded.
- **Reducing LOS/DTOCs** - weekly internal bed management, ICB deep dive weekly, EDD Confirm and challenge process (more proactive approach for patients with longer LoS) – senior ICS support required
- **Optimising Capacity** - daily bed states shared to ensure contracted beds are used first, then KN before only PICU OOA are considered – now business as usual
- **Locality Model** – ensuring that teams work within locality across the patient pathway – 50% embedded and roll-out continuing. FTB aligning with model where possible.
- **Clinical Oversight Team -** senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients – informal processes in place. Formal SOP to be signed off this week

Talking Therapies waiting times 6 &18 weeks





The aim is to reach the 75% target by January 2025. February 2024 performance at 70.04%, improving trend and remains above 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 being in place. February 2024 performance at 83.64% just below trajectory.

Talking Therapies – update on action plan

The trajectory for 6 weeks is not due to be met until January 2025. Good progress being made with current performance being above trajectory. 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 improvements 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.

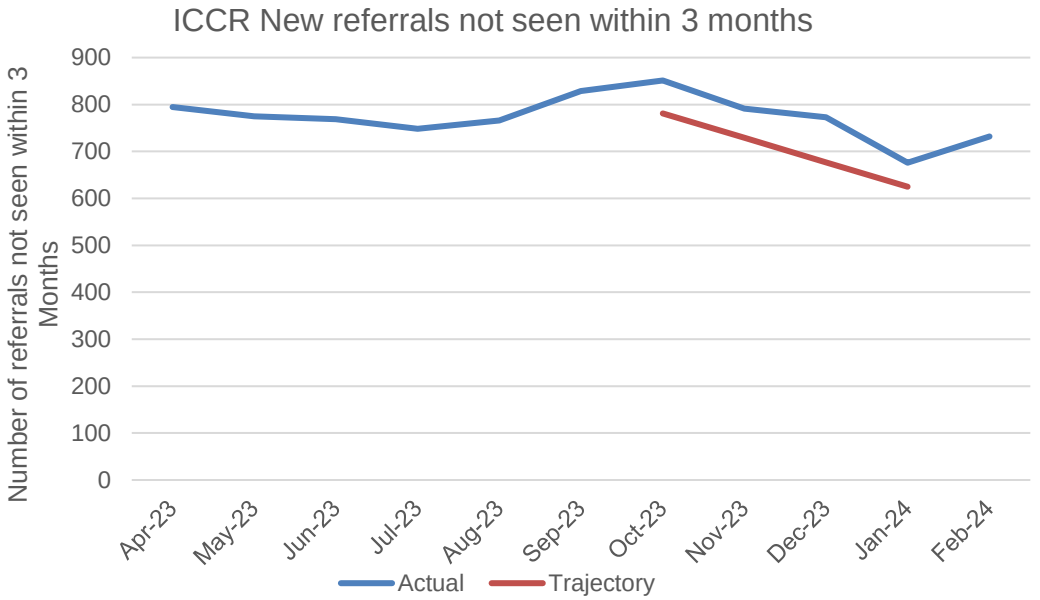
The service level recovery plan is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times and achieve improved outcomes.

Workforce Update: An update on progress is provided below:

- 5 x High intensity trainees – Commenced Jan' 24 Keele University
- 1 x High intensity trainee – Commenced March 24 Reading University
- 5 x Low intensity trainees – Commenced March 24 Birmingham University
- Substantive posts – 1 PWP newly qualified (was the first apprentice in the service)
- Advert out for PWP's closes 26th March 24
- Band 7 Psychological interviews conducted 5th & 6th March 24 x 2 job offered x 2 Hi trainees nearing completion of the course. 3 x qualified external to the trust offered jobs however 2 x wanting remote only posts and 1 not accepting Trust relocation guidance. 1x in Trust and is considering waiting to apply to her present service for a permanent contract.
- Training plan for Y24/25 **(tbc)** – 12 x High intensity trainees; 4 x apprentice PWP's
- Upskilling of staff in supervision training - 7 for High intensity supervision and 3 for Low intensity supervision. Further psychological modalities training e.g. 1x Interpersonal Psychotherapy(IPT); 1 x counselling for Depression (CfD); 1x Dynamic Interpersonal Therapy (DIT); 2 x Eye Move Desensitisation and Reprocessing (EMDR); 1x Trauma Focussed CBT

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. Progress has been slower than anticipated with February position at 732 referrals and above trajectory of 625.



Action Plan:

Short Term: ICCR continue to review all CMHT activity via twice monthly waiting list & KPI oversight meetings. Clinical service managers review the detail and take away actions for their teams. Progress achieved with waits over 52 weeks reduced by 70% since November 2023 from 94 to 25 in January 2024. Other areas of work include a focus on reducing 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 Teams (NMHT) are now seen as the 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 screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. The service plan over the next 12 months as the NMHTs grow is that this will have a significant impact on reducing waits and capacity within CMHTs.

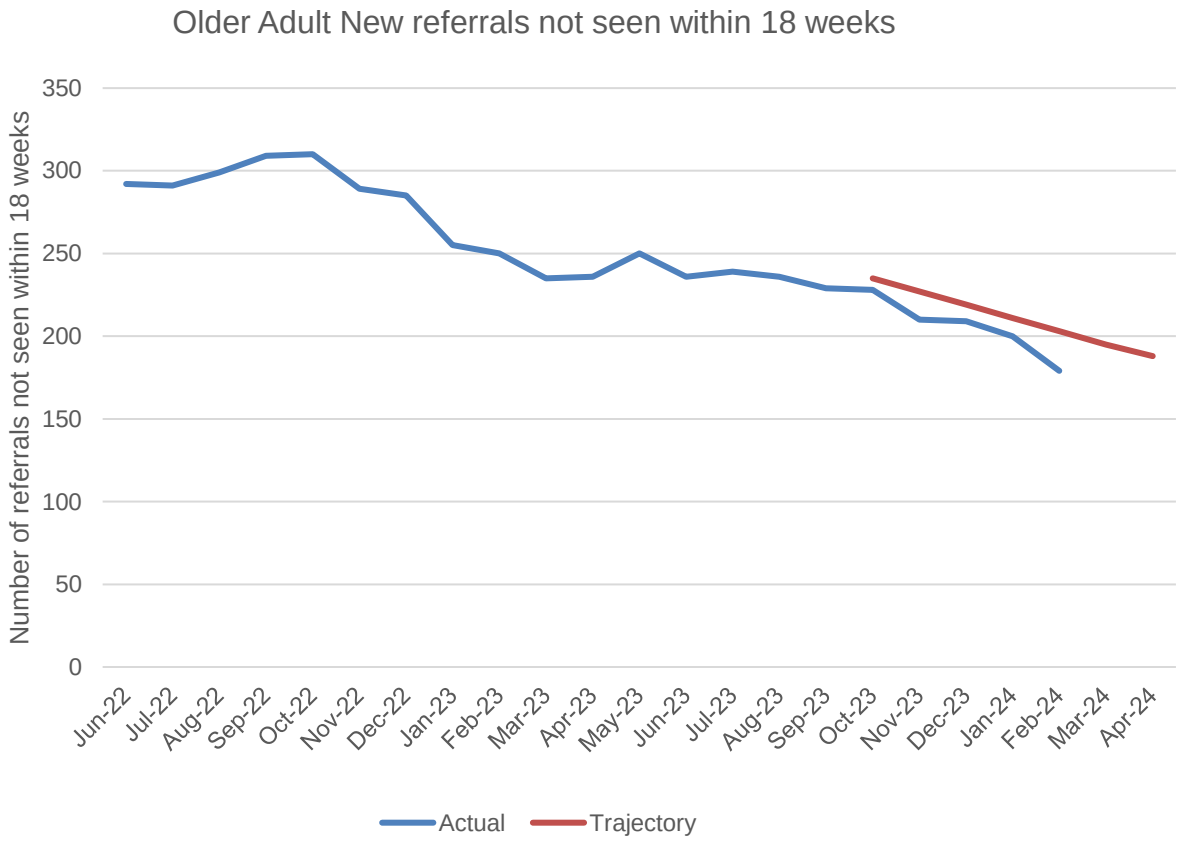
Medium Term:

- The 5 NMHTs are at varying levels of staffing and are working through recruitment plans, the aim is to be fully recruited by May 2024.
- Engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHTs to take on low level CMHT cases (the service leads have noted that 70% of referrals to the NMHTs are for presentations of depression & anxiety who should be signposted to talking therapies as the appropriate service to meet service user needs) and reducing DNA rates for first appointments to 20% by May 2024.

Longer term:

- To achieve capacity within CMHTs and to achieve a 4 week wait by end of 2024. Current plans are that by end of 2024, complete coverage of all PCNs will have been achieved and this will therefore have greater impact on ability to manage referrals effectively.

New Referrals not seen within 3 months- Older Adults



Older Adult CMHTs are focusing on achieving a 20% reduction in those waiting for more than 18 weeks by the end of April 2024.
Progress continues to be made with February 2024 position at 179 and below the trajectory of 203.

The service continue to monitor waiting times and have focused initially on those waits over 26 weeks and 52 weeks which have both seen reductions.

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:

Demand challenges: Referrals and Caseloads remain high, resulting in patients waiting longer. They are being proactively managed by the team managers to ensure that service users are being prioritised based on need and risk.

Capacity challenges: Staffing levels in Solihull Older Adult CMHT beginning to ease and now have a 0.6 WTE Band 6 Vacancy therefore there is now 3.7 WTE Band 6 and a 1.0 WTE Band 7 ANP in post and once the 0.6 WTE post is recruited to, they will be fully staffed.

Recruitment plans: New Roles: multi-disciplinary based, ANP Role to be utilised in all hubs, ACP Role 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 towards manageable caseloads.

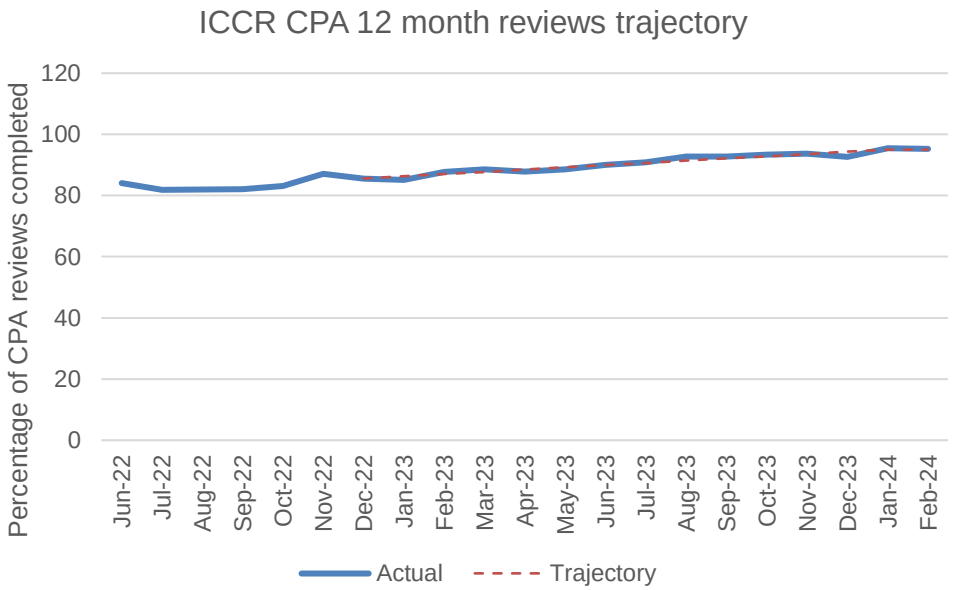
Note - Older Adult CMHT position confirmed by the Associate Director for Specialities.

CPA 12-month reviews - ICCR

ICCR performance – progress achieved and maintained with February position at 96.1%, with adult CMHTs at 95.2% reaching the target and trajectory of 95%.

There are a total of 54 reviews outstanding in February for adult CMHTs, which continues to be the lowest number outstanding in the last 3 years. Performance varies between the CMHTs between 0-9. Twice monthly meetings with clinical managers have been retained by the division supported by the Information team to review the data for all CMHTs and identify actions to manage. These meetings cover a range of other issues including ICR completeness and waiting times.

The number of CPA reviews due in the next couple of months have been shared with the service to allow them to continue planning future CPA reviews.

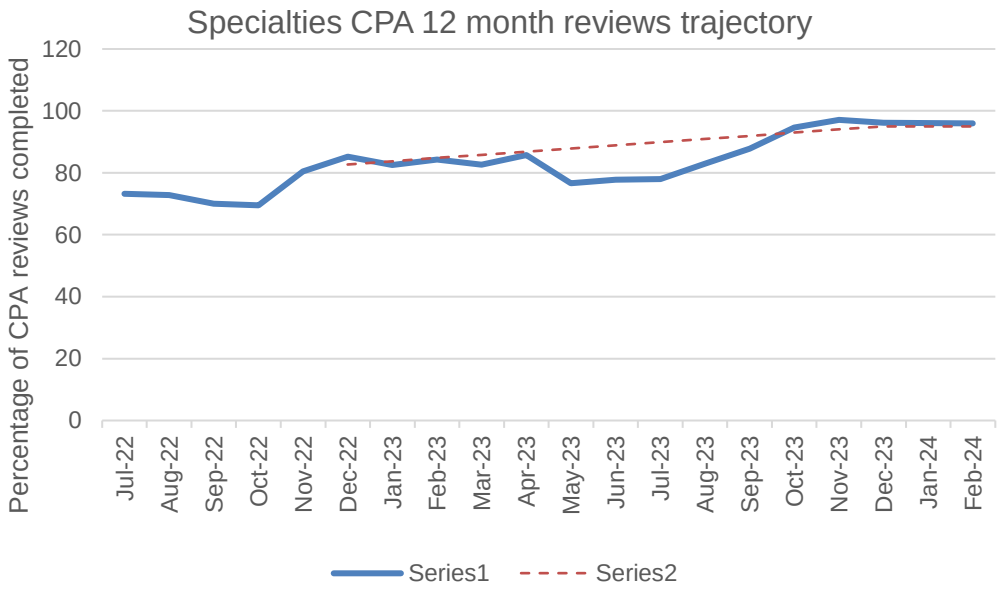


Note - Trajectory position provided by Associate Directors for ICCR

CPA 12 month reviews - Specialties

Specialties performance – progress achieved and maintained in February 2024 with performance at 96.7%, and older adult CMHTs at 95.9% continuing to meet the 95% local standard.

Older adult CMHTs –The revised improvement trajectory to achieve 95% by January 2024 was achieved ahead of time in December 2023 and has been maintained since then. There are only 4 outstanding reviews. 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 to maintain performance.



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 as this still requires a form to be completed, this is not intuitive for staff and we are exploring whether these can be included without any additional data entry.
- Late data entry to RIO service user records 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 February 2024 was at 92.7% - below the target of 95%, this relates to 9 outstanding follow ups from 124 discharges. Of these 9 exceptions, one service user discharged to the care of another trust requiring staff to check whether they have been seen, one service user seen within 7 days but data entry has not yet been completed and attempts have been made to see other service users without success in 7 days.

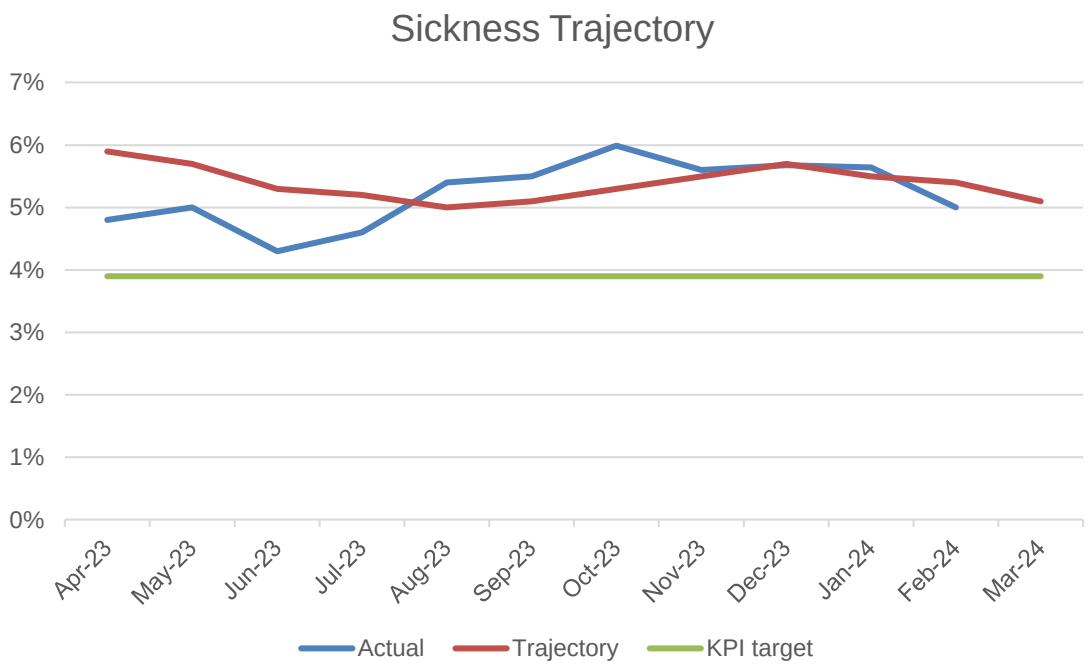
Note – Commentary above provided by the AD for Performance & Information

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories

The workforce trajectories commenced in April 2023

Sickness Absence



Reducing trend in sickness levels observed and February 2024 reduced to 5.0% below the improvement trajectory of 5.4%. Long-term sickness has reduced for the last 6 months with February at 2.92% and short-term sickness has reduced to 2.07%.

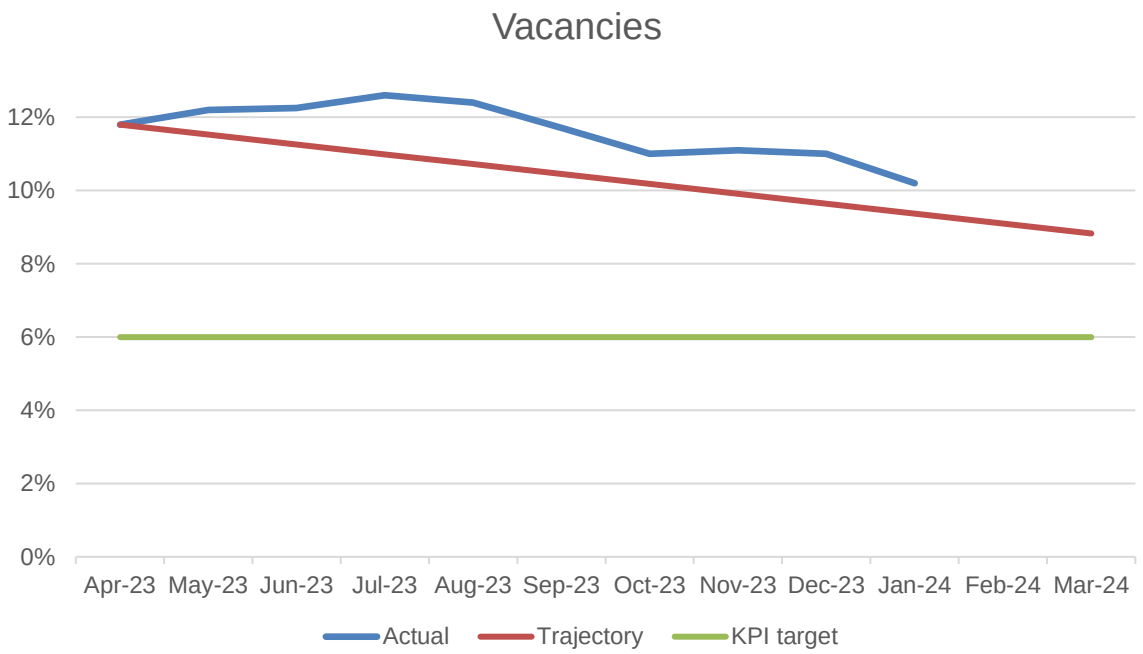
Return to work contact has increased from 66.5% to 67%. Having these increased contacts is positive in supporting the health and wellbeing of staff.

Action Plan:

- HR clinics continue to run across divisions, supporting managers to manage sickness absence.
- Working with PAM (Occupational Health Provider) to provide bespoke support, dealing with stress and anxiety which are main reasons for sickness absence.
- People team have launched new training for sickness absence management for line managers. The People team continue to promote other health and wellbeing offers to support staff. Deep dives are planned and will commence into reasons for sickness for staff groups (nursing as a starting point).

Note - Trajectory and commentary provided by People team

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%. **Vacancy data for February 2024 has not yet been received.**

Recruitment initiatives: BSMHFT's People Partner for Resourcing and Temporary Staffing met and presented to Nursing Students at the University of Birmingham and hosted a stand at both the Birmingham City University and University of Wolverhampton Nursing Careers Recruitment Events. Approximately 40 students in their final year were spoken to in detail at both recruitment events and their names and contact details were collected, with a view to being able to facilitate making offers to them upon completion of their studies and them acquiring their PIN's.

Note - Trajectory and commentary provided by People team

Vacancies

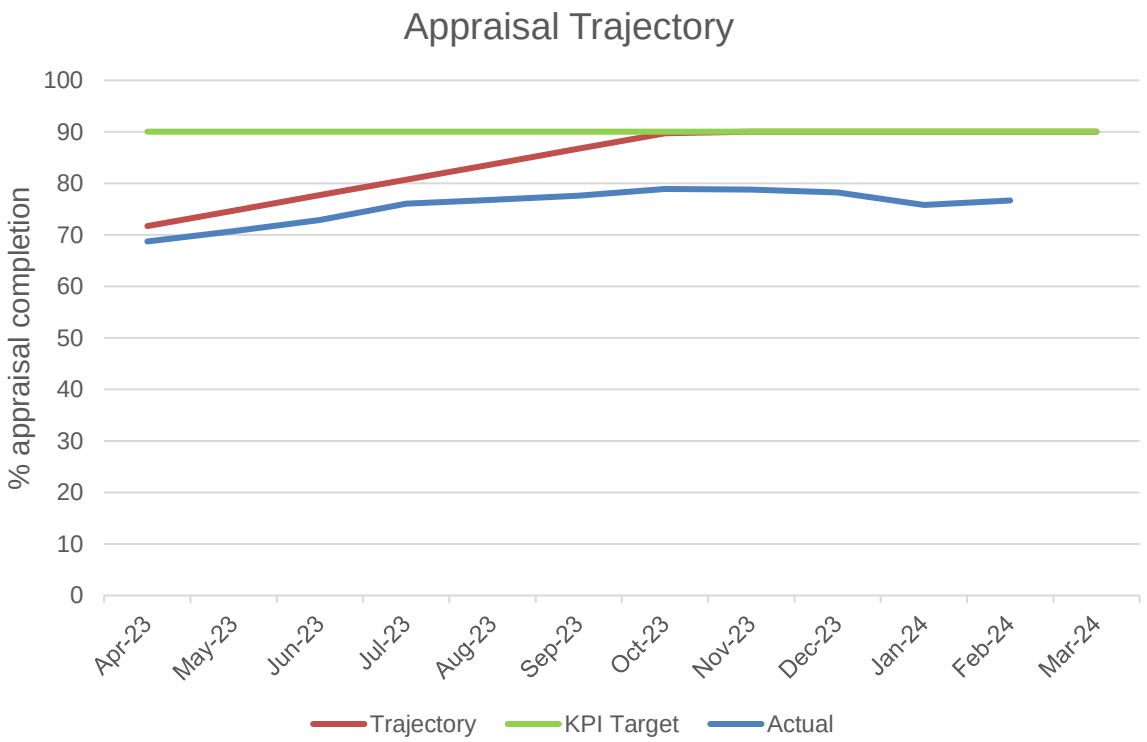
- BSMHFT will be hosting a stand at the RCNI Recruitment event on the 11th March with up to 500 Nurses in attendance, with a proportion of those being Mental Health Nurses. Interviews will be held of the day with a view to makings offers to those successful.

- The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel (now in its 6th full month) 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.

- 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.

- A sixth 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.

Appraisals

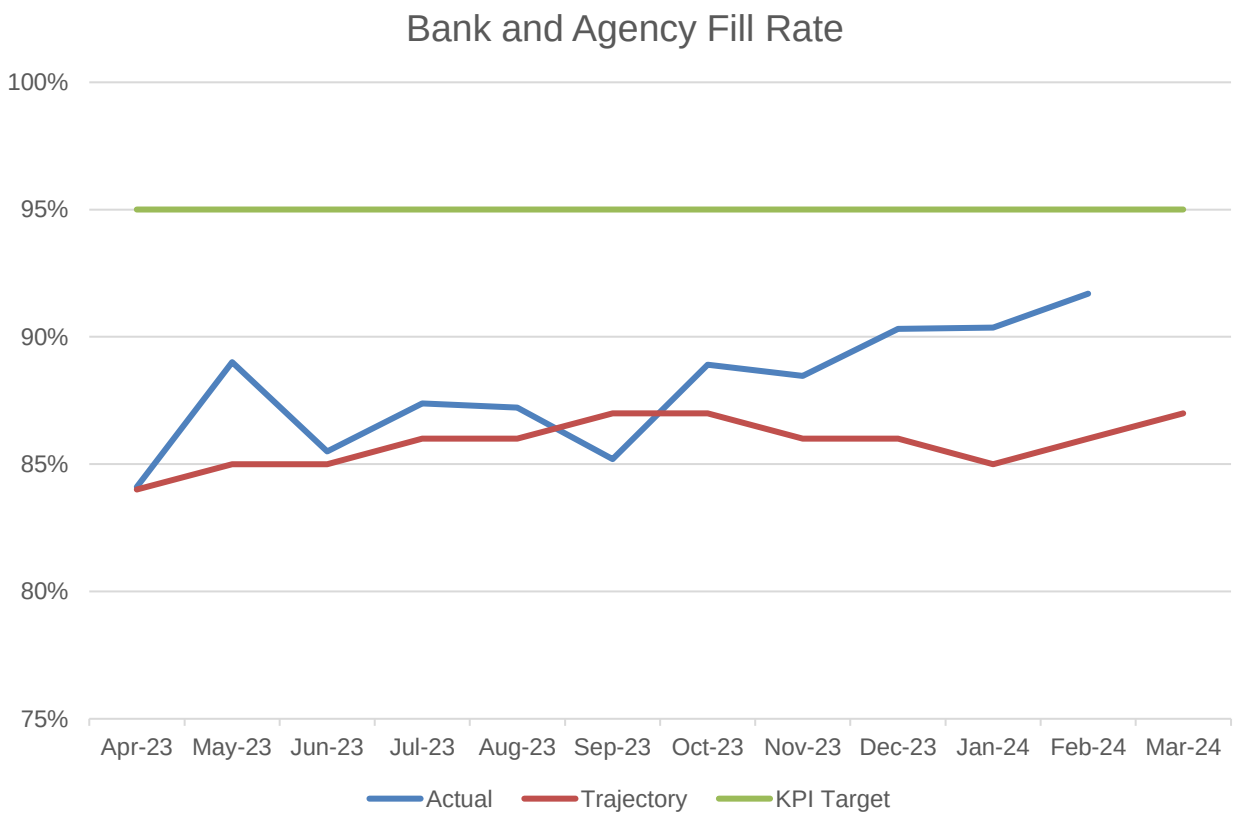


February 2024 appraisal performance at 76.7% and remains below the Trust standard of 90%.

- L&D are undertaking targeted face-to-face sessions across the Trust where teams have been identified as hot spots and recent work has focused on Acute and Urgent care at Oleaster and within talking Therapies
- L&D are working with the comms team to draw up a plan to communicate that staff will need to renew their appraisal as the new system has now been in place for a year. This will direct staff to resources available to support this.
- The QI project work continues, and we are currently in the process of arranging workshops with the working group to support the development of a driver diagram.

Note - Trajectory and commentary provided by People team

Bank and Agency fill rate



Bank and agency fill rate improved to 91.7% and above the trajectory of 86% for February 2024.

A detailed agency reduction programme is in progress working in conjunction with ICB policies and restrictions.

Bank overall Fundamental Training continues to be an area of focus and to be above 82% 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.

Note - Trajectory and commentary provided by People team

Bank and Agency fill rate

In February an additional 40 bank workers started with the trust, helping to alleviate the need for agency.

The TSS Management is going into partnership with NHS Professionals – who have considerably less charge rates than agency – with a view to transferring over high cost and long-term block bookings, which can also be recorded as bank spend, rather than agency.

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. The focus is training bank workers that will be with us long-term and able to work a consistently higher percentage of hours per week.

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.

Note - Trajectory and commentary provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- There has been a decrease in agency spend from c. £765K in January to c. £763K in February. In February an additional 40 bank workers started with the trust, alleviating the need for agency staff.

- A detailed agency reduction programme is in progress working in conjunction with ICB policies and restrictions and the Midlands and Lancashire CSU. Two areas of renewed focus are the expediating of the TSS bank workers 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.

- The TSS Management is going into partnership with NHS Professionals – who have considerably less charge rates than agency – with a view to transferring over high cost and long-term block bookings, which can be recorded as bank spend, rather than agency.

- Direct Engagement for Medical Agency workers is in the kick – off implementation stage, with the aim of meeting potential ICB and NHSE requirements. Direct Engagement will have a significant effect on fill rates and also have significant, tangible cost saving implications.

Appendix II Performance Management Framework

FPPC is asked to note that from March 2024, a revised framework is being implemented with service areas as part of the deep dive meetings. A service line review process has commenced to ensure that all services within the operational portfolios are covered. The process remains developmental and learning from the first round of meetings will be utilized to shape future meetings. As part of this framework, a service line RAG rating assessment is planned to be completed.

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 Board FPPC a summary of the deep dives is now being provided on a monthly basis.

Since the January 2024 FPPC meeting, the following service area deep dives have taken place:

- Secure and Offender Health deep dive on 16th February 2024
- Specialties deep dive on 7th March 2024
- Acute and Urgent care deep dive on 8th March 2024
- Integrated Community Care deep dive on 12th March 2024

2. Secure and Offender health Deep dive – 16th February 2024

The Associate Director (AD) for Secure and Offender Health Care services provided a summary update including Finance, Culture, Staffing and a focus on the accommodation challenges being faced by the FIRST team.

Finance

- A deep dive has been undertaken with the service and feedback on the key areas noted including, overspend position at Reaside although largely due to the pay award, training for managers and deputies in use of rostering required and agency usage in the prison and at Ardenleigh due to vacancies, substantive recruitment plans being taken forward.

Organisation Culture

- Service Leadership Team meeting with Executive Team to review the challenges and support requirements for the service was due to take place.
- The Organisational Development team have commenced working with service leads and developmental work being undertaken at Reaside and other wards.
- Staff survey results – show improvement in 45 areas notably in areas covering civility, relationships and discrimination. 16 areas showed a decline, and the rest were either maintained or slightly improved. Improvement work required at Reaside and offender Health.

Staffing Levels

- Staffing levels – a safer staffing review has been completed and is planned to be reviewed in conjunction with reviews completed for all service areas.

- The AD highlighted that there will be further changes in the management team at Reaside over the next few months and a service manager will be leaving Ardenleigh following successful appointment to the provider collaborative. This will increase staffing challenges whilst recruitment is undertaken.

FIRST team accommodation

The AD outlined that the FIRST team initially had 30 staff but this has now grown to over 70 and the accommodation is no longer appropriate due to insufficient facilities at their current location to accommodate the increase in staff. Options have been explored but to date a viable option has not been identified. Discussions are continuing to identify alternatives.

3. Specialties Deep Dive – 7th March 2024

The focus for the deep dive this month was on Memory Assessment Services and Clinical Health psychology and the presentations shared by the service managers can be found in IIa and IIb.

Memory Assessment Services (MAS)

Accountability Framework Domain RAG Rating Assessment: **AMBER.**

The Service Manager and Team Manager for the memory assessment services focused their presentation on the increase in demand and related recovery plan for MAS waiting times.

They outlined that they had a waiting list of approximately 1157 people, with an average waiting time of 203 days.

The service has engaged with NHS England and attended a dedicated webinar to look at good practise on sustainable waiting list sizes.

To take the work forward the team have been engaging with the Digital Transformation Team to help redesign the pathway and develop a range of forms on Rio which would help support the future state and enable an increased number of assessment slots. The whole team have been involved in the work and the revised pathway is due to be finalised and will be presented to the team for any final feedback prior to implementation. New reporting will be required to monitor progress against the revised pathway.

To minimise risk for those waiting for their first appointment, a review of the waiting list is being carried out and where appropriate service users are being referred to other teams/services.

Scans are being ordered on referral so that the information is available at the assessment appointment to reduce delays and need for additional appointments.

The service has created a ‘waiting well’ course which will be run via the Recovery College with 3 pilot courses due to take place. This will include education/sign posting/ peer support and providing questionnaire templates for them to start to complete prior to the main assessment.

Other service areas discussed include actions to review any longstanding local serious incident investigations and close these by the end of the month where appropriate and to raise with the mental health collaborative lead the need for a needs assessment and commissioning plan/strategy for MAS.

Clinical health Psychology (CHP) and Clinical Neuropsychology (CNP)

Accountability Framework Domain RAG Rating Assessment: **RED**

The service manager for these areas provided an overview of the services which are mainly provided to University Hospital Birmingham (UHB) and have grown over the years, resulting in 22 different SLAs with varying levels of resource. A service review took place in 2021 and this resulted in an agreement to use a new clinical/ workforce model for CHP from April 2022 onwards.

There are currently 10 SLAs in place with another 2 planned, whilst others have been terminated or paused as they do not have the workforce required to meet the clinical model.

The service has found a lack of senior leader engagement within UHB, which has also been complicated by an organisational restructure. Service specification reviews are taking place but pace on progress is impacted by the business case processes within UHB.

The current situation has impacted on performance and activity levels. To support reporting on clinical activity, reporting is being developed with the UHB informatics team.

Due to the current uncertainty about the SLAs, it has been difficult to retain staff.

The service manager highlighted that the service should be making a profit but due to the ongoing contractual issues is breaking even. The service manager meets with our trusts contracting team on a monthly basis and previous efforts to raise and escalate issues to UHB have been undertaken with no change to date.

Action agreed: The service lead to provide the Director of Finance with the main issues to escalate and raise with UHB.

4. Acute and urgent Care Deep Dive – 8th March 2024

The Associate Director (AD) and Clinical Director (CD) for Acute and Urgent Care, along with service colleagues provided and overview of the significant key service developments, challenges and risks being managed within urgent care services simultaneously and at pace representing an anxious time for staff as outlined below:

- Launch of Mental Health NHS 111 – nationally mandated and due to go live on 2nd April 2024. There are high levels of anxiety amongst staff to establish and embed this major change in the timelines available. Staff engagement in planning and implementation has been key and in order to retain staff where possible. A wider Trust implication is the need to ensure that service users are directed to appropriate service lines already in place at the Trust and that the NHS 111 service is appropriately used.

Action: Service Lead is meeting with Communication Team to ensure clear messages and directions are in place for Trust clinical teams about the use of NHS 111.

- Midland Metropolitan Hospital development – readiness for handover of the building is imminent, work ongoing and plan on track. Contracting arrangements to be agreed.
- Right Care Right Person phased work plan – Impact of changes in police working, next phase will be particularly challenging and high impact on both services and staff, system risk in that no transitional funding identified to support these changes.
  A further risk includes section 135/136 patient transportation operating in a system where the ambulance service are facing challenges to meet these needs and risk of having to use Prometheus with no funding to support this.

- Learning, Disability and Autism work plan impact – demand and capacity to manage including need for staff to complete the McGovern training (to be raised with the LDA Collaborative Leads).
- Staffing and vacancies – turnover and impact as a result at a time of high change.
- From a people plan perspective an away day was held and an organisational development focus is planned to support staff in urgent care.
- Locality work – has shown some good results, with improved relationships but has also shown some unintended consequences which are being reviewed.
- The 2024/25 inappropriate out of area placements trajectory is in the process of being agreed.

Quality Domain

Gaps in the management structure at matron level were highlighted resulting in pressure in terms of available management capacity to support all ward areas.

A range of areas and work plans are being taken forward and these are summarised below:

- Actions arising from the infection and prevention control audit in January 2024 being taken forward.
- Improvement plan for ELS and ILS training planned, including resus training covering children.
- Structure staffing gaps – being reviewed and plans to address include focus on safer staffing, responsiveness and working across the different teams.
- Review and close down of open serious incident where appropriate – these actions dating back to the last few years.

Action: Service Leads to complete the service level RAG by the end of March 2024 as part of the deep dive framework.

5. Integrated Community Care deep dive - 12th March 2024

The focus of the deep dive was on the Solar Service. The Associate Director (AD) for Integrated Community Care, along with service colleagues provided and an update on performance and Quality within the SOLAR service. The discussion focused on the following areas:

Performance

Eating Disorders service – noted good progress achieved and joint work with FTB to incorporate learning and good practise.

Mental health Schools Teams (MHSTs) – national requirement to improve mental health access support in schools. Significant progress achieved in Solihull, with 62 schools included representing 73% coverage of schools in Solihull. A further national wave is due to commence in January 2025, if taken forward would increase take up to 74 schools and 88% coverage.

Outcome measures – There is a challenge to get outcome measures completed and uploaded into Rio, where these are completed by the young person or a carer. The possibility of a digital solution to aid this process is being looked at. This is becoming increasingly important as the service want to ensure they are providing meaningful interventions.

Waiting times – the Service manager explained that a circuit breaker was undertaken to reduce waiting times for first appointment which reduced to 8 weeks (previously 9 months). However, the known impact has been an increase in waiting times for the second appointment and increased waits for therapy appointments. A QI project is being taken forward focusing on reducing these waits. To enable the therapy interventions appointments, 3 band 7 psychological intensive interventions staff have been recruited. Further vacancies planned to be recruited to.

Quality

The Associate Director of Governance highlighted that there are a number of open SI actions across ICCR prior to 2023 that need to be reviewed and closed where appropriate, progress to be reviewed at the next deep dive meeting.

Further work being taken to improve RMS and Clinical Supervision levels in the service.

Dementia Diagnosis Recovery Action Plan

MAS Birmingham and Solihull

The current position/As IS

- Currently MAS BSOL has a waiting list of 1157 service users. People who have been identified as requiring a memory assessment.
- This figure equates to an approximate wait of up to 203 days .
- This is the second highest in the midlands area and significantly above the midland average of 76.5 days

Sustainable Waiting lists

- Waiting lists are not inherently ‘bad’; a short waiting list can help to ensure efficient work flow.
- However long waits can be unsafe and unsatisfactory for SU and increasing waits are unsustainable
- Waiting lists have become unsustainable within MAS -

Calculating the Sustainable Wait List

from NHSE workshop

- Sustainable waiting list is 540-660- dependent on max wait time 12/16

R = number of referrals (demand) = **60** patients per week

E = start of booking window = **6**weeks

L = end of booking window (target maximum wait) = **12** weeks

Sustainable waiting list size = **(R x E) + ((L – E) x (R ÷ 2))**

= **(60 * 6) + ((12 – 6) * (60/ 2))**

= 360 + 180

= 540 (sustainable waiting list)

- Requirement to maintain current wait time is 60 assessments per week. To reduce waiting time, an increase in assessments would be required
- MAS currently offers approximately 40 assessments per week, however this doesn't take into account new AP's (12). Also taken into account-duty, leave, study, sickness, CPD etc

Dementia Diagnosis Rate (DDR)

- This indicator compares the number of people thought to have dementia with the number of people with a diagnosis of dementia, aged 65 and over. The target is for at least two thirds of people with dementia to be diagnosed.
- The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals. Significance is determined by the non-overlapping of confidence intervals with the 66.7% benchmark.

Current BSOL MAS state and projection

- Important to note that we cannot calculate what proportion the MAS service activity contributes to the DDR (because diagnoses are also made elsewhere in the system).
- BSol CCG DDR= 59.2% (Nov'22), 58.7% (Mar '23) and 60.7% (Nov'23).
- = Average +0.13% each month over the last 12 months but rate of improvement has picked up over last 9 months to 0.19% improvement each month.
- Last 2 months of data (Oct & Nov '23) the rate of improvement is 0.4% each month.
- If progress (in entire system) continues at current rate (0.4%), then we would reach target of 66.7 in 15 months

MAS Plans to address Waiting Times & Quality

1. Digital transformation & pathway redesign

   (At Stage4b/ 5: Defining the necessary Transformation stage)

2. Waiting well offering, via recovery college for those waiting for an assessment

   (Accepted to the recovery college prospectus for the Summer 24)

3. Review of service users on waiting list to offer assurance re risk and changes in presentation-

   (In progress)

Pathway/Digital Transformation Plan

1. IDENTIFY A PROJECT LEAD(S) WHO WILL RALLY AND MOBILIZE THE TEAM TO ACHIEVE THE NECESSARY CHANGES – TIM ADAMS AND NIKKI BELSHAM

COMPLETED

2. The future state pathway – The team will define the ideal pathway solution – this becomes the reference point which can be used to establish a diagnosis of the current situation

Completed

3. Share and communicate – each group will feedback to the rest of the team. If possible, supporting their presentation with other cases that have been implemented and have been successful in optimizing the care pathway

Completed

4. Defining the necessary Transformation –

4a. Identify the points of blockages that could prevent the changes being implemented.

4b. Prioritize the points for improvement; this is essential to ensuring commitment of the team and allocating resources.

4c. Identify simple and realistic solutions that consider local constraints.

4d. Spread the change solutions out over a period of 6 months to 1 year to prevent change overload

In Progress

5. Implementing and monitoring solutions

5a. Identify a key person who will drive change. This will include maintaining the commitment of the team.

5b. Evaluating the Impact of the project – Monitoring the impact of change is essential; identify key indicators for all change solutions being implemented. Evaluate the impact that the changes have had on the staff, measure engagement and wellbeing at work.

5c. Undertake a continuous improvement process – undertake regular impact analysis to identify new areas for improvement; this will enable change to take

Summary

- With the changes made to the pathway, expected increased in productivity from current 40 to 60 completed assessments per week (+50%) (no of assessments completed).
- This will reach the ‘sustainable wait list’ activity.
- A further increase in establishment or efficiency would allow us to further reduce the waiting time allowing for a better experience.

Review of waiting list

- A review of the waiting list is underway:
- Currently this has reviewed 160 service users
- Actions from review of waiting list:

1)service users are contacted

2)up to date information gained

3)review of any risks

4)referrals to (where appropriate)- Dementia advisors, ASC, Admiral Nurse, RDAC, CT/MRI Scan, CMHT

Waiting well

- Whilst the Service is committed to making necessary changes to improve flow through and service user experience by pathway redesign (reducing wait times), it is identified that a ‘Waiting well offering via the Recovery College would be of significant benefit to service users referred to MAS
- initial discussions have been completed, with recovery college.
- This course will include:

*Education

*Sign-posting to support service: dementia advisors, ASC, RDAC etc

*Providing templates for informants/carers to complete prior to assessment to assist Assessor

*Listening to concerns

*Peer support

*representation from OT, Psychology and Nurse’s

Clinical Health Psychology (CHP) and Clinical Neuropsychology (CNP)

Deep Dive

07/03/2024

Background

- CHP and CNP are services provided by BSMHFT into UHB hospitals
- Services are currently contracted at an individual service level
- The service has grown organically over a number of years, resulting in a 22 separate SLAs with varying levels of resource across UHB divisions
- There was significant variation in psychology provision across UHB sites and service areas
- A service review commenced in 2021 to ensure the service was sustainable and adequately resourced
- Following the review, there was agreement in April 2022 from UHB and BSMHFT to utilise a new clinical/workforce model for the provision of CHP within UHB, with a view to later applying this to CNP also

Current Situation

- Currently delivering on 10 SLAs across CHP and CNP – 2 more coming on board soon.
- A number of services have been terminated or paused as they do not adhere to the minimum workforce requirements of the clinical model
- Many services that are operational do not have capacity to meet the needs of the patient populations
- Recent loss of Clinical Lead with interim arrangements in place
- Despite agreement with UHB senior leaders in April 2022 to the proposed clinical model, there has been a lack of senior leader engagement with this from UHB

Current Situation

- Service specification reviews are being held at a local level, however signing off these reviews is challenging primarily due to the costs associated with the clinical model core team apportionment, but also compromised by slow/uncertain UHB processes re business case development
- Recent organisational restructure within UHB has impacted business case process and led to business being dealt with site by site, affecting UHB wide department discussions

Performance

- Progress towards strategy goals has been impacted by lack of UHB engagement with clinical model
- Cancer service has been impacted by the loss of clinical lead due to interim cover arrangements
- Service Specification reviews are including clear expectations relating to the clinical and non-clinical work that can be delivered within the funded establishment
- Work is currently underway with UHB informatics team to develop a report for the clinical activity within CHP, which will capture outpatient activity.
- Work still required to capture inpatient activity and to roll out this work to CNP

Workforce Issues

- Parallel UHB processes for psychology provision in some specialities results in repeated requests to support their workforce (e.g. with supervision) and…
- Some aspects of the CHP provision is charitably funded, with potential for this to grow through successful bidding processes
- No substantive operational management within CHP and CNP – current postholder is on a 12-month secondment
- Impact of death of clinical lead on the workforce, with current focus on ensuring the team is appropriately supported through the loss
- The team has endured a long period of uncertainty in their roles due to the continued lack of engagement from UHB in relation to clinical model and sustainable service

Workforce Narrative

ADR completion rate:

CHP – 1 outstanding but booked. 1 outstanding and not yet booked, related to the absence of our clinical lead.

CNP – 1 outstanding. Service manager has highlighted this.

Fundamental Training:

CHP – 4 staff with outstanding training requirements.

CNP -

Turnover Rate:

High due to low number of staff, however also difficult to retain staff due to prolonged uncertainty regarding future of the service

Vacancy Rate:

All vacancies are either filled or out to advert. Some reported vacancies refer to services we have paused as they do not comply with clinical model

Sickness:

LTS related to one employee. RTW: Requested detail of who these refer to

Finance

- Currently charging UHB actuals rather than full contracted figures due to lack of resolution to service reviews and continued non-engagement from UHB with regards to clinical model
- This results in the service showing as over budget as not bringing in the returns expected on each contract

14. Finance Report

Report to Trust Board						
Agenda item:	**14**					
Date	3 April 2024					
Title	Finance Report					
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy Director of Finance					
Executive Director	Dave Tomlinson, Executive Director of Finance	**Approved**	**Y**	✓	**N**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement		**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report					
Alert	✓	**Advise**	✓	**Assure**	

Revenue position:

The month 11 2023/24 Group position is a surplus of £2m year to date. The position comprises a £2.4m surplus for the Trust, £391k deficit for Summerhill Services Limited (SSL) and a £229k surplus position for the Reach Out Provider Collaborative. The year to date position for the Mental Health Provider Collaborative is £147k deficit.

Alert:

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

- Savings – Year to date delivery of £13.4m; a shortfall against plan of £0.1m. Although full savings delivery of £14.7m is forecast, this is mainly driven by £9.7m non-recurrent delivery, leaving a recurrent issue going forward. A challenging 3% savings target has been agreed as a system planning assumption for the first high level draft of the 2024/25 plan, this equates to £9.5m.

- Out of area – Year to date expenditure is £17m; an overspend of £9.6m. Following a reduction in run rate during quarter 3, non-Trust bed usage increased throughout January and has remained just below the peak January level during February. Total forecast expenditure for 2023/24 is £18m.

- Temporary staffing – Year to date bank and agency spend is £41m. Forecast total spend is £45m which is almost double the spend in 2019/20. We remain in breach of all but one of the NHSE agency rules.

Advise:

- Capital position:
  Month 11 2023/24 Group capital expenditure is £5.8m year to date. This is £1.7m adverse to plan.

We have been successful in securing additional capital funding from the system capital investment fund (SCIF) for 2023/24. £0.5m external PDC funding has also been secured in relation to the shared care record programme. Total 2023/24 capital forecast is now £9.1m.

- Cash position:
  The month 11 Group cash position is £92.3m.

Recommendation

The Committee is asked to review the month 11 financial position and discuss the key alerts.

Enclosures

Month 11 Finance Report

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People		
Quality		
Sustainability	✓	**Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.**

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**
Failure to focus on and harness the wider benefits of digital improvements.	✓	
Potential failure in the Trusts care of the environment regarding implementation of the Green Plan	✓	
Failure to operate within its financial resources.	✓	
Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	✓	
Potential failure to harness the dividends of partnership working for the benefits of the local population.	✓	

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2023 to 29th February 2024

Month 11
Group financial position

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Group Summary	Annual Budget	Revised Plan (including pay award funding)	YTD Position		
			Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000
Income					
Patient Care Activities	566,227	579,700	531,388	535,811	4,424
Other Income	18,832	18,832	17,263	26,046	8,783
Total Income	**585,060**	**598,533**	**548,651**	**561,857**	**13,207**
Expenditure					
Pay	(270,159)	(278,391)	(255,193)	(249,200)	5,993
Other Non Pay Expenditure	(277,459)	(282,700)	(259,136)	(276,253)	(17,117)
Drugs	(6,077)	(6,077)	(5,571)	(6,636)	(1,065)
Clinical Supplies	(795)	(795)	(729)	(540)	189
PFI	(12,611)	(12,611)	(11,560)	(14,066)	(2,506)
EBITDA	**17,959**	**17,959**	**16,462**	**15,163**	**(1,299)**
Capital Financing					
Depreciation	(9,906)	(9,906)	(9,080)	(8,915)	165
PDC Dividend	(1,717)	(1,717)	(1,574)	(205)	1,369
Finance Lease	(5,693)	(5,693)	(5,218)	(13,940)	(8,721)
Loan Interest Payable	(1,060)	(1,060)	(972)	(974)	(3)
Loan Interest Receivable	797	797	731	3,857	3,126
Surplus / (Deficit) before taxation	**380**	**380**	**348**	**(5,014)**	**(5,362)**
Taxation	(380)	(380)	(348)	(352)	(4)
Surplus / (Deficit)	**(0)**	**(0)**	**(0)**	**(5,366)**	**(5,366)**
Adjusted Financial Performance:					
Remove impact of PFI liability remeasurement under IFRS16				8,721	8,721
Remove PDC dividend benefit arising from PFI liability remeasurement				(1,370)	(1,370)
Adjusted financial performance Surplus / (Deficit)	**(0)**	**-**	**(0)**	**1,990**	**1,990**

Month 11 2023/24 Group Financial Position

The month 11 consolidated Group position is a surplus of £2m year to date (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS16). In month 11, NHSE advised that the PDC benefit that arises as a result of the PFI liability remeasurement cannot be used towards delivery of the financial position and so this £1.4m benefit is adjusted out.

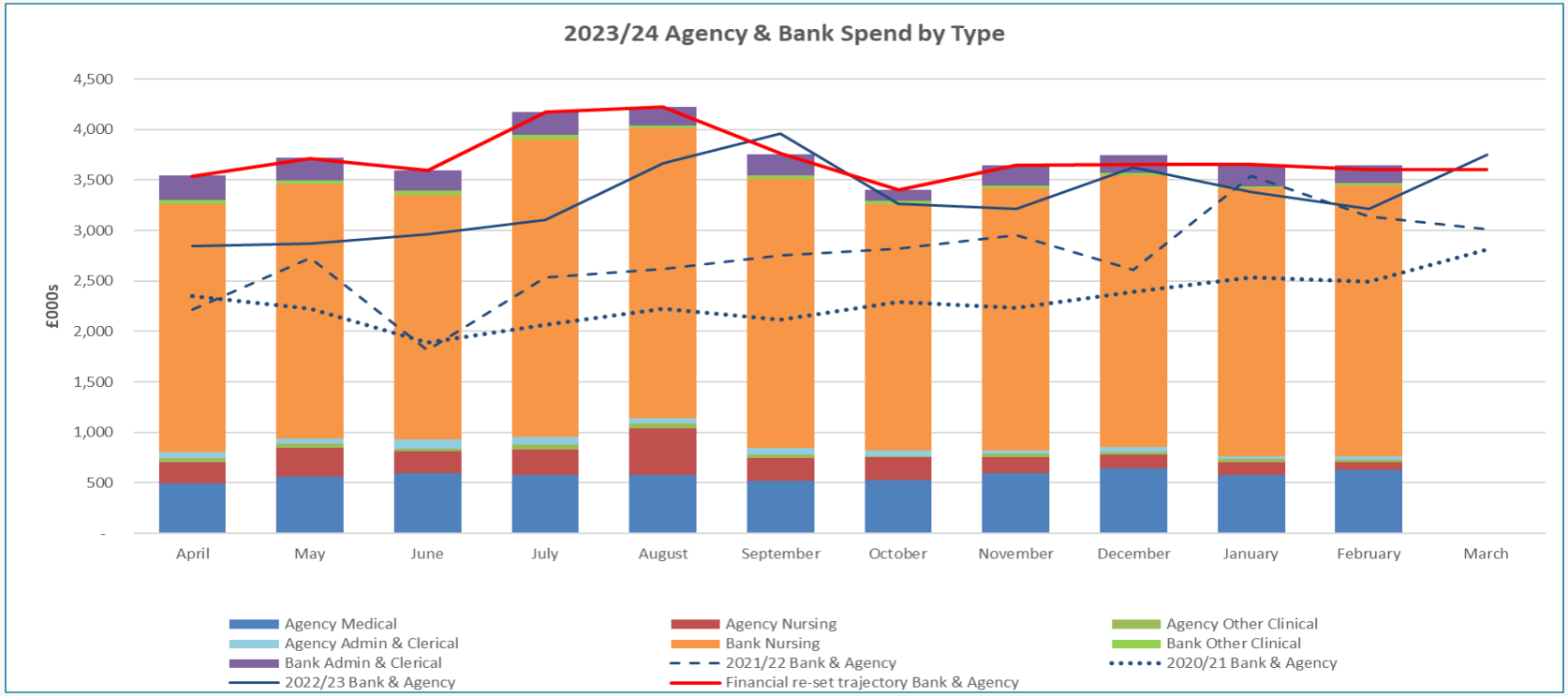
The 2023/24 forecast outturn, based on the financial re-set submission in November, is a £4m surplus. The year to date position is in line with the year to date trajectory.

The Group position includes a £2.4m surplus for the Trust and a £391k deficit for the wholly owned subsidiary, Summerhill Services Limited (SSL). The Reach Out Provider Collaborative year to date position is £229k surplus in line with agreed contribution to Trust overheads. The year to date position for the Mental Health Provider Collaborative (MHPC) is a deficit of £147k. For a segmental breakdown of the Group position, please see page 3.

Month 11 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	318,660	-	134,868	351,264	(268,981)	535,811
Other Income	25,624	26,865	-	1,530	(27,973)	26,046
Total Income	**344,285**	**26,865**	**134,868**	**352,794**	**(296,954)**	**561,857**
Expenditure						
Pay	(235,308)	(11,236)	(1,409)	(3,000)	1,754	(249,200)
Other Non Pay Expenditure	(76,923)	(8,172)	(133,229)	(349,942)	292,013	(276,253)
Drugs	(6,961)	(2,497)	-	-	2,821	(6,636)
Clinical Supplies	(540)	-	-	-	-	(540)
PFI	(14,066)	-	-	-	-	(14,066)
EBITDA	**10,488**	**4,960**	**229**	**(147)**	**(366)**	**15,163**
Capital Financing						
Depreciation	(6,025)	(2,800)	-	-	(90)	(8,915)
PDC Dividend	(205)	-	-	-	-	(205)
Finance Lease	(13,926)	(350)	-	-	336	(13,940)
Loan Interest Payable	(974)	(1,848)	-	-	1,848	(974)
Loan Interest Receivable	5,705	0	-	-	(1,848)	3,857
Surplus / (Deficit) before Taxation	**(4,937)**	**(39)**	**229**	**(147)**	**(119)**	**(5,014)**
Taxation	-	(352)	-	-	-	(352)
Surplus / (Deficit)	**(4,937)**	**(391)**	**229**	**(147)**	**(119)**	**(5,366)**
Remove impact of PFI liability remeasurement under IFRS16	8,721					8,721
Remove PDC dividend benefit arising from PFI liability remeasurement	(1,370)					(1,370)
Adjusted financial performance Surplus/(Deficit)	**2,418**	**(391)**	**229**	**(147)**	**(119)**	**1,990**

Temporary staffing expenditure



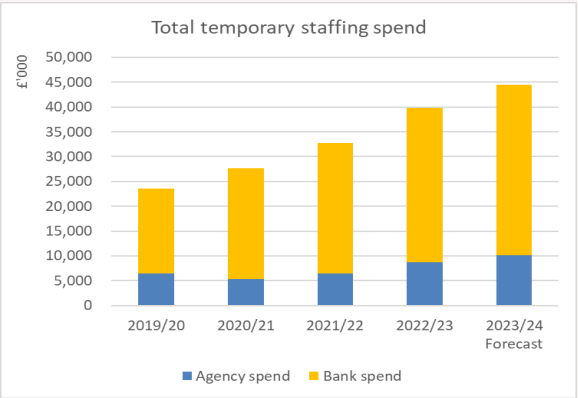
The month 11 year to date temporary staffing expenditure is £41m.

Forecast total spend for 2023/24 is £45m which is almost double the spend in 2019/20.

Bank expenditure £31.4m (76%) – the majority of bank expenditure relates to nursing bank shifts - £29m

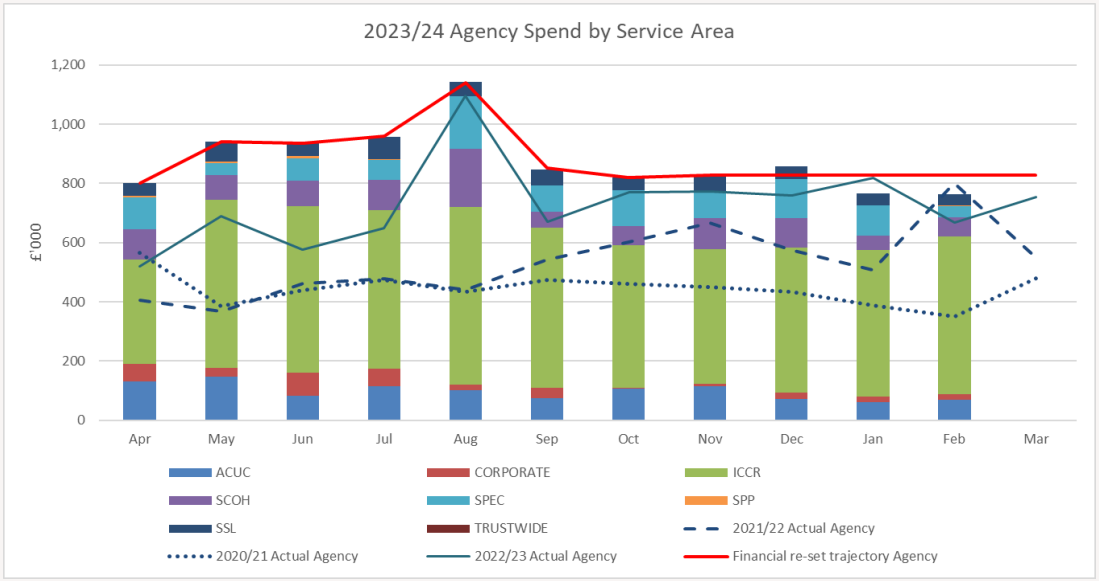
Agency expenditure £9.7m (24%) – the majority of agency expenditure relates to medical agency - £6m.

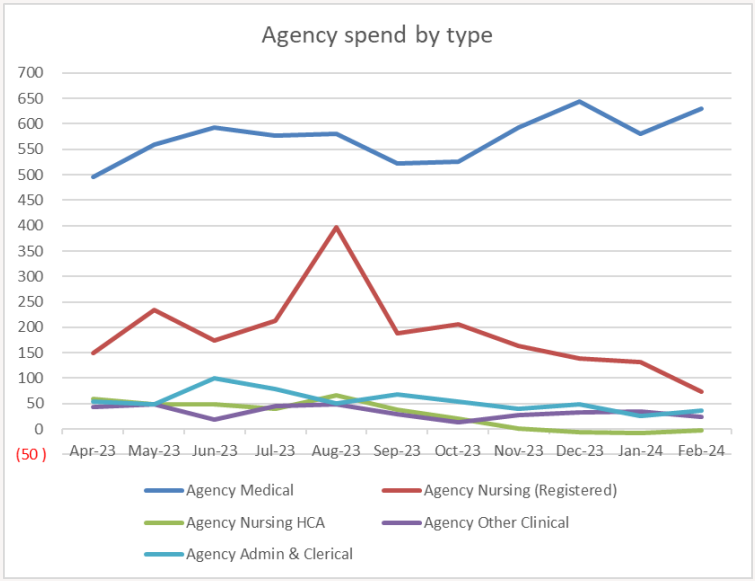
For further analysis on bank and agency expenditure, see pages 5 to 7.



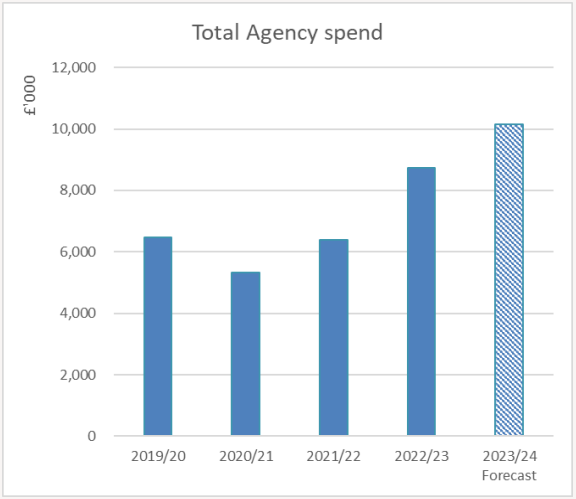
Agency expenditure

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust





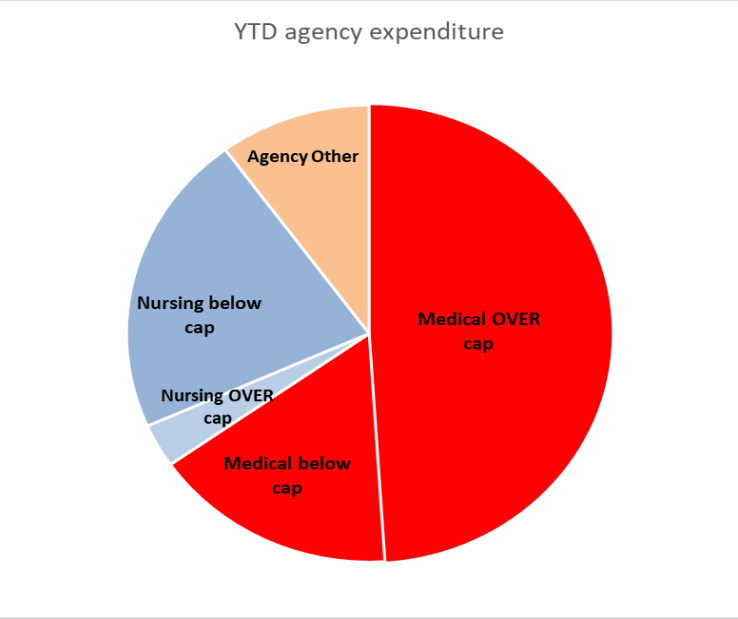
	2023/24 YTD
	£'000
Agency Expenditure	**9,650**
NHSE Ceiling (3.7% of pay bill)	**9,254**
Variance to NHSE ceiling	**(396)**
Agency Medical	6,300
Agency Nursing (Registered)	2,071
Agency Nursing HCA	303
Agency Other Clinical	367
Agency Admin & Clerical	608
Agency Expenditure	**9,650**



- Agency expenditure is £9.7m year to date. This is 3.9% of the year to date pay bill, compared to the NHSE ceiling of 3.7% - total breach of £396k.
- The financial re-set trajectory for 2023/24 agency spend is £10.6m. Year to date spend is £106k below trajectory.
- February agency spend is consistent with prior month and is the lowest monthly spend of the year to date.
- 65% of year to date agency bookings relate to medical with almost half the year to date agency spend relating to over cap medical bookings. There are currently 21 bookings, mainly in ICCR.

Agency Rules compliance

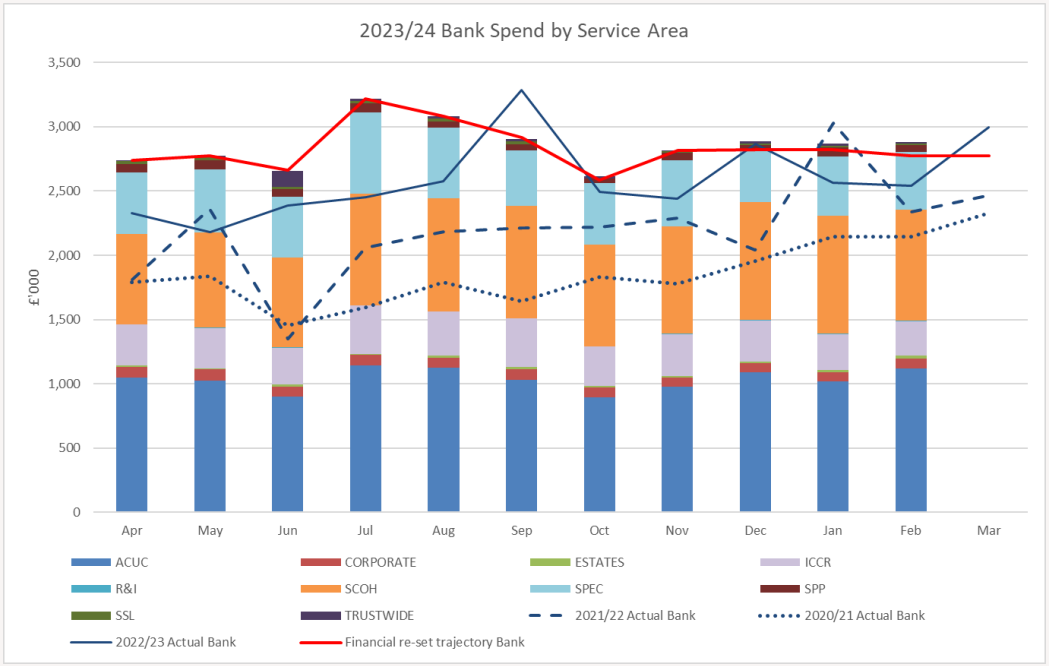
KPIs	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Agency spend as % of pay bill (YTD)	3.7%	4.2%	4.1%	4.0%	4.0%	3.9%	3.9%
Agency framework breaches	0	0	0	0	0	0	0
Above price cap agency bookings - medical	0	19	20	**23**	**23**	**21**	**21**
Above price cap agency bookings -nursing	0	19	16	12	11	9	9
Admin & Estates bookings - Trust	0	2	1	2	2	1	1
Admin & Estates bookings - SSL	0	17	15	11	9	9	7



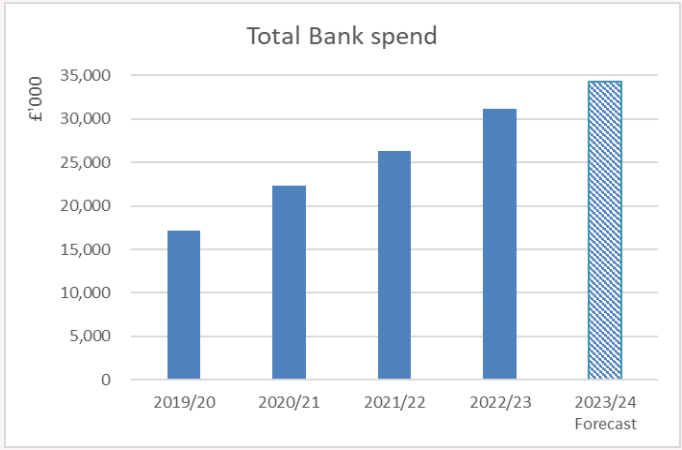
We remain in breach of all but one of the NHSE agency rules (there have been no agency framework breaches throughout the year to date).

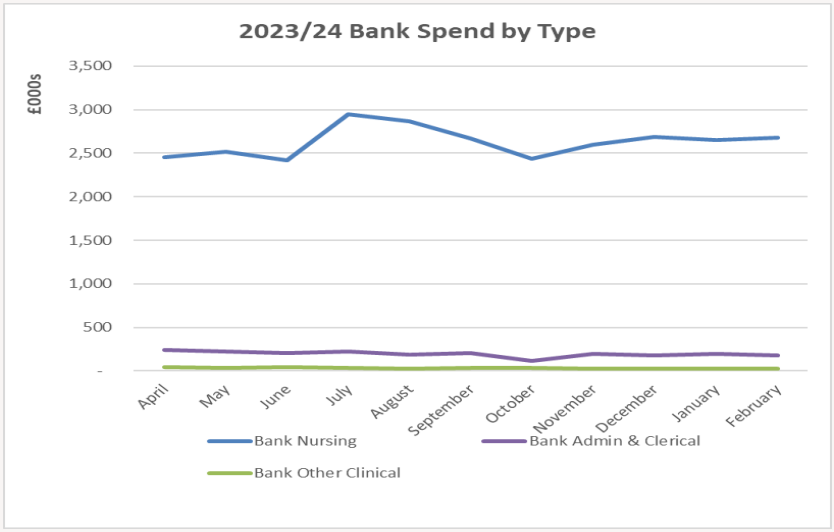
- Agency spend as a percentage of total pay bill remains at 3.9% in February. NHSE ceiling is 3.7%.
- Over cap medical agency bookings remains at 21 and accounts for almost half of all agency expenditure.
- Over cap nursing agency bookings remains at the lowest level all year at 9.
- Non clinical agency bookings in February has reduced to 8, lowest of the year to date (10 in January), with 1 in the Trust and 7 in SSL.

Bank expenditure analysis



Type	YTD £'000	% of spend
Bank Nursing	28,931	92%
Bank Other Clinical	357	1%
Bank Admin & Clerical	2,144	7%
Grand Total	**31,432**	**100%**

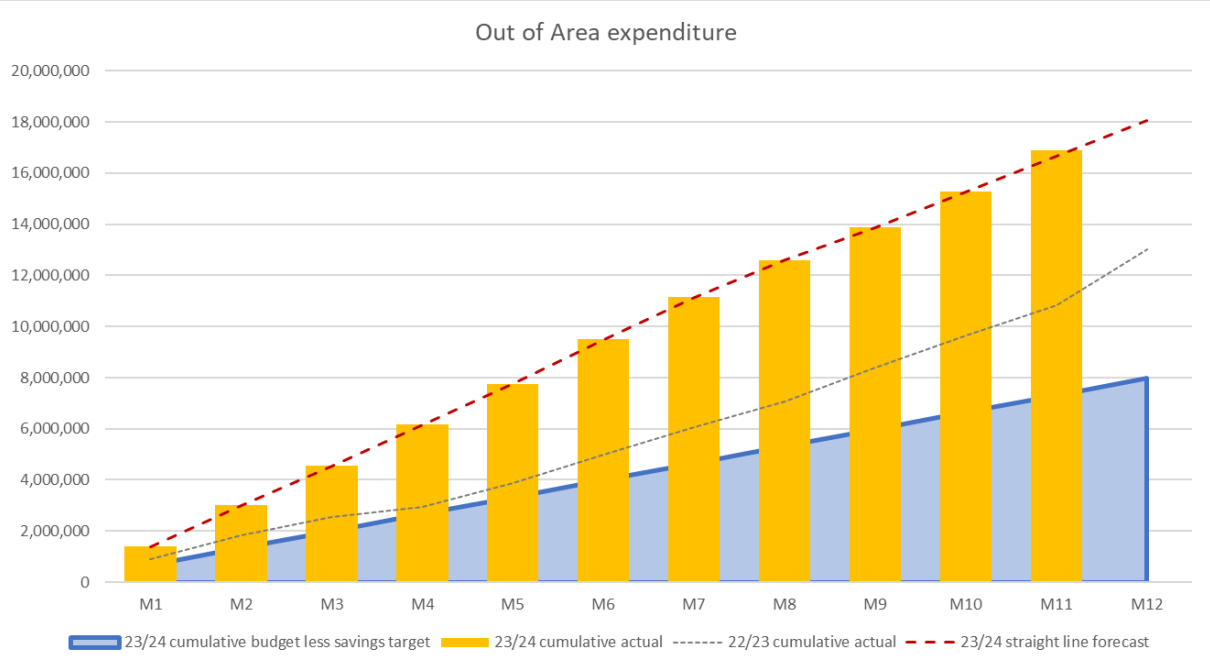


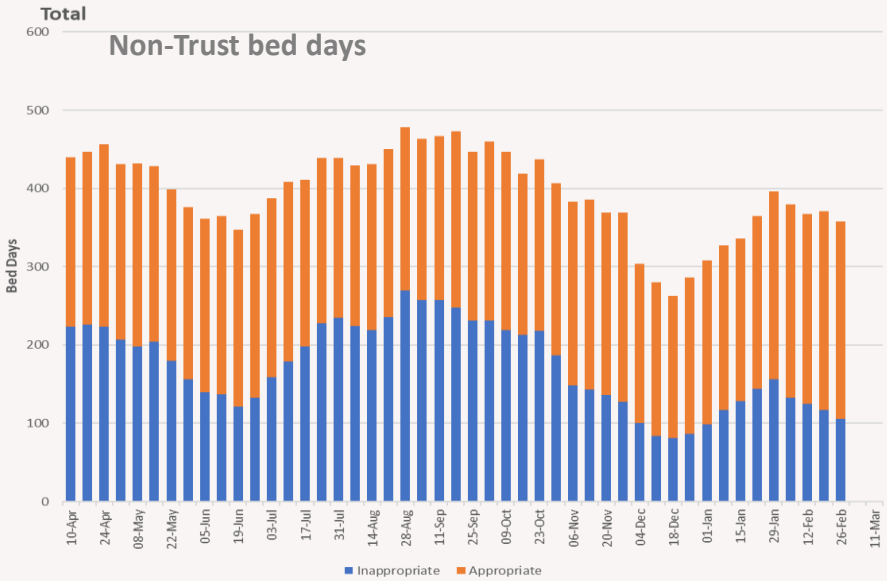


Bank expenditure

- Month 11 year to date bank expenditure is £31.4m. The financial re-set trajectory for 2023/24 bank spend is £34m. Year to date spend is £217k above this trajectory.
- February expenditure is in line with spend in the prior two months and consistent with the year to date monthly average of £2.9m.
- Year to date bank expenditure has predominantly been incurred within the following service areas: Acute & Urgent Care £11.4m, Secure and Offender Health £9m and Specialities £5.4m.

Out of Area overspend



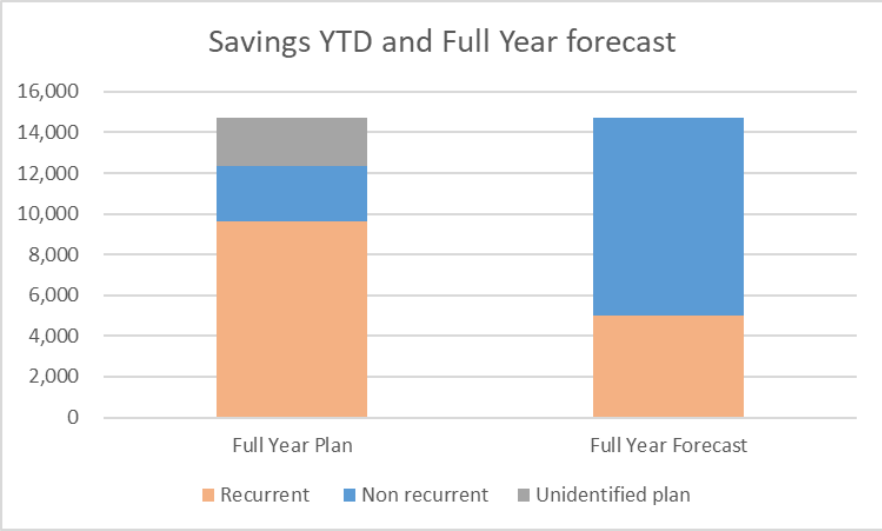


- Month 11 year to date out of area expenditure is £17m.
- Total 2023/24 plan for out of area, including a £5m savings target, is £8m.
- Year to date overspend is £9.6m. Following a reduction in run rate during quarter 3, non-Trust bed usage increased throughout January and has remained just below the peak January level during February. The full year forecast for 2023/24 is £18m.

Efficiencies

Birmingham and Solihull Mental Health NHS Foundation Trust

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)	458	458	-	500	500	-
	Budget setting pension review	1,283	1,283	-	1,400	1,400	-
	Interest receivable (1%)	229	229	-	250	250	-
	PFI - commercial performance settlement	550	1,357	807	600	1,357	757
	Unidentified	2,162	-	(2,162)	2,358	-	(2,358)
	Additional interest receivable	-	3,059	3,059	-	2,689	2,689
	NR income	-	2,411	2,411		3,503	3,503
Non-recurrent Total		**4,683**	**8,798**	**4,115**	**5,108**	**9,699**	**4,591**
Recurrent	Budget setting non pay review	1,146	1,146	-	1,250	1,250	-
	Budget setting pay review (not wte)	971	947	(24)	1,059	1,033	(26)
	Estates budget for Ross House (disposal)	138	69	(69)	150	75	(75)
	Interest receivable (@2.25%)	183	183	-	200	200	-
	OH contribution	1,788	1,788	-	1,950	1,950	-
	Out of Area reduction	4,583	-	(4,583)	5,000	-	(5,000)
	Additional OH contribution	-	468	468		510	510
Recurrent Total		**8,808**	**4,600**	**(4,208)**	**9,609**	**5,018**	**(4,591)**
Grand Total		**13,491**	**13,398**	**(93)**	**14,717**	**14,717**	**(0)**



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).

Savings achievement at month 11 totals £13.4m; a shortfall of £93k year to date.

It is forecast that the full £14.7m savings target will be achieved, with an under achievement of £5m against recurrent plans (due to out of area slippage) which will be offset by non-recurrent savings. 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.

Discussions continue around opportunities to drive savings through reduction of out of area, temporary staffing and energy expenditure. The agreed system planning assumption for the first high level draft of the 2024/25 plan is a 3% savings target which equates to £9.5m.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-23 £m's	NHSI Plan YTD 29-Feb-24 £m's	Actual YTD 29-Feb-24 £m's	NHSI Plan Forecast 31-Mar-24 £m's
Non-Current Assets				
Property, plant and equipment	214.2	211.8	211.1	211.3
Prepayments PFI	1.3	1.3	2.5	1.3
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	0.0	-	0.0	-
Deferred Tax Asset	(0.1)	-	-	-
Total Non-Current Assets	215.4	213.1	213.6	212.6
Current assets				
Inventories	0.6	0.6	0.4	0.6
Trade and Other Receivables	28.2	28.2	19.0	28.2
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	59.0	57.4	92.3	56.8
Total Curent Assets	87.9	86.2	111.8	85.7
Current liabilities				
Trade and other payables	(55.9)	(56.5)	(70.0)	(55.9)
Tax payable	(5.0)	(5.0)	(5.5)	(5.0)
Loan and Borrowings	(2.6)	(2.6)	(2.5)	(2.6)
Finance Lease, current	(1.1)	(1.2)	(1.1)	(1.2)
Provisions	(1.5)	(1.5)	(1.4)	(1.5)
Deferred income	(40.4)	(40.4)	(49.5)	(40.4)
Total Current Liabilities	(106.5)	(107.1)	(130.1)	(106.6)
Non-current liabilities				
Deferred Tax Liability	-	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(25.1)	(23.0)	(23.0)	(23.0)
PFI lease	(45.7)	(44.1)	(80.3)	(43.8)
Finance Lease, non current	(7.9)	(7.0)	(6.9)	(6.8)
Provisions	(3.7)	(3.7)	(3.2)	(3.7)
Total non-current liabilities	(82.4)	(77.9)	(113.4)	(77.4)
Total assets employed	114.4	114.3	81.9	114.4
Financed by (taxpayers' equity)				
Public Dividend Capital	114.5	114.5	115.0	114.5
Revaluation reserve	41.7	41.7	41.7	41.7
Income and expenditure reserve	(41.9)	(41.9)	(74.8)	(41.9)
Total taxpayers' equity	114.4	114.3	81.9	114.4

SOFP Highlights

The Group cash position at the end of February 2024 is £92.3m, 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 11 to 12.

Current Assets & Current Liabilities

Ratios

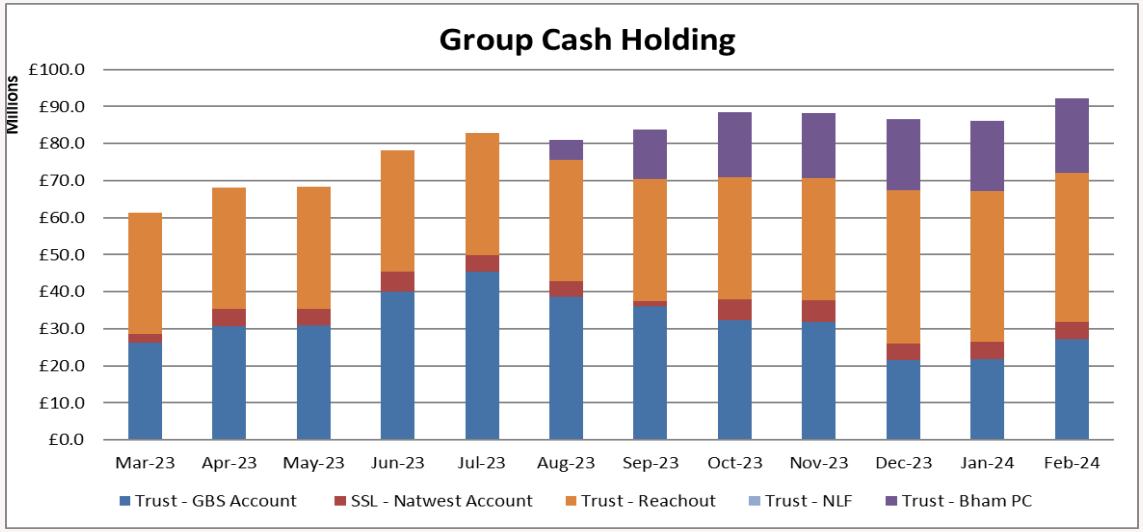
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

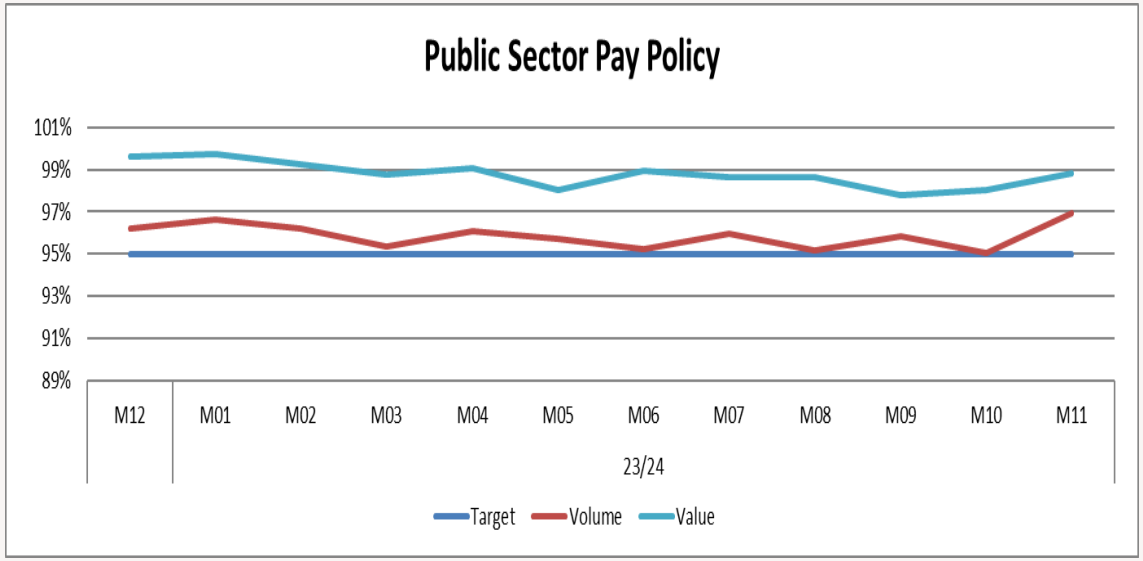
Current Ratio :	**£m's**
Current Assets	111.8
Current Liabilities	-130.1
Ratio	0.9

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of February 2024 is £92.3m.

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.

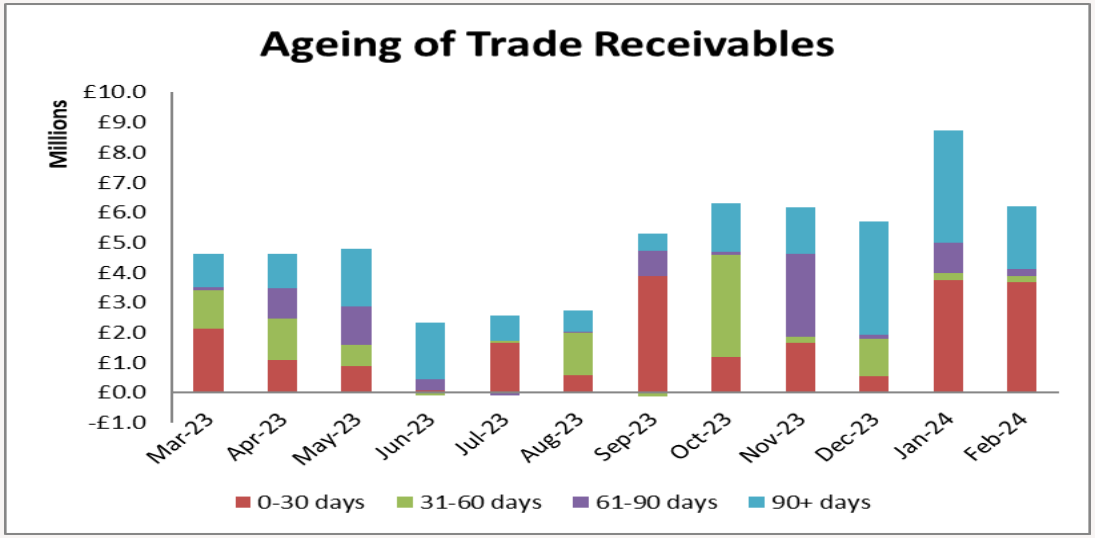
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

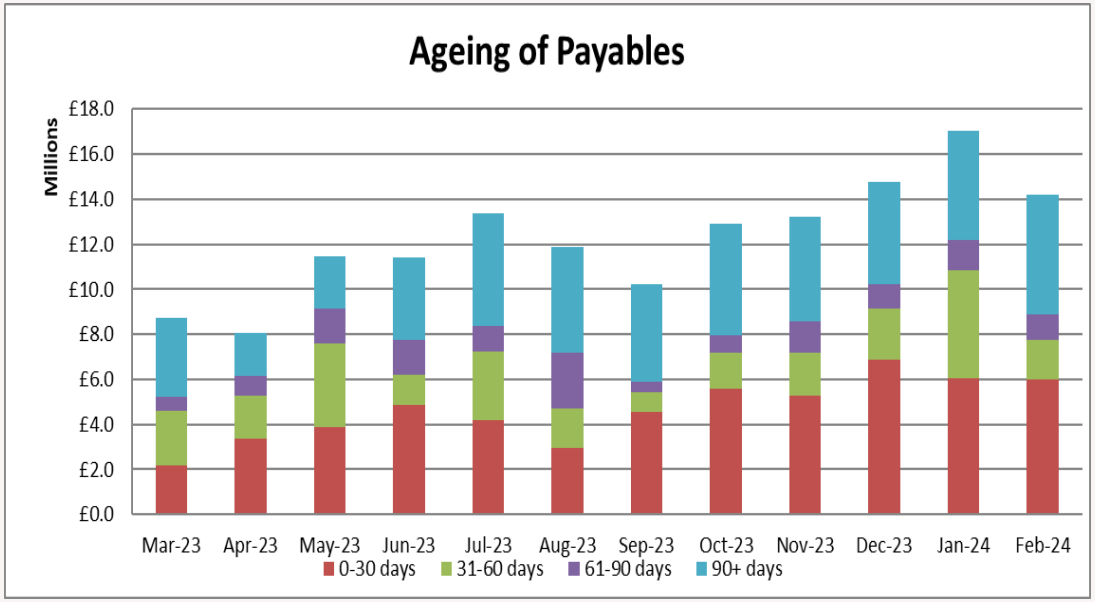
NHSE wrote to the Finance Team in September 2023 to commend them on this consistent performance throughout the year to date.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	95%	✓	100%	✓
Non - NHS Creditors within 30 Days	97%	✓	98%	✓

Trust Receivables and Payables





Trade Receivables & Payables

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

Receivables :

- **0-30 days-** balance due to monthly/quarterly ad hoc invoices raised in month with no known disputes/payments received up to 07.03.2024 £357k
- **31-60 days-** slight decrease in balance partly due to outstanding invoices moving up to 61-90 days & some balances being settled, balance staff overpayments (on payment plans).
- **61-90 days-** decrease partly due to invoices moving into 90+ days. BWC £69.5k, UHB £48k escalated to BSMHFT management, NHSE £53k-purchase order required, balance staff overpayments (on payment plans).
- **Over 90+ days** –decrease in balance as some of the outstanding UHB debt has been settled, the current balance UHB £1.3m – escalated to BSMHFT management, BWC £350K - awaiting purchase orders and resolution of queries, BUPA £107k still under query with ongoing discussions, SDSmyhealthcare £16k in query-payments coming through, WHSSC £141k reason for nonpayment under investigation, South Warwickshire FT £46k, balance staff overpayments (on payment plans).

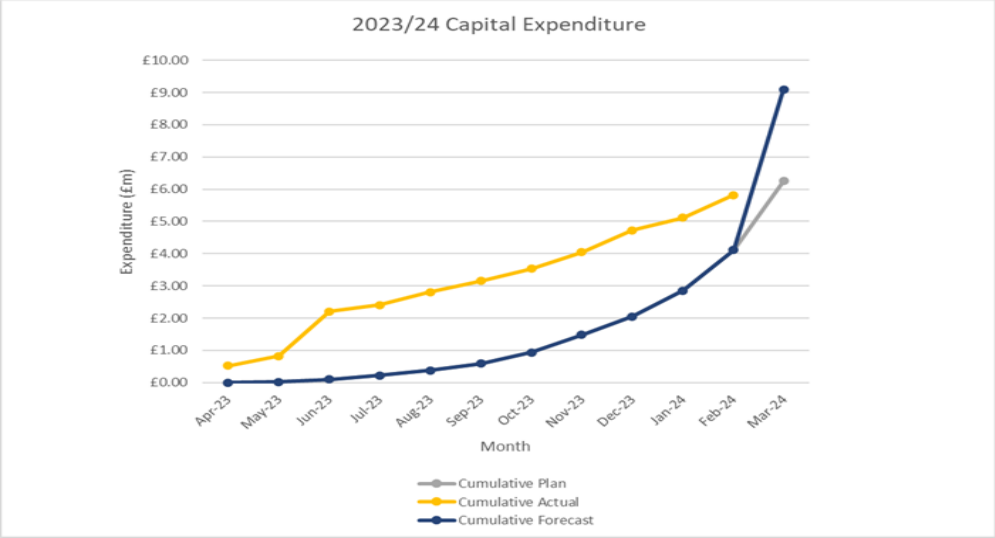
Trade Payables:

Over 90 days -

- Midlands Partnership £307k, Coventry & Warwickshire £209k Reach Out related awaiting approval, NHS Property £284k-historic invoices, UHB £284k in query with the contracting team, SWBH £121k awaiting approvals, awaiting approvals.
- Non-NHS Suppliers (72+) £4m – mainly bed/OOA fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in March 2024.

Month 11 Capital Expenditure

Capital schemes	Annual Plan	YTD Plan	Annual Forecast	Total Actual	Variance to plan	Variance to forecast
	£'m	£'m	£'m	£'m	£'m	£'m
Approved Schemes:						
Minor Projects (inc Carry-Forward)	1.7	1.1	1.5	1.5	0.4	0.0
SSBM Works	2.0	1.4	2.6	1.5	0.1	1.1
ICT Projects	0.9	0.7	1.9	0.9	0.2	1.0
Doorsets	0.4	0.2	1.3	1.3	1.2	0.0
CAMHS Seclusion Suite (PDC Funded)	1.3	0.9	1.3	0.6	-0.2	0.6
NEPT Lease Renewal	0.0	0.0	0.0	0.0	0.0	0.0
Shared Care (PDC Funded)	0.0	0.0	0.5	0.0	0.0	0.5
Total	6.3	4.1	9.1	5.8	1.7	3.3



Group Capital Expenditure

Group capital expenditure is £5.8m at month 11 year to date. This is £1.7m adverse to the year to date plan. The total forecast capital spend is £9.1m including additional spend above original plan, funded via system capital investment fund, see below.

Utilisation of System Capital Investment Fund

As reported in month 10, BSMHFT secured additional system capital investment fund for capital expenditure in 2023/24. During month 11, further system capital envelope was identified due to reduced capital forecasts across the system, particularly on IFRS 16 lease expenditure (including £441k slippage for BSMHFT). To ensure that as a system we fully utilise the capital envelope, all partners were asked to determine whether any future planned capital expenditure could be brought forward to 2023/24. BSMHFT has secured an additional £1m for ICT capital expenditure.

In February, we received notification of £0.5m PDC funding from the Department of Health & Social Care to support the shared care record programme. This increases 2023/24 forecast capital expenditure by an additional £0.5m.

Total capital forecast is now £9.1m.

Report to Trust Board						
Agenda item:	**14**					
Date	3 April 2024					
Title	Planning and Budget Setting 2024/25					
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy Director of Finance					
Executive Director	Dave Tomlinson, Executive Director of Finance	**Approved**	**Y**	✓	**N**	

Purpose of Report		Tick all that apply ✓	
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement		**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report					
Alert	✓	**Advise**	✓	**Assure**	

NHSE planning guidance is traditionally issued late December but has still not been published at the time of writing. The local planning process has continued based on agreed BSOL planning principles and draft guidance issued by NHSE.

Advise:

The Committee is asked to note the following:

- On 27.2.24 a high level system flash submission of the 2024/25 financial plan was submitted to NHSE with a deficit of £98m. This comprised a draft plan for BSMHFT of £13m deficit. The plan has been developed using the underlying run rate, with inflationary assumptions, known pressures, agreed developments and efficiency targets applied.
- A proposed approach to 2024/25 financial planning and a workforce framework was agreed at BSOL system financial recovery board on 5/1/23.

  Workforce framework ambitions include:

  - No overall workforce growth in 2024/25 at an organisational level
  - No agency price cap breaches or regular premium bank shifts by April 2025
  - No regular agency usage by April 2026.

- The first full financial plan submission to NHSE is due on 21.3.24.

Alert:

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

- The first draft plan for BSMHFT comprises a £14.5m savings target. This includes 1.1% national requirement, 1.9% locally agreed BSOL requirement and £5m out of area reduction target carried forward from 2023/24. There is a risk that further efficiency requirement will need to be

applied in order to reduce the system financial gap.

- £12.7m cost pressure funding requests were submitted as part of the BSMHFT planning process. It was only possible to fund £861k of these requests given the challenging financial position.
- The capital plan to be submitted in the first full plan submission on 21.3.24 is £6.6m. This includes a notional allocation of £0.4m relating to the system capital investment fund (SCIF), against which spend is to be prioritised across the system. To date, £5.3m capital pre-commitments have been identified for 2024/25.

Recommendation

- The Board is asked to review the planning and budget setting report and discuss the key alerts.
- FPP endorsed the £13m deficit revenue plan for the first draft plan submission to NHSE and the Board is asked to be aware of this.
- QPES and FPP endorsed the £5.3m capital pre-commitments plan identified to date and the Board is asked to approve this programme. There was comment at QPES regarding Reaside and this is being discussed for later proposals.

Enclosures

Planning and Budget Setting 2024/25 Report

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People		
Quality		
Sustainability	✓	**Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.**

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**
Failure to focus on and harness the wider benefits of digital improvements.	✓	
Potential failure in the Trusts care of the environment regarding implementation of the Green Plan	✓	
Failure to operate within its financial resources.	✓	
Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	✓	
Potential failure to harness the dividends of partnership working for the benefits of the local population.	✓	

Birmingham and Solihull Mental Health NHS Foundation Trust

2024/25
Planning & Budget Setting update

BSOL ICS local 2024/25 planning

- In the absence of full planning guidance for 2024/25, the local planning process has progressed. The key principles for the BSOL planning approach are outlined in Appendix 1.

- To calculate financial plans, 2023/24 underlying exit run rates have been adjusted for indicative cost uplift factor, known costs pressures and key developments. For further detail, see page 3.
- The national efficiency tariff of 1.1% plus a local system efficiency target of 1.9%, takes the applied savings requirement to 3%. For further detail on BSMHFT savings, see page 4.

- The BSMHFT high level first draft plan for 2024/25 was a deficit of £18.1m. The total system first draft plan, a deficit of £217m, was reviewed by system Chief Finance Officers (CFOs) on 9.2.24. Further actions were agreed, with a deadline set for the second draft plan of 21.2.24, in preparation for flash submission to NHSE on 27.2.24.

- The second draft plan saw a £61m improvement in the overall system plan, taking the draft plan from £217m deficit to a deficit of £156m. The improvement was mainly driven by confirmation of additional system allocations. The BSMHFT draft plan improved by £5m, taking the draft plan to £13m deficit. The improvement was driven by re-instatement of the £5m savings target for out of area reduction that was set in 2023/24 but not achieved. For a bridge of BSMHFT underlying exit run rate to draft plan see page 5. System CFOs reviewed the updated system plan on 23.2.24.

System flash submission to NHSE 27.2.24 - £98m deficit

- Following review by system CFOs, a number of mitigations were identified to further improve the second draft plan position by a further £58m. This resulted in a system plan of £98m deficit being submitted in the flash submission to NHSE on 27.2.24. It should be noted that some of these adjustments require further work to confirm the amounts but were considered most likely outcomes and so deemed necessary to include as stretching actions given the financial gap. This included a £20m additional target to drive down costs across each organisational plan, for consideration in system confirm and challenge meetings. Additional to this, a £20m improvement was applied relating to Elective Recovery Funding (ERF), £7m adjustment for double counts, £5m adjustment for convergence and £5m release of system business case reserve.

First full plan submission to NHSE due 21.3.24

- Work has continued to review plans following the flash submission and in preparation for the first full plan submission to NHSE on 21.3.24. Confirm and challenge meetings were held between the ICB CFO and providers during the period 8.3.24 – 14.3.24. System Chief Executive Officers will meet on 15.3.24 to agree any changes to the plan ahead of submission.

2024/25 cost pressures

The indicative cost uplift factor (CUF) published by NHSE provides 1.9% funding for cost growth, with a 1.1% national efficiency target applied to give a net CUF of 0.8%. Final confirmation of the CUF is expected once final planning guidance is issued and the outcome of medical pay awards is known.

CUF uplift	Assumed	Cost Weight	Cost-weighted
Pay	2.1%	69.3%	1.4%
Drugs	0.6%	2.4%	0.0%
Capital	1.7%	7.6%	0.1%
Headline CNST	0.6%	2.2%	0.0%
Other	1.7%	18.4%	0.3%
Weighted total			1.9%
Efficiency			-1.1%
Net CUF			0.8%

BSMHFT cost pressures

A total of £12.7m cost pressures were submitted as part of the planning process. The ability to fund cost pressures is particularly challenging given the financial gap. Following review at Sustainability Board and by the Executive team, it was agreed with the Director of Finance that £861k cost pressures would be funded, mainly related to inflationary pressures for services that we are required to use, where the cost increase in 2024/25 will exceed national tariff.

Additional to this, other significant cost pressures identified relate to:
- PFI: The North PFI contract is linked to RPIX and the South PFI contract is linked to RPI. The anticipated cost pressure in 2024/25 is £2.9m. There is a further £1m PFI pressure relating to water management costs at the Highcroft site.
- Estates & facilities: including 13.5% food inflation and 3.2% laundry inflation.
- Drugs: in particular, the potential impact of new dementia drugs.

Cost Pressure Heading	**Total £**
Audit Fees	103,623
Insurance	67,750
SBS Payroll	40,374
VAT Flow	32,754
Microsoft licences	420,000
CQC Fees	76,625
NHS Providers Membership Fee & Azeus Convene License Fee	30,470
NHS Benchmarking	8,000
Inflationary pressures	**779,596**
Corporate systems officer to support rostering team	34,412
Independent Domestic Violence Adviser	47,140
	81,552
	861,148

Other risks

Out of Area inflationary risk due to change in Priory contract terms, change from block to cost and volume contracts, lack of recurrent savings pipeline

Issues with unknown impact:

New workforce framework, transport, LDA commissioning transfer.

2024/25 draft Efficiency plan

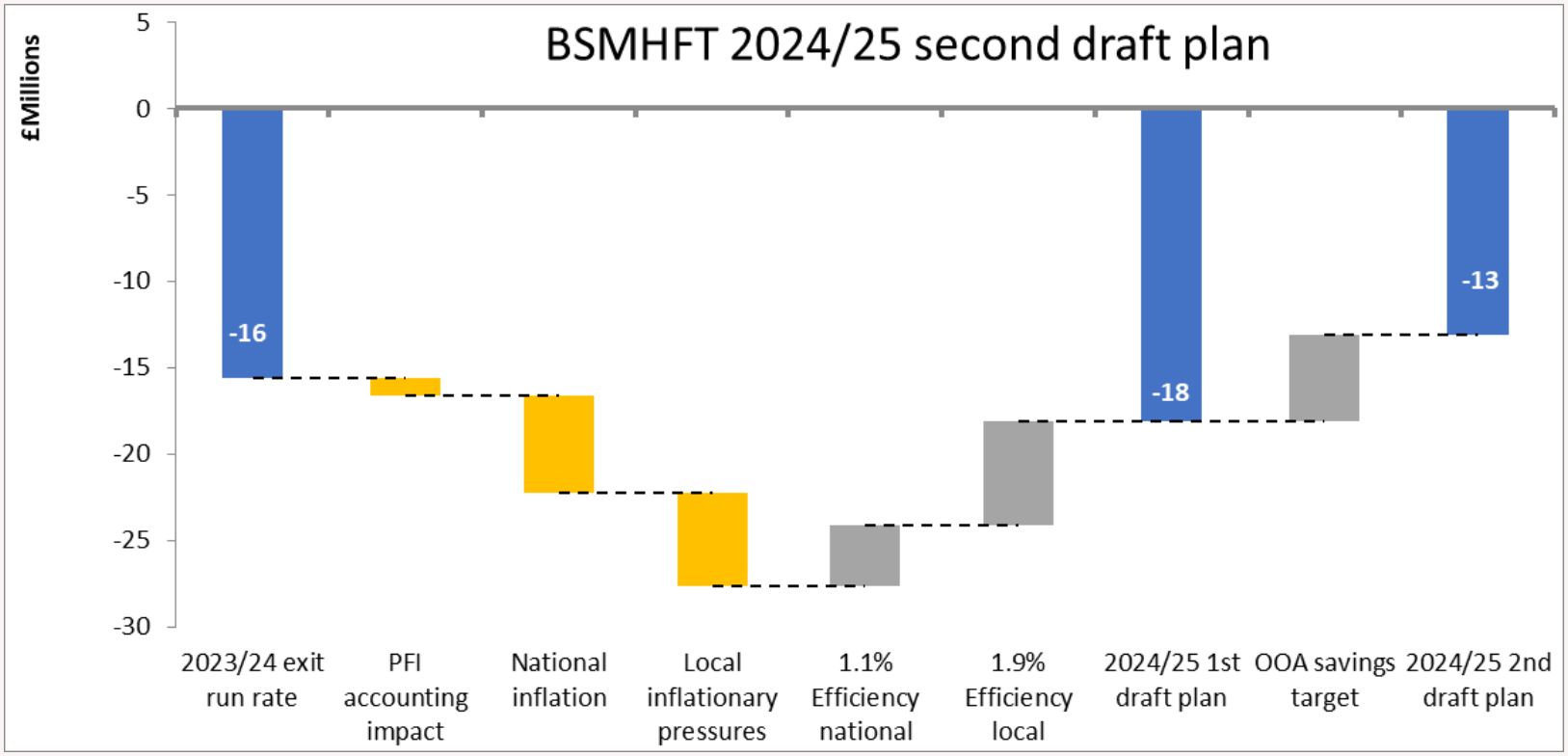
Efficiency target 2024/25	£
National Efficiency target 1.1%	3,486
Local BSOL Efficiency target 1.9%	6,035
Additional identified - OOA reduction	5,000
Total efficiency target	**14,520**

A £14.5m savings target was included for BSMHFT in the draft system plan submitted to NHSE on 27.2.24. This comprises £3.5m national efficiency target (1.1%), £6m BSOL local efficiency target (1.9%) and £5m out of area reduction target carried forward from 2023/24. There is a risk that further efficiency requirement will need to be applied in order to reduce the system financial gap.

The table below shows identified plans to date totalling £10.6m. This comprises £5m out of area target, £1.5m agency target to drive agency spend down to 3.2% of the pay bill. £3.7m non recurrent savings relating to agreed provider collaborative funding. The remaining £0.4m relates to overhead and margin on new funding. £3.9m is currently unidentified.

Organisation	Scheme	Value £000s	Recurrent / Non-recurrent	Developed Status	Risk
BSMHT	New Recurrent Funding Stechford Custody Suite - OH & Margin	60	Recurrent	Fully Developed	Low Risk
BSMHT	New Recurrent Psychology Post Foston Hall - OH & Margin	17	Recurrent	Fully Developed	Low Risk
BSMHT	CYP Re-allignment - OH & Margin	103	Recurrent	Fully Developed	Low Risk
BSMHT	Prevent Additional Funding - OH & Margin	93	Recurrent	Fully Developed	Low Risk
BSMHT	Agency Reduction Saving to meet 3.2% target - Support to Nursing	404	Recurrent	Fully Developed	Low Risk
BSMHT	Agency Reduction Saving to meet 3.2% target - Medics Consultants	757	Recurrent	Plans in Progress	Medium Risk
BSMHT	Agency Reduction Saving to meet 3.2% target - Medics Career/Staff Grades	340	Recurrent	Plans in Progress	Medium Risk
BSMHT	OOA Spend Reduction	5,000	Recurrent	Plans in Progress	High Risk
BSMHT	Non Recurrent 2 yr Pilot from Jan 24 Enhanced Reconnect - OH & Margin	118	Non-recurrent	Fully Developed	Low Risk
BSMHT	Non-Recurrent Income from Reach Out	2,782	Non-recurrent	Fully Developed	Low Risk
BSMHT	Non-Recurrent Income from Other External PC's	953	Non-recurrent	Fully Developed	Low Risk
BSMHT	Unidentified	3,892	Recurrent	Unidentified	High Risk
		14,520			

BSOL ICS 2024/25 planning approach



2024/25 Capital Planning

The indicative capital envelope for 2024/25 is £6.25m. This together with a notional allocation of the system capital investment fund (SCIF) of £0.36m will be included in the flash submission to NHSE on 21.3.24, giving a total plan of £6.6m. Spend against the SCIF is still to be prioritised and confirmed across the system. To date, pre-commitments totalling £5.3m have been identified as outlined below. This includes £1.8m for minor works approved in 2023/24 as part of a two year plan. **The Committee is asked to endorse the £5.3m capital commitments identified to date.**

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. A lessee is required to recognise a right of use asset on the balance sheet thus creating a charge against the capital envelope. A corresponding lease liability is also recognised. To date, £1.6m impact of IFRS16 has been identified for 2024/25 capital. It is anticipated that we will issue the break clause on the B1 lease in 2024/25 which would give a £2.6m capital credit to be used against IFRS expenditure only, leaving a balance of £985k.

Capital Plans	**£ 000's**
Minor works (approved in 23/24)	£1,755
Doorset Instalations	£710
Medical Device Replacement	£100
SS&BM	£2,000
Design work for forensics capital bid	£750
Total Precommitments	**£5,315**
BAU Capital Envelope	**-£6,250**
Balance to allocate	**-£935**

Lease Renewals/Recognitions	**£ 000's**
Pheonix House	£64
Orsbourne Car Park	£101
Lease Car Renewals	£1,000
NEPT Vehicle Leases	£441
B1 (revaluation if we issue break)	-£2,591
Total IFRS 16	**-£985**

Appendix 1 - BSOL ICS 2024/25 planning approach

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Key principles and approach for BSOL ICS 2024/25 planning

- All planning decisions taken should be in line with the ICS 10-year strategy, and we should look to retain focus on these priorities as well as any short-term targets set out in planning guidance.
- Where relevant, planning decisions should be taken at a programme level, utilising the emerging system governance around provider collaboratives and place.
- Planning decisions should be transparent and evidence-based, should involve appropriate multi-professional engagement and be subject to appropriate clinical governance at an organisation and system level.
- The **system has a statutory duty to deliver a break-even plan**. It is important that we fully understand the options available to us to reduce our cost pressures and deliver against this duty, even if these actions are difficult to deliver or may taken longer than 2024-25 to fully achieve. Without an understanding of these priority areas, we are unable to take transparent action as a system to support these improvements.
- The ICB will be reviewing and relaunching it's decommissioning and disinvestment policy, and a process will be worked up with provider collaboratives and place partners to identify where current funding is not adding appropriate value and should be considered for reallocation to other priorities.
- Where possible, operational improvements should be delivered through a focus on increased productivity rather than a requirement for additional investment.

Workforce framework

- Workforce planning decisions should be taken in line with the system's workforce planning framework. This includes the principle that we should plan for **no overall workforce growth in 2024/25 at an organisational level.**
- Each organisation should be planning for a **significant reduction in agency expenditure,** with the ambition that we have **no agency price cap breaches or regular premium rate bank shifts by April 2025** and **no regular agency usage by April 2026**.

Reflections

15. Living the Trust Values

16. Board Assurance Framework reflections

17. Any other business

18. Questions from Governors and members of the public

Close by 12.30

Date and Time of Next Meeting:

Wednesday 5 June 2024, 09.00-12.30