Board of Directors Public

Schedule	Wednesday 4 June 2025, 9:00 AM — 12:30 PM BST
Venue	Uffculme Centre
Organiser	Kat Cleverley

Agenda

Agenda

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Board of Directors Public Meeting
09.00, Wednesday 4 June 2025
Uffculme Centre
AGENDA

Ref	Item	Purpose	Report type	Time
	Staff 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 2 April 2025**	Approval	Enc	09.35
5	**Matters arising from meeting held on 2 April 2025**	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, Executive Director of Operations*	Assurance	Enc	09.50
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	10.10
9	**Integrated Performance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	10.20
	Quality and Clinical Services			
10	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.30
11	**Quality Improvement: A Year in QI Report** *Julie Romano, Head of Quality Improvement and Clinical Effectiveness*	Assurance	Enc	10.40
	People			
12	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	11.00
	Sustainability			
13	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.10
14	**Finance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	11.20
15	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.30
16	**Caring Minds Committee Report** *Monica Shafaq, Non-Executive Director*	Assurance	Verbal	11.40
17	**Trust Seal Report** *Kat Cleverley, Company Secretary*	Approval	Enc	11.50
	Reflections			
18	**Living the Trust Values** *Dave Tomlinson, Executive Director of Finance*		Verbal	11.55
19	**Board Assurance Framework reflections**		Verbal	12.00
20	**Any other business**		Verbal	12.05
21	**Questions from Governors and members of the public**			

Close by 12.30
Date and Time of Next Meeting: Wednesday 6 August 2025, 09.00-12.30

1. Chair's Welcome and Introduction

2. Apologies for absence

3. Declarations of interest

4. Minutes of meeting held on 2 April 2025

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 2 April 2025, 09.00, Uffculme Centre			
Members	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	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
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnerships
	Monica Shafaq	MS	Non-Executive Director
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Kat Cleverley	KC	Company Secretary (minutes)
	Aairon Dalton	AD	Service User (item 1 only)
	Paige Harrison	PH	Business Partner/Assistant to CEO and Chair
	Shakil Patel	SP	Head of ICT (item 19 only)
	Emma Randle	ER	Freedom to Speak Up Guardian (item 16 only)
	Hari Shanmugaratnam	HS	Guardian of Safe Working Hours (item 15 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
Observers	Three governors and two members of staff/the public observed the meeting in person.		

Ref	Item
1	**Service User Story** The Board welcomed AD to the meeting to share their experiences of the Trust and its services throughout their mental health journey. AD thanked the Board for the opportunity to share his story, confirming he had been receiving support for the last three years including a period of time sectioned at the Zinnia Centre. AD shared the background of how he became known to services, and the impact of the pandemic that led to the closure of his business and additional support for declining mental health. Following discharge AD continued to be supported by the team at Maple Leaf Early Intervention Services. AD shared that his business, "Food 4 Thought" had been re-established and had received Lottery funding for expansion. There was an open offer to support the Trust in supporting others to improve their wellbeing through nutritional diets. AD thanked the Board for providing the services that saved his life. PG thanked AD for sharing his inspirational journey. AD noted that improvements could be made with GPs offering access to Early Intervention Services as part of the initial referral. RFW thanked AD for his passion and commitment to supporting others through sharing his journey and through his business. RFW asked what the Trust could do to support. AD commented that work-based rehabilitation training was key for recovery, leading to breaking the cycle and allowing positive focus for people struggling with their mental health.

	LSG confirmed there was an ongoing effort to reprioritise activities at Maple Leaf, with data captured through various service user and family feedback methods. AD noted that he had arranged a 24-hour cook out in January 2025 in support of the Trust, but had been advised that he was not permitted to use the Trust's name. The Board committed to understanding how this misinformation was given and confirmed that the Trust and Caring Minds Charity would be happy to support any future events. The Board thanked AD for his honesty and sharing his inspirational journey with the Trust.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
3	**Apologies for absence** None.
4	**Declarations of interest** No new interests were declared.
5	**Minutes of meeting held on 5 February 2025** The minutes were approved as a true and accurate record.
6	**Matters arising from meeting held on 5 February 2025** All actions were updated.
7	**Chair's Report** The Board received the report for information. PG advised that a celebration of life event for Mustak Mirza, Deputy Lead Governor, would be held following the Board meeting. PG commented on the number of services he had visited recently, including Zinnia Centre, Tamarind Centre, and the Community Mental Health Teams. The impact of the NHS planning guidance was noted, particularly in relation to financial challenges for trusts.
8	**Chief Executive and Director of Operations Report** The Board received the report for information, noting the following key points: • RFW commented on the period of change that the NHS was entering, with a lot of messages on key changes in quick succession. RFW acknowledged that language used could create anxiety and questions about what it meant for colleagues working within the NHS. RFW noted that the Trust planned to collectively consider what was best for our organisation, with the majority of opportunities identified through the productivity plan to make services better for service users. RFW advised that the financial plan and workforce plan for the Trust had been submitted to NHSE on 27 March. The workforce plan did not include a reduction in numbers of staff in-post, but included work in relation to temporary staffing. • VD noted that it had been a difficult winter period, with significant pressures on the emergency pathways. • The Board was advised that the Community Mental Health Teams continued to prioritise the reduction of long waits, with extended out of hours duty established. • VD noted that divisions were showcasing their work and looking at how they could work more closely together to learn from each other. • The Early Intervention in Psychosis service continued to meet waiting time standards for referral to treatment. • The Board was advised that there were several innovative projects underway to enhance ADHD services, including testing of AI for clinical recording and introduction of job plans to ensure standardisation across the service and full use of capacity.

	• A staff wellbeing and development reflective practice had been established within acute and urgent care. • The Recovery House procurement process had been finalised. • The Culture of Care programme at Reaside continued and the Board was advised of the energy and commitment from the service to make improvements. • The FIRST team had held a Winter Fayre, which was successful. SB asked about Early Intervention in Psychosis data, querying whether it would be included in health inequalities performance data. VD confirmed that the team had been asked to ensure this was included. BC queried whether the data was utilised to showed when patient cohorts presented and asked why services could not be covered 24/7. BC commented that if all hours were not covered, patients would attend A&E. BC also acknowledged that there was a 24/7 pilot ongoing, but it felt like an obvious gap. VD advised that the gap was understood and there were plans for the 24/7 service to be extended. RFW advised that there were services available at all hours, including Call Before You Convey, Crisis Line, Places of Safety, and the Psychiatric Decision Units which were all available on the emergency care pathway. PG added that additional promotion of these services would be useful to raise awareness. VD commented that there would be a Board strategy session on 24/7 services in May. NM asked how the Trust could link increased productivity to outputs that were sustainable and measurable. DT advised that there was a lot of work taking place across the system to ensure service users were seen at the right place. WW commented on the community care collaborative and the operating model that had been endorsed, noting that operational change would take three years. WW asked whether there were any issues that needed to be addressed as this seemed like a long time. WW also asked, from a community perspective, what the changes would be and whether it would address health inequalities. RFW advised that the CEOs in the system were reviewing the community care collaborative to understand the length of time it would take to mobilise. RFW advised that there were no prescribed health inequalities issues to address, as the community would understand the challenges, but there would be common principles to work within. PG commented on the national context of the NHS and the significant changes that were taking place. The Board would need to provide reassuring messages to our staff and colleagues and be clear about what the plans were to make savings and reduce inefficiency. DT commented that the plans seek to reduce increases that have been seen in certain areas of the organisation and to consider the investments that had been made. PG asked about the triage at A&E in the Queen Elizabeth Hospital, noting that bank staff were being utilised, and queried whether there was potential to relocate the psychiatric liaison team. VD advised that these discussions were ongoing and options were being considered. WW asked about length of stay and out of area placements which were key things that stood out when receiving benchmarking information at Finance, Performance and Productivity Committee, seeking greater understanding on how savings would be made without reducing staff numbers. RFW noted that the biggest opportunities were around improving patient experience. SB queried Clinically Ready for Discharge and how the team was unable to discharge people who were ready to leave due to housing and social care aspects and asked how this would be managed. RFW commented that the teams needed to understand what was in the Trust's control and consider what we may need to review as a commissioner.
9	**Board Assurance Framework** The Board received the BAF for assurance. BC commented on the clear link to the Trust strategy, noting that this would need to be revisited once the Trust strategy had been refreshed. WW commented on the need to reflect effective future-looking strategy within the BAF.

10	**Integrated Performance Report** The Board received the report for information. DT advised that the level of staff had increased significantly over the last 18 months. BC commented that there had been real progress made in a number of areas during the year. BC felt that the IPR required further development, but the deep dives were a useful and informative inclusion. BC raised a challenge in relation to incidents of self-harm and psychological harm to patients. It was noted that there was a deep dive into this in June. FA advised that safety huddles took place weekly, with continuous discussions into incidents, learning and sharing across the organisation. FA noted that safeguarding representation was present at all huddles, and FA invited non-executive directors to observe these at any time. BC noted that he did not read a sense of urgency from the data presented and felt uncomfortable with the amount of time taken to collect data before action was taken. LC advised that she had observed some of the safety huddles and confirmed that there was continuous, ongoing response to incidents, including sharing learning and reviewing processes. This would continue to be tracked and monitored through the Quality, Patient Experience and Safety Committee.
11	**Quality, Patient Experience and Safety Committee Report** The Board received the reports from February and March. LC advised on the following key points: • The Valdo Calocane independent review had been undertaken and was being considered in depth in the organisation. Significant work to learn from the review was ongoing and the Trust would embed the learning within the organisation in a sustainable way. • A report from the Mental Health Act Legislation Committee had been received. • The Committee had been assured by the progress made on the Culture of Care programme at Reaside. • The Committee had been assured by improvement plans for Zinnia Centre. • The Safer Staffing Report highlighted that an MHOST review had identified significant need for increased staffing due to acuity of services. This would be considered alongside the financial challenge and need to reduce bank staffing. LSG Commented that the outcome of the MHOST review would be taken to Quality, Patient Experience and Safety Committee, noting that there had been good progress in closing the vacancy gap.
12	**Health Inequalities Report** The report was received for information. FA advised that the report had been taken through each of the Board's Committees during March and positive feedback had been received on the difference the approach would make to local communities and how this could be reflected through our governance arrangements and reporting mechanisms. BC commented on the positive initiatives and noted the need to capture the actions and measure the impact it would have on local communities. The Board Committees would continue to consider how health inequalities could be reflected through reports and how Committees could continue to raise its profile.
13	**People Committee Report** The Board received reports from February and March. SB advised on the following key points: • A People strategy session had been held in February on workforce transformation. The Committee had considered the Trust's achievements and plans for the future, noting the particular ask for corporate benchmarking to fully understand how the Trust was performing against its partners and where the Trust may be an outlier. • The Committee had been assured by the increase in substantive recruitment.

	• The workforce plan focused on hot spot areas to address organisational productivity, oversight of corporate issues and bank reduction. • The Gender Pay Gap Report had highlighted an ethnicity pay gap. • Fundamental training compliance had increased to 93.4%. • The Committee had received a Quality Mark for its Race Equality Code Assessment. • The Committee had received a positive staff story on preceptorship. • Following a successful pilot phase, 'stay' conversations were being rolled out to community services alongside corporate services.
14	**Staff Survey Results Report** The Board received the report for information and noted the following key points: • The Trust had achieved a 57% response rate, which exceeded the People Goal of 55%. • Colleagues recommending the Trust as a place to work had risen significantly to 65.7%. • There had been significant progress in three of the seven People Promise themes: "Always learning", "We work flexibly" and "We are safe and healthy". • Morale had increased and was now above average, however the staff engagement score had not increased for over five years. The Trust's local question around assessing the effectiveness of senior leader communication continued to decline from 44.6% (2023) to 40.2% (2024). • There had been significant year-on-year improvement in 22 questions, with only 4 questions declined. • The Board was advised that bullying, discrimination and other negative behaviours from the public remained a key concern, with scores unchanged and significantly worse than the mental health trust average. However, the survey demonstrated that more people were likely to report bullying. PN advised the Board that the People Committee was holding a strategy session into the staff survey results in April, which would focus on assurance on planned actions to address the issues identified. RFW thanked the teams who were proactively reviewing improvements based on feedback they had received and who were actively approaching the Organisational Development and Freedom to Speak Up teams. BC queried whether these improvements could be used as part of the recruitment process to demonstrate why people should come and work with us. RFW noted that these successes and improvements were used as part of recruitment processes and were having a positive impact.
15	**Guardian of Safe Working Hours Q3 Report** The Board received the report for information, noting that there were no immediate safety concerns. HS advised the Board that exception reports had decreased during the reporting period, with 9 out of 11 reports related to overtime working. There had been two fines levied against the Trust. BC asked about the 19% vacancy rate and how the report was stating there were no safety concerns if there was such a vacancy gap. FA confirmed that all shifts were covered and therefore no safety concerns in relation to the Safe Working Hours regulation.
16	**Freedom to Speak Up Guardian Annual Report 2024/25** The Board received the report for information. ER provided some key highlights from the report, noting that staff continued to feel racially abused by patients on wards which was also reflected in the staff survey results. It was felt that some of the sanctions were ineffective in addressing this concern. RFW thanked ER and the team for the continued work, recognising the independence of Freedom to Speak Up Guardians in receiving concerns and feedback and reflecting this back to the organisation and Board. The Board would consider the Guardian feedback and the links between this and the staff survey results. RFW asked if there

	was Freedom to Speak Up Guardian presence in specialties, including primary care and dementia services. ER would clarify this. FA commented that ER had been featured in a national publication for her work on the Freedom to Speak Up Guardian process. PG commented that feedback he had heard on site visits consisted of sexual safety at work and asked how this was fed through Freedom to Speak Up. ER noted that this had not historically been an issue, however there had been more questions about the sexual safety process and would be reported through quarterly reports. PN advised that the Trust had signed up to the Sexual Safety Charter, with a policy in development. The Board noted that conversations had been held with Staff Networks on this, and it had been through People Committee.
17	**Finance, Performance and Productivity Committee Report** The Board received reports from February and March. BC advised on the following key points: • The Trust had achieved a surplus of £10.7m at year-end. The Committee had acknowledged the excellent work undertaken by everybody involved and noted that the Trust's contribution towards the system position had been recognised. • The Committee had acknowledged challenges for 2025/26 and the key issues that were driving this challenge. • BC advised that the Committee was less assured by the delivery of the savings plan and how this would be sustained. A forecast breakeven position had been submitted for 2025/26. PG asked how confident the Committee was that the breakeven position for 2025/26 was achievable within the current financial climate. BC commented that the Committee fully recognised the challenge and concern had been raised around the deliverability of the plan.
18	**Finance Report** The Board received the report for information and noted the following key points: • The Month 11 consolidated Group position was a surplus of £2.6m. This was £556k better than originally planned. Following work across the BSOL system to address the significant system deficit, non-recurrent benefits were identified to increase the BSMHFT forecast to a surplus of £10.7m. • The Board noted that, whilst the Trust position was positive, the underlying position was a significant deficit of c£16m, with key drivers including non-Trust bed expenditure and insufficient recurrent savings. • The 2024/25 savings target was £17.8m, with £16m achieved year-to-date. Current forecast reported that the full target would be achieved however £8m would be via non-recurrent means. • The month 11 Group capital expenditure was £5.5m year-to-date, which was £3m behind forecast. The revised forecast expenditure for 2024/25 was £14.2m. • The Group cash position at month end was £88m.
19	**Digital and AI Assurance Report** The Board received the report and noted the following key points: • The Trust was performing well in terms of cyber security controls. • Priorities for 2025 included: • Guidance had been updated from January 2025. • A revised service desk system was in development and had been shaped by feedback from colleagues. • Applications were being developed alongside the O365 transition. • A project for more efficient use of the UBook system continued. • SP noted the opportunities that AI would create for the Trust, including tools such as Chat GPT. The team was working on incorporating these aspects into the organisation via NHS policy.

	SB asked how these tools could be transferred into workforce development and how AI could be utilised to capture people data. SP commented that ESR was the national system for capturing workforce data, however there would be different versions that would improve utilisation and reporting. BC commented on the need to align digital initiatives to build a transformational programme to contribute to the Trust's financial challenge. NM commented on how AI could be used to improve future analysis. The Board was encouraged by the robust approach to cyber security and future opportunities for use of AI, and thanked SP for attending.
20	**Trust Strategy 2025/26 Goals Report** The Board received the report for information and noted that each of the Board's Committees had received and approved the strategic goals for 2025/26. The Board formally **approved** the goals for the final year of the current strategy.
21	**Caring Minds Committee Report** The Board received the report for assurance, noting the following key points: • The Committee had reviewed the development proposal for 2025/26, noting the benefits associated with the revised SLA and collaboration with Birmingham Community Healthcare NHS Foundation Trust (BCHC) to provide additional capacity and developmental support. The Committee had approved the proposal in principle. PG asked if the Charity received many applications for funding. MS advised that the Charity was more embedded in the organisation and a lot of requests for support were received. PG asked if the Charity was satisfied with its level of investments. MS commented the performance of investments was sound, with independent investment managers providing regular advice and reports on the Charity's interests.
22	**Trust Seal Report** The Board endorsed the use of the Trust Seal.
23	**Living the Trust Values** Deferred.
24	**Board Assurance Framework reflections** No further reflections.
25	**Any other business** The Board congratulated the Trust's Deputy Director of Operations, Marimouttou Coumarassamy, on receiving an MBE.
26	**Questions from Governors and members of the public** The following questions were posed to the Board: • The Board was asked if sign language would be accommodated if needed. The Board responded positively and confirmed that this service was available. • A question was asked on the Early Intervention Psychosis service. The Board responded that there were workshops planned to review the clinical pathway, and bipolar diagnosis would be included as part of the review.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Trust Strategy 2025/26 Goals	The Board approved the goals for the final year of the Trust's strategy.		
Trust Seal Report	The Board endorsed the use of the Trust Seal.		

5. Matters arising

6. Chair's Report

Report to the Board of Directors

Agenda item:	**6**					
Date	4 June 2025					
Title	Chair's Report					
Author/Presenter	Phil Gayle, Trust Chair					
Executive Director	Phil Gayle, Trust Chair	**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**	

The report is presented to Board of Directors in public to highlight key areas of involvement during the month and to report on key local and system wide issues.

Recommendation

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

Enclosures

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

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**

Acronyms

BOARD OF DIRECTORS CHAIR'S REPORT

1. INTRODUCTION

I am pleased to offer the Board a summary of my activities as Chair over the period since our last meeting, which was on 2nd April 2025. The Trust is continuing to improve in areas such culture change although there is further work needed in this area along with the roll out of the culture of care across some of our inpatient wards which is having a positive effect with staff. II would like to take the opportunity to thank our Executive team, operational managers and all our staff who work tirelessly in our community services and in patient wards. This is especially in a national climate where we are encouraging and expecting our staff to pay special attention to the tightening of expenditure as most NHS Trust are communicating this same message.

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.

Throughout the month of June, Roisin, Chief Executive, and the Non-Executive Director's will be having their mid-year appraisal meetings with myself. We look forward to these, which are vital in providing a structured approach to assess performance, align strategic goals and ensure accountability at the highest level. These appraisals promote transparency, support succession planning and reinforce a culture of continuous improvement which is essential for maintaining trust and driving long-term organisational success.

Additionally, after a lengthy recruitment process, and after personally taking time to speak with a large volume of interested candidates, we have now selected the newest member of our Board, a Non-Executive Director with immense experience. We are certain that they will provide great value and contribution to BSMHFT. We will look forward to sharing more details and introducing the NED at a later date once they are onboarded.

I was pleased to be able to Chair the Council of Governors meeting in May 2025 where we had the opportunity to extend our thanks and appreciation to lead governor John Travers as the May Council of Governor meeting was his last meeting as lead governor due to his term of office ending in June 2025.

SERVICE VISITS

2.1 Visits to our Trust services are ongoing and both the NEDs and Governors are joining us on these visits over the coming months.

This is a really 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 of improvements.

Listening to staff

2.2 It is important as chair to ensure I get the opportunity to visit our services which may not receive visits from NEDs or the chair. I have thoroughly enjoyed spending time with our staff, visiting service areas of service provision within the Trust to meet staff and listen to them about how it feels to work at BSMHFT.

2.3 Ardenleigh – I spent a great morning at Ardenleigh shadowing staff and attending meetings to listen to staff and hear about celebrations and challenges alike in the workplace, visiting different wards, and had some great conversations with service users. It was great to once again experience the services and care that Ardenleigh facility offers to our service users and the ongoing difference they are making. I visited this unit about six months ago and it was a quite challenging service in many ways. However, since my last visit I experienced a notable change particularly with staff who were so positive about their work environment and how staff volunteer to take up extra shifts where needed and there was no agency usage and bank staff usage was at a minimum and the staff were proud to share this. I congratulate the leadership and staff on turning around what was a challenging ward to one where individuals are choosing to work on the unit. and I look forward to visiting again in the near future

2.4 It was a privilege to co-host, alongside Roisin, our 2025 Staff Values Awards at the iconic Aston Villa Football Ground. The evening was truly exceptional and provided a fitting platform to celebrate the remarkable contributions of our colleagues. I had the honour of presenting awards to a number of outstanding individuals; each of whom exemplifies the values we hold dear. Hearing their stories of dedication and the profound impact they have on their teams and the wider organisation was both humbling and inspiring. Staff awards recognition such as this event is not only a celebration of individual achievement but also a vital reminder of the unwavering commitment and professionalism shown by the vast majority of our staff. Recognising and valuing their hard work is essential to fostering a culture of appreciation, motivation and excellence across our organisation.

3. Partner and System Development / Stakeholders

3.1 Regular meetings continue to be attended by myself. In recent months, the meetings I have attended include the BHP Board (Birmingham Health Partners), NHS Confed Mental Health Chairs Group, Midlands Chairs meeting and the ICCR Partnership, Operations and Co-Production meeting, to name a few.

I regularly attend meetings to ensure involvement and relationship building and maintaining with Partner's and Stakeholders regionally.

I continue to attend the BSOL Chairs meeting every month which has varied agenda for discussion.

4. Stakeholder Engagement

4.1 I continue to Chair the Council of Governors meetings where we dedicate time to receiving assurances from the Non- Executive Director colleagues on key areas of focus for the Trust and engaging in productive discussions and development.

I maintain my regular monthly meetings with and Dale Bywater, Regional Director of the Midlands NHS, Shane Bray from SSL where our meetings continue to be informative and valuable.

I also continue to meet bi-monthly with Rebecca Farmer, Director of System Co-ordination and Oversight for NHS England where we discuss key areas of focus for the Trust

5. PEOPLE / QUALITY

5.1 I chair the Board Strategy sessions where important discussions are held, and information shared. Progress is discussed with a collective focus to enable and ensure continuous progress Trust-wide.

I hold regular 1:1's are held with Roisin, Chief Executive, also Patrick Nyarumbu Deputy Chief and the Executive and Non-Executive Directors.

I continue to meet with the Freedom to Speak Up Guardians monthly to ensure I continue to have oversight of the key themes. These discussions are varied, and can cover any concerns raised around workplace culture, workload pressure and constraints, management practices, health, safety and well-being, and shared experiences related to diversity and respectful treatment.

I continue to support in areas of process improvements and innovation and fostering our most inclusive and supportive environment at BSMHFT.

PHIL GAYLE

CHAIR

7. Chief Executive Officer and Executive Director of Operations Report

Report to Board of Directors							
Agenda item:	**7**						
Date	4 June 2025						
Title	Chief Executive Officer and Director of Operations Report						
Author/Presenter	Vanessa Devlin, Executive Director of Operations Roisin Fallon-Williams, Chief Executive Officer						
Executive Director	Roisin Fallon-Williams, CEO	**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**	✓

Purpose

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

The report to the Board provides information on 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.

Recommendation

The Board is asked to note the contents of the report.

Enclosures

N/A

PEOPLE

Medical Work Force Team and Learning & Development

This month the new subcommittee- Multi-Professional, Education and Training Sub-Committee met for the first time and will be a key forum for governing all aspects of training and Education provision across the Trust and for all professionals. This meeting will also meet the requirements set by NHSE in regards the review of the Statutory and mandatory training offer across the NHS.

Ballot of Resident Doctors for Industrial Action

The BMA will ballot its resident doctor members between 28th May – 7th July regarding the pay award and potential of Industrial Action. They state that this relates to the trade dispute in respect of the lack of an acceptable and timely pay offer for resident doctors in England for the 2025/26 pay round. The proposal is for discontinuous industrial action to take place no earlier than 21st July 2025.

Workforce, Recruitment and Temporary Staffing Service

The vacancy rate for April was 7.8%. This is our lowest rate in a rolling 12 months and shows appropriate increases in the number of substantive staff in the Trust. (289.6 WTE in the last 12 months)

Turnover have also remained stable in the last 12 months. (April rate was 9.87%) We now have an agreed system wide definition of turnover which will help with our benchmarking.

Bank and agency usage continues to be monitored. In April, our agency usage dropped further, to 1.3% of our total pay bill which is significantly below target. Our key focus therefore remains on reviewing our processes and practices related to bank staff utilisation with the aim of significantly reducing our bank usage over the next financial year.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

In response to the learning national following the Nottingham homicide incident, we are taking a number of actions including, ICCR teams reviewing caseload complexity, implementing Patient Initiated Follow-Up (PIFU), and improving diagnosis and Next of Kin data collection. These measures aim to enhance service safety, quality, and patient outcomes.

Neighbourhood Mental Health Teams (NMHTs) are preparing for an 8-week Dialectical Behaviour Therapy skills group launching in June. Colleagues have completed the specialist training and the required supervision is in place. Joint NMHT and CMHT referral meetings are progressing well, and involvement of wider practitioners is supporting a more holistic approach and timelier triage.

Community Mental Health Teams (CMHTs) are strengthening collaboration with acute and urgent care teams to streamline interface processes and improve coordination across the patient pathway. This work supports delivery of the Trust's 3-year Inpatient Strategy. Additionally, Clinical Service Managers are working closely with the Psychiatric Liaison Team to review daily A&E attendance lists, identifying individuals who use this entry point for

support and addressing recurring themes through tailored interventions. Work is also on going between our CMHT and Assertive Outreach Team (AOT) colleagues aimed at reducing waiting times.

The Homeless Health Exchange Team is now fully operational at Attwood Green with rising engagement. NHSE has confirmed continued funding for the Rough Sleeper Mental Health Team.

Solihull Integrated Addiction Service (SIAS), in collaboration with the Trust's Safeguarding Team, is transitioning to a new safeguarding model and expanding remote access to care. Telephone and video conferencing options are now available to widen engagement. Despite stigma-related challenges, SIAS has exceeded discharge KPIs and remains above national averages for treatment outcomes.

The COMPASS Dual Diagnosis Team is embedding its revised training and consultation model, advertising new training for frontline clinicians and launching a consultation offer to support staff dealing with individuals with a dual diagnosis.

In SOLAR CAMHS, job planning and demand-capacity alignment is ongoing. Staff are benefiting from a range of funded training opportunities to meet the evolving needs of children and young people. Clinicians are receiving specialist training, and collaboration with our Autism West Midlands partner has grown, with an additional 12-month consultant role now being in place. The outcome of three bids we have made to specialist commissioners to enable expansion of CYP support are expected shortly.

The Early Intervention in Psychosis (Solihull) service continues to meet referral-to-treatment targets despite staffing pressures and a physical health nurse pilot is underway.

The Recovery Near You substance misuse service is seeing an increase in first-time referrals and continue to meet key performance targets. Plans are underway to align the dual diagnosis services in Wolverhampton. The current service contract is in a 6-month extension pending a longer-term commissioning decision.

The Steps to Recovery service has introduced new Patient-Reported Experience Measures (PREMs) to capture feedback on service user satisfaction and pre-discharge reflections. These insights are helping to drive quality improvements. A newly approved Recovery Business Case will fund a dedicated team to support the transition of patients from out-of-area rehabilitation placements back into local services and community-based care. Recruitment for this team is now underway.

Acute and Urgent Care

Reducing non-NHS bed usage is a key focus for the division. A set of key performance indicators (KPIs) will underpin the action plan, which will be monitored through our internal governance and presented to the Finance, Productivity, and Planning Committee. By concentrating on these actions, the divisions can work more seamlessly and collaboratively, ultimately supporting patient pathways and optimising outcomes in terms of admission avoidance, reducing length of stay, and maximising discharge efficiency.

As part of the improvements required by NHSE, we have submitted trajectories to reduce patient Lengths of Stay (LOS) across all inpatient services and these will be monitored internally via our Patient Flow Improvement Programme.

A second interface meeting was held between the Acute and Urgent Care and ICCR divisions, leading to positive and productive discussions, which will feed into the overall action plan and inpatient strategy supporting pathway improvements. The mobilisation of the Recovery House (formerly Crisis House) is progressing, and will go live in September, we will provide additional care options to support admission avoidance and optimise discharge planning.

The North locality has had a £40,000 bid approved by our charity Caring Minds to support the establishment of the Highcroft Staff Rest Centre, which will be housed in a single-story modular building between George Ward and Eden Unit. This facility will directly serve staff from George, Eden PICU, and Eden Acute wards. Additionally, it will serve the Highcroft site, including Northcroft, Endeavor House/Court, and Reservoir Court, providing staff with a designated space to take breaks away from the ward environment—something they currently do not have access to.

Improvements in patient flow, both via internal services and for out-of-area placements, have been sustained over recent months and this in turn supports the divisions financial plan to reduce spend thorough making better use of in patient facilities, progress on this is monitored weekly within the division and will be overseen on a monthly basis by the boards Finance, Performance and Productivity (FPP) Committee. The outcome of this work has also resulted in some positive feedback from the Patient Council and Experts by Experience.

The division has attracted some System Development Funding to enable Enhanced Home Treatment and Low Intensity Psychological Skills Training for service users.

Additionally, a training pilot for inpatient staff in providing low-intensity psychological interventions with patients is about to be introduced. After evaluation, this training will be expanded to all service areas within the Acute and Urgent Care Division.

Primary Care, Dementia Services & Specialties

In the Dementia and Frailty, the Older Adults Community Mental Health Team (CMHT) and Memory Assessment Service (MAS) teams have been focused on a data cleansing initiative, prioritising those individuals waiting longest for first and second contacts. As a result, significant progress has been made in reducing wait times for first appointments. In April, for the first time post Covid, there were no patients waiting over 52 weeks for a first appointment across the CMHTs.

Dementia and frailty wards are collaborating with NHSE on the Enhanced Therapeutic Observations and Care (ETOC) approach. This involves analyse of enhanced levels of observations across the wards to identify trends, assess demand, and evaluate the quality of the observations. Additionally, Rosemary Ward has been recognised in the student bulletin for staff excellence, while Sage Ward was nominated for Team of the Month for providing exceptional care to a very unwell service user.

The Neuropsychiatry Service is conducting a comprehensive review of its data and informatics to address long waiting times for the service. They are working alongside the outpatient department, which is auditing room usage, and collaborating with the Quality Improvement (QI) team to increase clinic space, allowing clinicians to see more service users face-to-face.

The monthly Birmingham Healthy Minds (BHM) performance meetings with the commissioning colleagues have resumed, where updates are provided on service action plans regarding completed treatment contacts, rates of non attendance, and recovery. BHM is now commissioned to provide long-term condition (LTC) services.

The Bipolar Service – Mood on Track (MoT) – will be offering four MoT courses simultaneously for the first time, increasing the annual offering to twelve courses. We will also be collaborating with Coventry and Warwickshire Partnership Trust to train several clinicians to deliver the MoT intervention. This expansion will improve access not just for Birmingham and Solihull residents, but for people across a wider region.

The Occupational Therapy service has recently acquired a 'Magic Carpet' – a ceiling-mounted interactive projector that transforms any floor into a dynamic, engaging space. This innovative tool enhances communication, encourages interaction, and supports cognitive abilities. It is expected to significantly aid in the therapeutic journey for patients with dementia, and training in its use is underway.

Secure and Offender Health (SCOH)

Staffing capacity continues to improve, with vacancies decreasing month by month (turnover: 5.9%, vacancies: 7.4%). However, occupational therapy (OT) capacity remains a challenge due to vacancies and sickness. To address this, a referral-based OT system has been implemented to prioritise urgent cases, and active recruitment efforts are underway across services.

At Reaside Clinic, the CQC has confirmed that the Section 29A notice put in place last summer, has been lifted, following improvements in the delivery of care, estate conditions and governance arrangements. Quality Network and Reach Out Quality reviews have been conducted, with positive initial feedback. Inpatient teams are committed to the Culture of Care standards, ensuring all service users receive 25 hours of meaningful activity. Feedback has been extremely positive from both the staff and the service users regarding the new programme of work.

Population pressures at HMP Birmingham continue, with regular late-night receptions and prisoners being transferred out on Saturday mornings to create capacity for afternoon courts. Psychoactive substance uses and realted incidents remain high, placing pressure on the system and impacting proactive healthcare delivery. The teams continue to support each other, whilst exploring additional ways to ensure the wellbeing of both service users and staff continues to be a priority.

The Health & Justice Vulnerability Service is actively recruiting for custody settings, with additional fixed-term posts to support the significant increase in service user engagement within outreach pathways. The Custody/Court pathway remains under strain due to the Right Care, Right Person (RCRP) initiative, and temporary measures have been put in place to mitigate risks. A recent visit from NHS England Commissioners resulted in positive

recognition of the service's work in both custodial settings and the community. The FIRST service continues to engage in quality improvement projects and digital transformation efforts. The division has successfully trained more than 70 Experts by Experience (EbEs). Experts by Experience are attending divisional clinical governance and FPP meeting, which is a supporting greater inclusion and co-production.

The Enhanced Reconnect service has secured additional funding for another year, extending its pilot phase and becoming part of a national evaluation. The remaining Offender Personality Disorder (OPD) contracts have been renewed, with some funding increases.

SUSTAINABILITY

Strategy Refresh

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

Each year we agree goals for each strategic priority and we completed in April, the end of year review of performance against the 2024/25 goals.

We want our refreshed strategy to celebrate the successes we have achieved during the life of the current strategy.

Set out our aspirations *and the* direction of travel for our Trust, being clear about where we want to be at the end of the next five years.

Describe our roadmap of what we need to focus on, helping us to prioritise our work and ensure we are doing the right things to achieve our priorities.

We want to have the same level, if not more, engagement than we did in developing the current strategy. We aim to replicate and build on the success of the **'**help us brew up our Trust Strategy' campaign, which engaged people in a fun and creative way of making the strategy meaningful for colleagues across the Trust and is still remembered and referenced to this day.

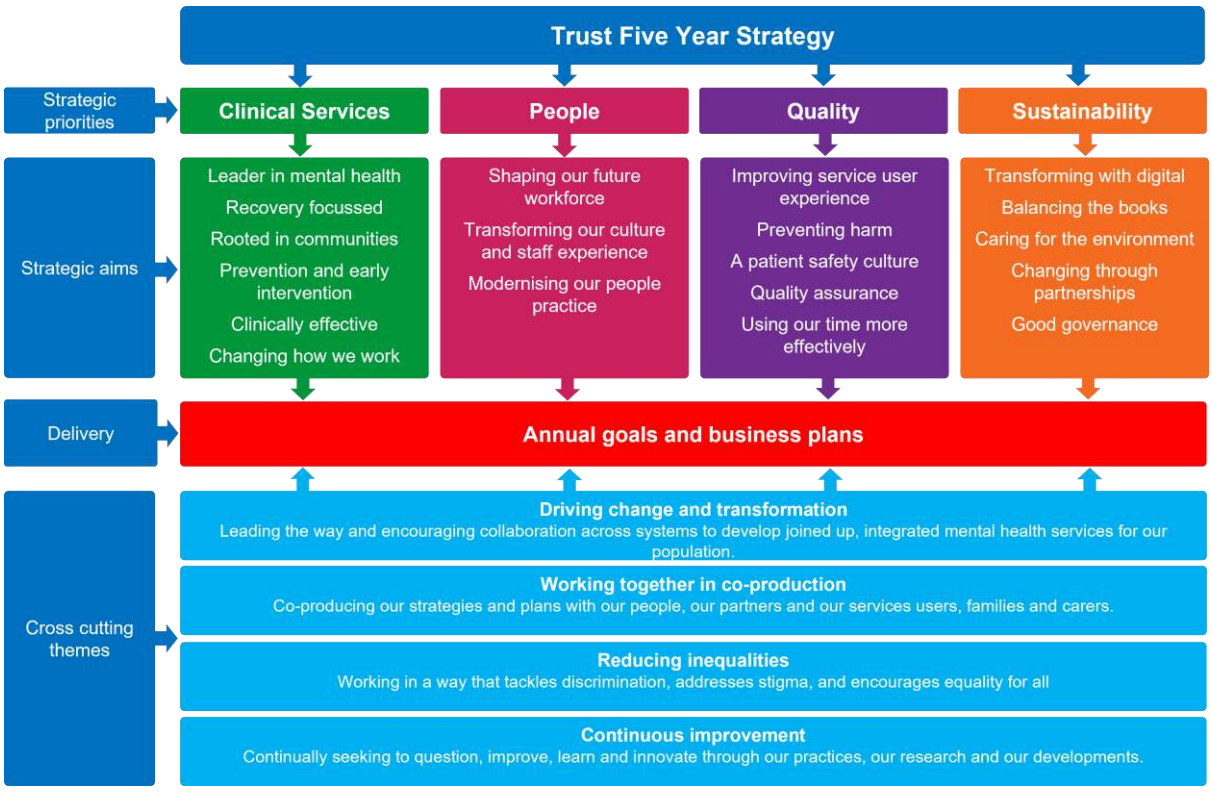
We will take multi-channel approach to engagement, including face to face conversations with teams at Trust sites, service and profession-based focus groups, online surveys, comment cards, online and offline materials and use of existing Trust wide communications channels.

We will be encouraging and equipping local leadership to support engagement with frontline teams so that when asked staff say they feel connected to the strategy.

We will maintain and grow the involvement of Experts by Experience, our local communities and partners ensuring that we retain the Recovery for All Quality Mark for the Trust Strategy, demonstrating the principles of recovery and co-production throughout the strategy development.

Last time we started with a blank page, this time we will celebrate our successes from the past 5 years and identify what more we need to do.

We will take the learning from the development of the current strategy and take more time, using the whole of the 2025/26 financial year to refresh our strategy.



Our strategy will align with the national direction of travel, the ICS 10 Year Strategy, and the local strategies of the Provider Collaboratives we are the lead provider or a partner of.

Locality working

ICBs and local authorities have been asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs. More mature systems will be working to develop an integrated neighbourhood delivery plan across the 6 initial core components, published as part of Joint Forward Plans and informed by engagement with local communities.

In Birmingham and Solihull (BSoL) system we have been working for some time now on establishing a model of locality working and putting in place Integrated Neighbourhood Teams. In recent months this work has been accelerated and strengthened through the commitment of all organisations to allocate key leaders, align resources and agree a small number of key outcomes we expect the dial to shift on via this approach.

As a Trust Dr Fabida Aria has been agreed as one of the Senior Responsible Officers of the the six localities and we have identified and agreed six senior leaders, one for each locality, to join the Locality Teams to support the development of the integration model and provide leadership in mental health.

We look will continue to provide updates on this important work to provide more care and treatment at locality and neighbourhood level.

Funding and Finances

The financial position, across the Trust, system and wider NHS continues to be extremely challenging – BSMHFT is reporting a significant deficit during the first month of this new financial year driven by slippage on delivery of our savings plans. Work therefore continues to improve this position and deliver our plan.

Mental Health Learning Disability & Autism (LDA) Provider Collaborative (MH/LDAPC)

The Following a call for comments on the proposed new model of care for children and young people across BSOL, an evaluation report setting out the feedback and next steps has now been published on the ICB website.

On the 28th of March 2025 the MHPC attended the Birmingham Health & Wellbeing Board alongside Public Health colleagues to present on both the draft Creating a mentally health city strategy and the mental health strategy blueprint. It was agreed that both strategies have detailed plans which underpin the transformation priorities and demonstrate synergies across the vision for Birmingham.

On the 11 April 2025 the MHPC facilitated an engagement session with a group of senior Black Leaders from across BSOL to review the draft Health Needs Assessment and share their views on the blueprint of the Mental Health Strategy.

The MHPC have continued to seek assurance and have oversight of the transition of the Children and Young Peoples Services into BSMHT during 2025 ensuring the appropriate due diligence and impact assessments are undertaken and reported into Board.

QUALITY

Section 29As and Focused Inspections

The Trust is moving to a positive position in terms regulatory notices from the Care Quality Commission (CQC), in that the only Section 29A notices that remain in place are those associated with the Zinnia inspection that was completed in October 2024. Good progress has been made against the improvement plan to date, and we expect this to be reflected on re-inspection of the wards.

The draft CQC report for Reaside inpatients and the FIRST teams has been reviewed for factual accuracy, and we expect to receive the final report by the end of May , for publication in June 2025.

Door Alarm System

To understand the impact of installing the door monitoring alarm system to date, a brief incident analysis was completed, and it was noted that the system enables the detection and therefore timely intervention of staff in 9 reported incidents. The bedroom door alarm system installation programme remains on track for completion by the end of June 2025.

Quality Management

To strengthen our assurance processes, further work continues to develop our quality management system, with a recent workshop held with key stakeholders to discuss how we

most effectively implement each aspect of the system. Additionally, targeted work is also being done to review all assurance audits completed by clinical teams to ensure they align with the requirements of Trust policies and procedures and enabling measurement of the most effective metrics that inform us about the quality of care being provided to service users. This includes the addition of all such audits to the new AMaT recording system enabling quick access and oversight of performance of a team or service.

Reducing Restrictive Interventions

The Reducing Restrictive Practice Steering Group (RRPSG) has continued to progress multiple workstreams, with a strong emphasis on incorporating the voice of Experts by Experience.

Seclusion posters have been finalised and are in the process of being rolled out across multiple inpatient areas, while communication videos are being reworked for potential integration into services.

Results from the Inpatient Questionnaire, led by one of our EBEs, have been discussed at RRPSG, shared via local Clinical Governance Committees (CGCs) and key actions incorporated into the 2025 service action plans.

The staff assault workstream has seen positive feedback from the Steps2Recovery Action Tracker, with plans to develop a staff resource pack.

Governance for soft restraint equipment has been strengthened with a new flow chart (incorporated into the relevant policy), and a re-audit of Seclusion and Long-Term Segregation is underway across all service areas.

Following on from the discussion of the use of Seclusion at Trust CGC at the end of 2024, a Seclusion Action Plan has been developed which is being actively worked through to continue to reduce the use of seclusion across inpatient sites, including a plan to relaunch of the Seclusion Review panels. Additionally, the Trust supported a national data submission on MHLDA services.

The November 2024 stocktake session confirmed good progress across directorates, with updated and new priorities now incorporated into 2025 workplans using Quality Management System principles; these workplans were shared at the February 2025 RRPSG meeting and will be monitored at regular intervals across the year.

The RRPSG continue to support discussions of trends observed of Restrictive Interventions used, as well as reviewing from a Health Inequalities and LDA perspective. These discussions have informed targeted pieces of work, e.g. activities at specific times on wards, increased training and awareness on the use of deltoid administration of depot medication.

NEWS

Culture of Care Programme update

The Culture of Care Programme continues to be scaled up across the Trust. The twelve standards care provide a co-produced, trauma informed and community connected framework for patient care and outcomes and have en of gaged colleagues locally in leading change challenges to improve patient and staff safety and their therapeutic environments.

We have a plan to extend the programme offer to all in-patient sites now and are working with the Care Quality Commission to align their new inspection framework based on ‘I

Statements' to create a single approach to understanding excellent inpatient care. You can see what the Reaside and Hillis Lodge staff, service users, stakeholders and EBE's got up to here - Coproduction in the Culture of Care: Live Love Life Programme at Reaside.

CQC Updates

Sir Mike Richards has been announced as the new Chair of the Care Quality Commission, along with the announcement of the first ever Mental Health Inspector role, to which Dr Arun Chopra has been appointed.

Sarah Bennett, who is our local BSoL inspector has recently announced her retirement. This is unfortunate news for us as we have developed a great working relationship and understanding with Sarah, but we hope to meet our new allocated inspector in the coming months and continue to maintain our good work and on system-wide improvements, and wish Sarah all the best for the future.

NHS Performance Assessment Framework

The updated Assessment Framework is replacing the current Oversight framework, setting out how success and areas for improvement will be identified and how Organisations will be rated. This will apply to trusts who provide services, and to integrated care boards (ICB) who have the responsibility to assess population need and arrange services to meet those needs.

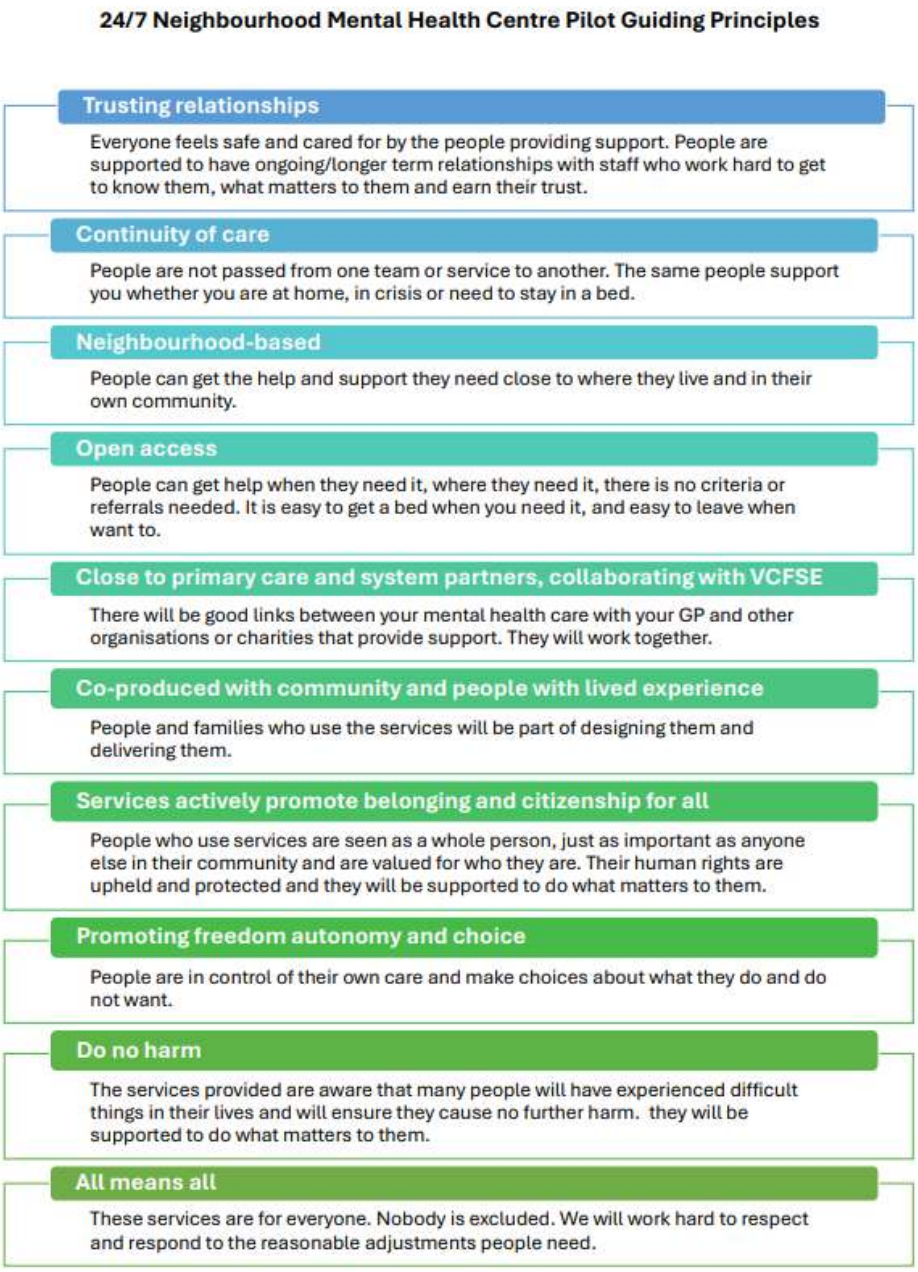
This updated framework, to reflect the new government's mandate to the NHS and the 3 shifts as part of the Health Mission, builds on the one which was developed following engagement with organisations such as the Local Government Association, Healthwatch, Association of Directors of Children's Services, National Voices, Local Authority Chief Executives and think tanks and was subject to a public consultation in summer 2024.

You can read about the consultation, testing, alignment and next steps here NHS England

NHS England » The NHS Performance Assessment Framework for 2025/26

24/7 Neighbourhood

Funded by NHS England over two years, the 24/7 neighbourhood pilot will adopt a successful model of mental health care used in other countries. Recognised by the World Health Organisation, it is regarded by many of our mental health clinicians as one of the best models of mental health care in the world. BSMHFT is one of six areas in the country developing this approach as 'pilot site'



This innovative initiative marks a significant step in transforming mental health care for our communities, *covering three wards in East Birmingham: Small Heath, Bordesley Green and Heartlands.*

Following the soft launch of the NMHC pilot, we're reintroducing regular Meet and Greet sessions for colleagues to learn more about the service, its delivery model, progress so far and future plans. These sessions will be held monthly thereafter, allowing everybody an opportunity to get involved.

ICB Blueprint

In early May, NHSE shared the first version of the Model ICB Blueprint , which is intended to help ICBs reduce their running costs by 50%.

NHS England asked all ICBs to submit cost reduction plans by the end of May 2025. In many areas of the country this is leading to discussions about new 'clustering' arrangements for ICBs to operate over larger populations than is the case. This is the case locally in the midlands with a number of options being considered. These changes are also leading to wider discussions on future Provider Trust responsibilities and arrangements.

For more information on the blueprint, please visit this web page - Model ICB Blueprint

BSMHFT NEWS

2025 Values Awards

We marked this year's Values Awards with a spectacular evening at Aston Villa Football Ground on Friday 23 May 2025. With over 300 guests in attendance and an incredible 450 nominations, this year's ceremony was our biggest and most inspiring yet.

The evening was dedicated to honouring our exceptional colleagues and services across 10 award categories. Thirty individuals and teams proudly took to the stage to receive their well-earned accolades, selected by our judges from a record-breaking number of nominations. Each of them has truly embodied our Trust Values - compassion, commitment and inclusivity - and made a significant impact on the mental health care we provide to our service users, carers and one another.

Our Values Awards are a cherished opportunity to reflect on and celebrate the remarkable achievements of Team BSMHFT over the past year. It's a moment to acknowledge the progress we've made, the challenges we've overcome and the countless lives we've touched.

This memorable event was made possible thanks to the generous support of our sponsors, Summerhill Services Ltd (SSL) - we are incredibly grateful for their partnership in helping us recognise the amazing work of our colleagues.

While we celebrated 30 outstanding winners on the night, we want to extend our heartfelt thanks to the 4,000+ dedicated colleagues who make up Team BSMHFT and continue to support people across Birmingham and Solihull every single day.

Roisin Fallon-Williams

Chief Executive Operations

Vanessa Devlin

Executive Director

8. Board Assurance Framework

Report to the Board of Directors						
Agenda item:	**8**					
Date	4 June 2025					
Title	Review of the 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:**

This report presents the Board Assurance Framework (BAF) to the Board of Directors for review, scrutiny and oversight following its review and recommendation by QPES, the FPP and the People Committee at their meetings in May 2025. Its purpose is to provide the Board with an update and assurance on the effective mitigation and management of strategic risks linked to the delivery of the Trust`s Quality, Clinical Services, People and Sustainability strategic priorities/objectives.

2. **Introduction:**

A BAF sets out and pulls together all strategic risks linked to the delivery of the Trust strategy while leveraging assurance that such risks are robustly and efficiently mitigated and managed in line with best practice and the Trust`s risk management arrangements.

There was some constructive challenge at Board Committees as members of QPES, the FPP and the People Committees reviewed and scrutinised their BAF risks. They noted the progress that has been made in mitigating and managing some of the BAF risks and requested that the scores of others be reviewed and aligned to reflect the commensurate progress that has been made. Changes to this iteration of the BAF are captured in `orange` and will be presented at the Risk Management Group on 19th June 2025 for approval and inclusion in the next BAF updates.

Key changes to this iteration of the BAF include:

- Request for the current score of SR1– ***(Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care)*** *to be reduced* from *Impact 5 x Likelihood 4 = 20 to Impact 4 x Likelihood 3 = 12* to reflect some of the progress that has been made with mitigating this risk.
- Request for the current score of **SR2** - (***Inability to attract, retain or transform a resilient workforce in response to the needs of our communities***) to be reduced from Impact 5 x Likelihood 4 = 20 to Impact 4 x Likelihood 3 = 12 to reflect some of the progress that has been made mitigating this risk.

- Both actions being implemented to manage SR4 – **(Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services),** to attain its target score and those actions RAG-rated `green` have now been completed and will be removed from the next iteration of the BAF.
- The current score of SR9 – ***(Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs)*** *has been reduced* from *Impact 4 x Likelihood 4 = 16 to Impact 4 x Likelihood 3 = 12* to reflect some of the progress that has been made with mitigating this risk.
- Some new actions have been added to this iteration of the BAF (*Please see SR6, SR7, SR8 & SR9 for details*).
- Request for current score of **SR8** - (***Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities***) to be reduced from Impact 4 x Likelihood 4 = 16 to Impact 4 x Likelihood 3 = 12 to reflect some of the progress that has been made with mitigating this BAF risk.
- The current scores of all three FPP BAF risks have been reviewed and a decision made not to recommend a reduction at this moment as the plan is to further mitigate, monitor and manage these risks in ensuring expected progress is accomplished.
- **SR6** – Title slightly tweaked with the word `national` replacing `environmental` to have it read as **`Failure to maintain acceptable governance and national standards`** for better alignment with the rest of the BAF risk entries.

3. Key issues and risks:

The main issue worth noting is the need to re-align the BAF to reflect any changes which may arise from the ongoing piece of work aimed at refreshing the Trust`s Strategy for 2026 – 2031.

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 of Directors is *requested to:*

1. ***REVIEW, SCRUTINISE*** *and provide* ***STRATEGIC OVERSIGHT*** *of the BAF.*

2. ***GAIN ASSURANCE*** *that the Trust`s Board Assurance Framework is effectively mitigated and managed in line with the Trust`s Risk Management Policy and best practice.*

Enclosures

Table 1: Summary of the Board Assurance Framework.
Table 2: Heat Map of the BAF.
Appendix 1: Details of the People Committee Board Assurance Framework.
Appendix 2: Details of the QPES Board Assurance Framework.
Appendix 3: Details of the FPP Board Assurance Framework.
Appendix 4: Details of QPES & FPP Shared BAF Risks.
Appendix 5: Details of the QPES Board Assurance Framework – continuation

Table 1: Summary of the Board Assurance Framework (BAF)

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**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.**						
SR1	Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.	June 2024	February 2025	DSPP	**3x3 = 9**	N/A	**5x4=20 4x3=12**
SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.	June 2024	February 2025	DSPP	**3x3= 9**	N/A	**5x4=20 4x3=12**
2.	**Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve.**						
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	Sept 2024	April 2025	CN	**4 x 2 = 8**	N/A	**4 x 4 = 16**
SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.	Sept 2024	April 2025	CN	**4 x 2 = 8**	N/A	**4 x 3 = 12**
3.	**Sustainability: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population**						
SR5	Failure to maintain a sustainable financial position.	Sept 2024	October 2024	DOF	**5 x 2 = 10**	N/A	**5 x 4= 20**
4.	**Shared Risks:** **Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve.** **&** **Sustainability: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population**						
SR6	Failure to maintain acceptable governance and national standards.	Sept 2024	April 2025	DOF / COO	**3 x 3 = 9**	N/A	**5 x 4= 20**

SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	March 2025	DOF / CN	**3 x 3 = 9**	N/A	**4 x 4 = 16**
5. 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.							
SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.	Sept 2024	April 2025	MD	**3 x 3 = 9**	N/A	**4 x 4 = 16** **4 x 3 = 12**
SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.	Sept 2024	April 2025	COO	**3x 3 = 9**	N/A	**4 x 3 = 12**

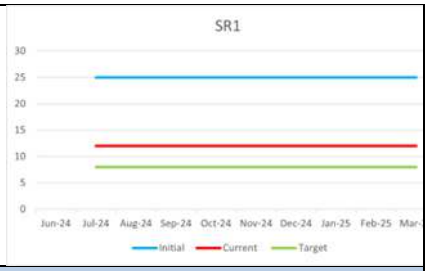
Table 2: Board Assurance Framework - Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic				SR1 SR2 SR5 SR6	
4 Major				SR3 SR7 SR8	
3 Moderate				SR4 SR9	
2 Minor					
1 Insignificant					

Appendix 1: Details of the People Committee Board Assurance Framework.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.**	• **Shaping our future workforce** • **Transforming our culture and staff experience** • **Modernising our people practice**	• Increased FTSU contacts. • Lack of early local resolution • Staff survey results • Colleague feedback	• 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.	People Committee	Executive Director of Strategy, People and Partnerships	SR2
RISK APPETITE		**Open** - Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. ***Target risk score range 9-10.***		**INHERENT RISK SCORE**	Impact 5	Likelihood 5	Risk score 20
				DATE RISK WAS ADDED	June 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5x Likelihood 4=20 **4 x 3 = 12**	Due to the consistent improvements in colleague engagement and improvements experienced across people processes although events are likely it is considered	**Impact 3 x Likelihood 3= 9**	A number of workforce plans focused on improved culture would have a positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce.	

	there will be moderate impact due to the consistency of the cultural improvements in place, this is further reinforced through programmes of work like that culture of care and the engagement seen through the authentic leader programme	**DATE OF LAST REVIEW**	13th May 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ Robust international recruitment process ▪ Robust workforce plan ▪ Stay Conversations ▪ Grow your own initiatives ▪ Apprenticeships ▪ Values in Practice Framework. ▪ FLOURISH ▪ Data with Dignity ▪ Divisional Reducing Inequalities Plans ▪ Restorative Learning and Just Culture programme. ▪ No Hate Zone ▪ Community Collaborative ▪ Training Needs Analysis ▪ First line manager training ▪ Compliance with Trust policies ▪ Staff survey ▪ Pulse survey ▪ Leavers surveys ▪ Stay conversations ▪ Active bystander training ▪ PSRIF ▪ Reducing Health Inequalities ▪ Complaints and concerns ▪ Restorative Just and Learning Culture roll out ▪ Culture of Care-Incorporates Anti Racism ▪ Authentic Leadership programme	▪ No formalised marketing and attraction strategy/plan. ▪ Inability to match recruitment needs (due to national and local shortages). ▪ . ▪ Colleagues not engaging in controls set. ▪ Lack of local accountability. ▪ Not following values and behaviors framework. ▪ Colleagues not completing surveys. ▪ Non-attendance at training.

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	30th September 2025	All Divisions now have reducing inequality plans, milestones are currently being reviewed. Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed.
Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	31st March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. Policy awaiting final confirmation at TCSE in March 2025. Anti Racist practitioner and leader remaining to be rolled out.
Take PCREF from pilot to full implementation.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	31st March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. PCREF to be incorporated into HI plans and also key corporate frameworks i.e. PSIRF.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • 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 Programme • Patient Carer Race Equality Framework.	• Diversity gaps in senior positions. • Gender pay gap. • Cost of living increases with AfC pay-scales not as competitive as some private sector roles. • WRES and WDES indicators.	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management	• Data quality concerns for all demographics. • Changes not translating into change of experience at the pace and levels of sustainability we would require.

• Values In Practice feedback process. • Behavioral framework • Inclusive health & wellbeing offer. • Management essential and people related training. • Improved experience scores on staff survey Improved retention rates. • EDI Improvement plan. • Increase in staff survey engagement ▪ Reducing time to recruit ▪ Exec and system vacancy controls in place ▪ Temporary Staffing reduction plans ▪ NHSP and Direct Engagement being utilised • Divisional Workforce plans in place • Culture of Care roll out • Race Code Quality Mark			

Update since last review:

30 Jan 2025
Risk newly assessed with inputs from the team and presented for Exec sign-off.

31/01/2025
BAF risk has been updated to reflect the recommendations from the last People Committee as specific action due dates have also been included.

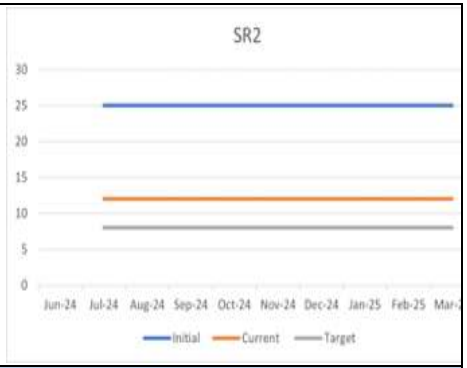
15 Feb 2025
Gaps in assurance have been added.

13th May 2025
Increased assurance and reduced gaps in assurance with a proposed reduction in score

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	**Inability to attract, retain or transform a resilient, productive and affordable workforce in response to the needs of our communities.**	• **Shaping our future workforce.** • **Transforming our culture and staff experience.** • **Modernising our people practice.**	• Increased demand. • Reduced pipeline locally and nationally to fill workforce gaps. • Reduced training commissions. • Hard to fill specialty posts across multiple professions on a national scale. • Poor management of people related matters. • Insufficient HWB offer.	• Reduced capacity to deliver key strategies, operational plan and high-quality services. • Increased staff pressure. • Continued reliance on temporary staffing. • Reduced ability to recruit the best people due to deterioration in reputation. • High turnover • Increased sickness levels.	People Committee	Executive Director of Strategy, People and Partnerships	SR1

RISK APPETITE			INHERENT RISK SCORE	Impact	Likelihood	Risk score
Open - Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. ***Target risk score range 9-10.***				5	5	25
			DATE RISK WAS ADDED	June 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY

Impact 5 x Likelihood 4=20 4 x 3 = 12	Despite continuing demand and acuity pressures, workforce is in a healthier position with the vacancy factor reduced, turnover improved and pipelines have been strengthened. The staff survey results show improvements in staff experience particularly against the People Promise. Challenges remain in hotspot areas which are now being addressed through a more targeted approach.	**Impact 3 x Likelihood 3 = 9**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce.	
		DATE OF LAST REVIEW	13th May 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ International recruitment pipeline. ▪ Safer Staffing model ▪ MHOST ▪ E-Rostering compliance. ▪ Training Needs analysis. ▪ Leaver's questionnaires. ▪ Stay conversations ▪ Staff Survey ▪ Pulse survey ▪ Values and Behavioural framework. ▪ Robust People processes. ▪ Robust temporary staffing processes. ▪ Retention plan ▪ Health & wellbeing offer. ▪ Flexible retirement options ▪ To support and implement system priorities such as 4 Rs (Reconnect, Recruit, train and Retain, Resilience and reform). ▪ Focussing on hotspots ▪ Reducing time to recruit ▪ Exec and system vacancy controls in place ▪ Temporary Staffing reduction plans ▪ NHSP and Direct Engagement being utilised ▪ Divisional Workforce plans in place	▪ Delays in time to hire. ▪ No formalised marketing and attraction strategy / plan. ▪ Inability to match recruitment needs (due to national and local shortages). ▪ High dependency on temporary staffing. ▪ Not using E-Rostering to full ability. ▪ Not following values and behaviours framework. ▪ People processes not being adhered to.

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Decrease use of bank in line with growth of substantive workforce.	Head of Workforce Transformation	31st March 2026	Bank has decreases but at a slower rate than the substantive workforce had increased. Working alongside Trust and system colleagues to implement robust plans to achieve bank reduction.
Monitor and support the implementation of divisional workforce plans through SOFW	Head of Workforce Transformation	31st March 2026	Plans have been developed and will be reported on a rolling basis to SOFW which will be targeted on their hotspot areas
Implementation of the agreed People Promise priorities for 25/26	Head of workforce Transformation	31st March 2026	Following the workshops and the staff survey res

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • Values based recruitment • Flexibility with the targeted use of Bank incentives and Trust-wide reward. • Improving vacancy and turnover performance. • Customer satisfaction survey positively improving. • Values based recruitment • Stay conversation data • Comprehensive health & wellbeing offer. • Increased % of staff recommending BSMHFT as a place to work. • Improved staff engagement scores.	• Diversity gaps in senior positions. • Gender pay gap • Workforce gaps • Cost of living increases with AfC pay-scales not as competitive as some private sector roles. • WRES and WDES indicator 2 (likelihood of appointment from shortlisting). • Colleagues not adhering to flexible working initiatives in some areas. • Non-adherence to values-based recruitment principles.	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention. • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management.	• Data quality concerns for all demographics. • Changes not translating into change of experience at the pace and levels of sustainability we would require.

• Reduction of the vacancy gap from 10.4 to 7.1% in 24/25 • Improved recruitment timeline. • HR KPI reports • Increased use of social media to attract.			

Update since last review:

21st October 2024
Risk newly assessed with inputs from the team and presented for Exec sign-off.

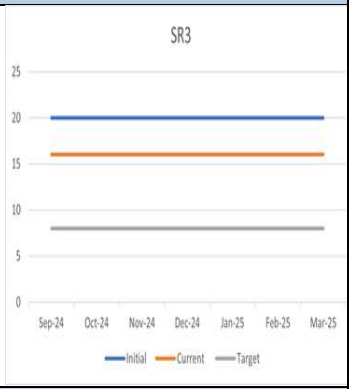
29 January 2025
Risk newly assessed. Has not achieved target score due to the following - Hot spot areas remain in terms of vacancies, turnover and temporary staffing usage. Issue with culture, bullying harassment, increasing sickness and ER cases are still impacting staff experience, team effectiveness and resilience.

15 Feb 2025
Gaps in assurance have been added.

13 May 2025
Risk has been reviewed and a recommendation for a reduction in score suggested.

Appendix 2: Details of the QPES Board Assurance Framework

SR3	**Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.**	• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively	• Lack of implementation & embedding of QI processes. • Unwarranted variation of quality of care. • Insufficient focus on prevention and early intervention. • Poor management of the therapeutic environment. • Limited co-production with services users and their families.	• Failure to meet population needs and improve safety. • Variations in care standards and outcomes. • Unwarranted incidents • Failure to reduce harm. • Poor patient experience.	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR4 SR8 SR9
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.***		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Risk score 20
				DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	12th May 2025	
CONTROLS/MITIGATIONS			**GAPS IN CONTROL**	

• Process in place to review and learn from deaths • Clinical Effectiveness process including Clinical Audit, NICE • Implementation of PSIRF • Trust Safety Huddle • Safer Staffing Committee • Transition to LFPSE • Patient safety education and training • Implement a culture of continuous learning and improvement. • Mental Improvement Programme work as defined in the Patient Safety Strategy. • Development and application of RRP Dashboard. • Process in place to for staff, service users and families to raise concerns • Programme of external audit. • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Internal adoption of a transparent Quality/assurance process AMaT implementation. • QI Resources and projects in place • CQC Insight Data and regular joint meetings. • Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme). • Coroner's Reports • QSIS compliance • Shared Care Platform • Capital prioritisation process • Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation. • Bronze Silver Gold Escalation/Resolution Process. • Agreement on process for sharing information and providing assurance to stakeholders in place with MHPC, ICB, NHSE and CQC.	• Gaps in MHA Action Plan oversight arrangements from CQC inspections – now complete, in place and reporting through CGC • Clinical Governance structures from Ward/Team to Board. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR and documentation framework for RMS highlighted as a challenge. • Levels of training and support for supervision, protected time for all substantive registrants now completed Clinical supervision in excess of 83% for three months • Inability to embed a culture of continuous learning and improvements, sharing learning across the organisation. Sign off of SJRs and assurance on PSIRF now incorporated into Trust Clinical Governance Committee. • Clinical Audit Framework and full implementation of the audit framework on AMAT. • Full implementation of Dialogue+ • Workshop on QMS held in May

ACTIONS PLANNED

Action	Lead	Due date	Update
Roll out of Culture of Care Programme across all in-patient areas during 2025/26	CN	31st March 2026	Reaside Clinic programme progressing, wards in all divisions now participating in the programme, plan in place for sign up for all areas. Ardenleigh site to go live from May. Reaside CQC regulatory notice now removed. Eight additional wards now

			signed up to National process. Discussion with NHSE and CQC about aligning CQC I Statements with 12 Culture of Care Standards, to be presented at National CoC steering group. Scaled roll out plan now in place for the Trust. Monthly Executive chaired CoC meeting remains in place at Reaside Clinic.
Implement new policy in support of Clinical Supervision, providing a framework for professional uptake above 80% each month	CN	30th June 2025	Draft policy ready for approval, includes protected time for professional staff to participate in clinical supervision Clinical supervision uptake and recording above 83% for three consecutive months.

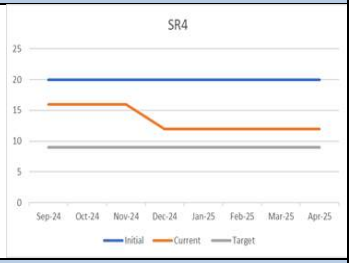
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
<u>Learning for improvement</u>: • Structured Judgment Reviews reviewed at local safety panels. • Corporate led learning from deaths meeting. • Executive Director's Assurance Reports to QPES Committee and Board. • NHS Digital Quarterly Data • Commissioner and NED quality visits. • CGC Local review has been completed and actions implemented. • Action in place in respect of the learning from Greater Manchester and Nottingham. • Physical Health Strategy	• Reaside regulatory notice environment and governance. • Reaside FTSUG Regional escalation. • Reaside CQC Report • Zinnia Centre CQC Sec 64 Letter. • External Audit Clinical Governance Review (18 recommendations). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation. • Zinnia CQC report	• CQC planned and unannounced inspection reports. • Reaside commissioned support programme and Culture of Care Programme. • Door alarm implementation programme. • Internal and External Audit reports. • Triple A reporting to QPES from CGC. • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • QMS update reporting to QPES • QI reporting to Trust and Local CGC's, STMB and requested for regular QPES/Board- This has been embedded from June 2024 with regular reports built into committee planning structures. • Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board. • Independent annual assessment against the 68 NHS Core Standards for EPRR. • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation Meeting.	• The availability of real time safety data to triangulate information. • Analysis and triangulation of data across different sources needs is weak and inconsistent. • Lack of an accountability framework in place for how actions from Ligature and Environmental risk assessments are overseen/managed at Divisional level with stratification of associated risk at trust level.

	• PFD on learning identification through internal investigations.	• Submission made to the CQC in response to the Sections by the required deadline in December 2024, showing improvement in the areas that were highlighted. • Safer staffing assurance report for QPESC	
LINKED TO RISK REGISTERS/CRR RISKS			
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.		
Update since last review:			
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**			
5th March 2025 Local CGC (LCGC) Review completed. TOR adjusted and standardised across all directorates. LCGC Agenda also updated, refreshed, and used similar TCGC style template for agendas (3 as per theme months). Consultation exercise undertaken with executive colleagues. Consultation exercise undertaken with Directorate SLT – concluded 6th of January. Final amendments to be made and new LCGC process rolled out. New LCGC process has been augmented with improved, bespoke reporting on quality, safety and experience, with learning from death reporting due to be rolled out in March. Transition of senior leadership roles in Nursing and Quality Directorate in support of new structure. Review and consolidation of learning to date and next steps in respect of Greater Manchester and Nottingham, learning to link in with steps to develop integrated community working in addition to review of Paranoid Schizophrenia Pathway. Bronze Silver Gold escalation Protocol implemented for patients waiting in Emergency departments for assessment or admission for treatment. Review of transfers to Acute Trust due to physical health needs. PEAR ToR updated and agreed at QPESC			
8th April 2025 BAF actions updated. CQC removed regulatory warning notice from Reaside Clinic.			

2nd workshop on clinical governance completed – focussed on integrating PSIRF and effective Divisional Governance Meetings. Culture of Care Programme four more wards sign up to national programme. Clinical supervision 83% compliance. Meeting between ICCR and Acute Care to enable safer transfers of care between community teams. Waits for patients with a mental health presentation reducing in Emergency Departments.
12th May 2025 Workshop with Clinical Governance Committee members on use of data and structure of local meetings, workshop on use of Quality Management System. Incorporation of oversight of PSIRF process and sign off of Subject Judgement Reviews moved to executive chaired Clinical Governance Committee Quality priorities for 2015/26 agreed, updated BAF actions to be provided in June. ICB Summit on Mental Health in Emergency Departments attended; assurance on progress provided and actions agreed in terms of provision and partnership working with Queen Elizabeth Hospital. Policies identified for update and renewal, Trust lead in place with plan to address policy position, presentation given at SLT on plan with action agreed to utilise artificial intelligence as a tool. Senior staff nurse vacancies in ICCR appointed too in support of learning from Nottingham. Appointment of substantive lead for Learning Disability and Autism.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.**	• **Quality** ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively.	• Inability to effectively collate, share and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover • Overreliance on bank and agency staff. • 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. • Increased waiting list time affecting care and support for patients and their families and carers. • Families and carers not always engaged in care planning. • Estate /environment not fit for purpose in some areas. • Poor food choices and opportunities in some settings. • Lack of understanding of sphere of influence for clinical facing teams.	• 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 from staff and patients, families and carers. • Reactive rather than proactive service model • Increased service demand.	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR3 SR8 SR9

RISK APPETITE	**Cautious** - Accept need for operational effectiveness with risk mitigated through careful management limiting distribution. ***Target risk score range 6-8.***	INHERENT RISK SCORE	Impact	Likelihood	Risk score
			4	4	16
		DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	8th April 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Community transformation • The design of a Community Engagement Framework being led by the ICBQI Programmes with our EBE`s/ HOPE Strategy. • IPEAR representation • Recovery for all team • Trust induction sessions • EBE educator programme • Recovery College • Participation & Experience team members in each division. • HOPE (Health, Opportunities, Participation, Experience) action groups. • LEAR action groups • EBE recruitment panel programme. • Carer strategy • QPESC Visits • Chair and Non-Executive and Executive Director Visits. • Board and QPESC Stories • Healthwatch reports • PALS and Complaints access, resolution and learning.	• Challenges around workforce as genuine engagement requires sufficient and consistent staff. • Turning off part of CPA where family and carers were being recorded and offered family engagement tool – risk that Dialog + won't always capture family and carers needs / support Ongoing work around preventative needs and stigma 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 use of bank and agency staff can impact on our capacity to build relationships with families. • Implementation of 'In Mustak's Steps' 15 steps for BSMHFT. • Framework for aligning reporting to QPESC using 'I statements'.

ACTIONS PLANNED

Action	Lead	Due date	Update
Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement	31st March 2025	• Review in scope working with MHPC. • Definition required for the interface between community engagement and patient experience. • Workshop held identifying how to increase the voice of service users through Trust governance. • Regular reporting to QPESC in place. • Completed
Development of Fifteen Steps Model 'In Mustak's Steps'	AD	31st March 2025	Coproduction of this in development with EBE's. Model to commence in April 2025 and project plan to be presented at PEAR in December 2024 and shared with QPES in January 2025. Completed.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• FFT • Healthwatch • EbE Observer project • Patient councils in Secure Care. Urgent care, CMHT and D&F.	• Community Mental Health survey	• Monthly reports on participation and engagement presented QPES • QI Reports • Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey. • Executive oversight of the engagement activities. • Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated through PEAR.	• Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance through clinical governance committee. • Inability to integrate and effectively use data in reporting – Inability to integrate and triangulate data from patient experience and PALS/Complainants effectively. • Patient safety partners are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised Clear reporting structure and attendance at safety meetings Project overview available.

LINKED TO RISK REGISTERS/CRR RISKS

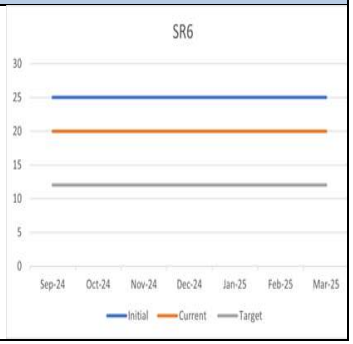
Risk 824	Failure to ensure that patient information leaflets and posters are available in a range of languages would result in a breach of regulation 10(2)(c) and the Equality Act 2010.
Risk 1023	Risk that families and carers are not consistently involved in risk history, risk assessment and care planning for patients, resulting in the potential for inadequate support and avoidable harm to patients.
Update since last review:	
5th March 2025 Additional actions being taken to align capture of patient experience data with 'I statements' Addition of EBEs to Culture of Care Programmes in services	
8th April 2025 15 step programme pilot commenced. Led by Participation & Experience Manager, monthly updates will be shared at PEAR and advised through Triple A to QPESC. Patient / Service User Council action plans to be shared through PEAR to provide further assurance of the patient Voice. Action have been updated.	

Appendix 3: Details of QPES & FPP Shared BAF Risks.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS

SR 6	Failure to maintain acceptable governance and national standards.
	
	• **Progress in delivering national standards including:**
	  • **Reducing Inappropriate Out of Area Placements in line with agreed reduction targets (0 for acute and 10 for PICU) and maintenance.**
	  • **Service users followed up within 3 days of discharge.**
	  • **Reducing long waits for accessing CMH and CYP services.**
	  • **Achieving and maintaining national waiting time standards for accessing Talking Therapies services.**
	  • **Achieving and maintaining Reliable Improvement and Recovery rates for**
		• **Operational Strategies and Transforming Care Programmes covering Acute & Urgent Care, ICCR, Specialties and Secure Services.**	• Low number of adult and older adult beds per weighted population, below national average
			• High levels of admissions under the mental health act
			• Acuity of patients impacting on having longer lengths of stay
			• Available bed capacity in adult and older adults constrained by high number of Clinically Ready for Discharge (CRFD) patients also impacting on increasing length of stay.
			• Availability of timely access to discharge destinations for CRFD patients including impacts
				Service users being placed in OOA placements moving patients away from local networks/support and incurring additional increased expenditure.
				
				Agreed national reduction targets for inappropriate OOA placements not being met and impacting on patient experience.
				
				Patients not being admitted to a local bed in a timely way, service users waiting for admission and being managed in the community.
				
				Patients who are CRFD remaining in inpatient care longer than is required impacting on increasing length of stay.
				
				Long waits for ADHD assessments affecting CYP waiting times
				
				Financial impact on Trust if Talking therapies activity levels not met
				
				Increased risk to service users not followed up with 3 days of
					FPP / QPES	Executive Director of Finance
						
						&
						
						Chief Operating Officer
							SR5
							SR7

	service users accessing Talking Therapies services.		of social worker availability, funding of placements, availability of appropriate placements. • High bed occupancy levels reducing bed availability. • High CMHT caseload numbers – maintain contact and engagement with service users.	discharge. High DNA rates in CMH services. Impact on ability to manage patient flow across services from early intervention/prevention, reducing escalation in service user's needs and reducing admission/reducing need for crisis support.			
RISK APPETITE		**Eager** - Application of dynamic environment-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements. ***Target risk score range 12.***		**INHERENT RISK SCORE**	Impact 5	Likelihood 5	Risk score 25
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5 x Likelihood 4 = 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 3 = 12**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	6th May 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• 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. • Trust Sustainability and Net Zero Group established. • Heat De-carbonisation reviews across sites. • Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme. • Delivery of the Trust Green Plan and the built in Action Plan. • 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. • Inappropriate Out of Area numbers/ 3 day Follow up reported via Trust FPPC and local Service FPPCs and included in IPD • Daily 3 day follow up notifications in place for clinical teams • Community waiting times reported via FPPC against trajectory and granular reports available to clinical teams to manage and progress at patient level. • Patient Flow Steering Group in place to oversee reduction is use if out of area placements with workstreams looking at demand management/ Locality Model/CRFD and Length of Stay. • Service level Deep dive meetings cover national indicators, waiting times and benchmarking.	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • 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. • 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.

ACTIONS PLANNED

Action	Lead	Due date	Update
Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	31st March 2027	Helps to mitigate impact on carbon and environment. The Sustainability / Green Group does not impact on major factors in for example 'Failure to maintain acceptable operational governance and environmental standards I.e. death / serious injury'. The Green Plan is in direct response to the NHS E mandate and Carbon Net Zero with targets at 2030/32, 2040 and UK wide legislation at 2050.

Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust/ SSL	31st March 2027	Mitigation of backlog is progressed via SSBM, Capital programmes and Maintenance regimes where Trust finances allow Replacement of current Reaside facility to address poor functionality, Service user accommodation and environmental system life cycle impacts is a Trust led major project This is as before a Trust not SSL action. In any event it is logical that the action will remain until either the Trust decides to stop trying to replace Reaside and / or secures the necessary funding for a major project.
Development of Action Plan to address under performance in Talking Therapies.	AD for Specialties	22nd April 2025	Completed
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31st Dec 2025	On track
Productivity Improvement Plan developed and implemented within Acute & Urgent Care.	AD for Acute & Urgent Care	31st March 2026	On track

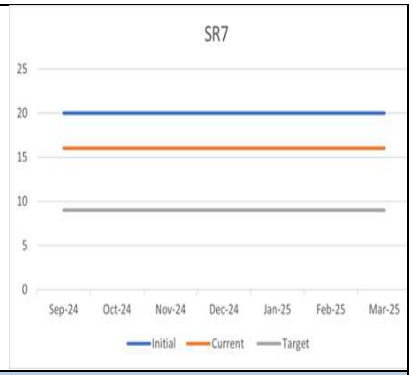
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Performance reported to FPPC. • Governance arrangements for monitoring the quality of care	•	• Inspection reports. • Compliance audits. • Self-assessment, accreditation and self-certification reports. • External visit reports. • Peer Reviews • Board Assurance Framework Report.	• Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Poor learning from previous regulatory inspections. • Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. • Peer review not very regular. • The culture of BAF not fully developed and embedded.

provided to patients in non-BSMHFT beds in place.			
LINKED TO RISK REGISTERS/CRR RISKS			
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.		
85	Non-compliance with E and F statutory standards in external landlord-controlled buildings.		
1459	Reaside- backlog condition and clinical functionality.		
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.		
Update since last review:			
21st October 2024 Risk newly assessed with inputs from the team and presented for Exec sign-off.			
10th February 2025 SR6 reviewed and new entries captured.			
15th April, 2025 Specific action due dates have been inserted in replacement of using the expression `ongoing` as due date and in response to the recommendation of the Internal Auditors.			
6th May 2025 S29A notice (around environment and related governance arrangements) has been removed from Reaside.			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 7	**Failure to deliver optimal outcomes with available resources**	• Achieving and maintaining delivery of 'Culture of Care Standards for Mental Health Services', comprising: ❖ Lived Experience — We value lived experience. ❖ Safety — People feel safe and cared for. ❖ Relationships — High-quality and trusting. ❖ Staff support — Present alongside distress. ❖ Equality — We are inclusive, value difference and promote equity. ❖ Avoiding Harm — Actively avoid harm and traumatisation. ❖ Needs Led — We respect people's own understandings. ❖ Choice - Nothing about me without me. ❖ Environment — Spaces reflect the value we place on our people ❖ Things To Do — Requested activities every day. ❖ Therapeutic Support — We offer a range of therapy. ❖ Transparency — We have open and honest conversations	• Inadequate resources • Staff do not understand or commit to the standards • Competing priorities • Variation in performance between teams • Shortage of suitably qualified and experienced staff and leaders • Lack of meaningful data and evidence. • Unwarranted variation of quality of care.	• Patient outcomes and satisfaction are less than optimal • Services are not responsive or consistent	FPP / QPES	Executive Director of Finance & Executive Director for Quality & Safety/ Chief Nurse.	SR3 SR4 SR5 SR6 SR8

RISK APPETITE	**Open** - Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. ***Target risk score range 9-10.***	INHERENT RISK SCORE	Impact	Likelihood	Risk Score
			4	5	20
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY

Impact 4 * Likelihood 4 = 16	We are developing measures to demonstrate these outcomes in a systematic way, or focus our resources on their achievement, so there is currently no data to provide assurance of a lower risk	**Impact 3 * Likelihood 3 = 9**	It is a core purpose of the Trust to deliver against the culture of care standards, although there will always be competing demands	
		DATE OF LAST REVIEW	12th May 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ Process in place to review and learn from deaths. ▪ Clinical Effectiveness process including Clinical Audit, NICE. ▪ Implementation of PSIRF ▪ Implement a culture of continuous learning and improvements. ▪ Mental Health Improvement Programme work as defined in the Patient Safety Strategy. ▪ Development and application of RRP Dashboard ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. ▪ Internal adoption of a transparent Quality/assurance process AMaT implementation. ▪ CQC Insight Data and regular joint meetings ▪ Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme). ▪ Use of workforce resources; e-roster compliance, reduction in temporary staffing. ▪ Coroner's Reports ▪ Capital prioritisation process ▪ Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation.	▪ Lack of aligned comprehensive assessment of delivery against culture of core standards. ▪ Lack of process that explicitly prioritises process against culture of care standards. ▪ Discharge for patients under section who are clinically ready for discharge requiring social care assessment and placement

ACTIONS PLANNED

Action	Lead	Due date	Update
External Culture of Care and Leadership Review of Reaside.	Executive Director	30th April 2025	External review launched and underway at Reaside Clinic, involvement of staff and service users, initial launch with leaders completed, launch with staff and service users in April with 'sort our

	Quality & Safety		site out' event, external reviewers reporting excellent cooperation. CQC regulatory notices removed and draft report received for factual accuracy
Agree a set of metrics aligned to the programme.	EDQ&S	31st May 2025	Work underway with National Programme to develop metrics. Alignment of CQC I Statements to the 12 core standards in the CoC Programme
Programme to be scaled up from four wards across the Trust to all wards from April on a rolling programme.	EQD&S	31st August 2025	Programme plan now agreed with prioritisation of areas, Phase 1 - Secure and Offender Health, Phase 2 -Steps 2 Recovery, Phase 3 – Specialities and Older People, Phase 4- Acute Wards. All Divisions have at least one ward now actively engaged with the programme

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting. • Participation Experience and Recovery (PEAR) Group.	• Reaside regulatory notice environment and governance. • Leadership and culture issues identified at Reaside which are being tackled. • Reaside FTSUG Regional escalation. • Zinnia regulatory notices.	• Ongoing culture of care and leadership external review of Reaside. • CQC planned and unannounced inspection reports. • Internal and External Audit reports • Triple A reporting to QPES from CGC • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • Co-produced Trauma informed recovery focussed training rolled out (NMHT).	• Lack of real time safety data to triangulate information. • Strengthening of processes is required for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded. • Lack of a strong service user/carer voice across all of our governance forums. • Variations in inputs across pathways.

LINKED TO RISK REGISTERS/CRR RISKS	
1023	Risk that families and carers are not consistently involved in risk history, risk assessment and care planning for patients, resulting in the potential for inadequate support and avoidable harm to patients.
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.
Update since last review:	

9th March 2025 Programme plan in place, all divisions signed up to participate, External review of Reaside Clinic has started and CQC re-inspection has taken place.
12th May Launch for Ardenleigh planned for June 2nd. Experts by experience embedded in local governance groups and Executive chaired programme board for Reaside Clinic. Visit with CQC Inspector and NHSE Lead, agreement to align CoC standards and CQC I Statements to provide framework for excellence for Mental Health Inpatient Services. Trust wide project on 'A good working day' launched. Reaside declutter and decorate completed with plans to complete patient bedrooms and hold an annual tidying programme.

Appendix 4: Details of the FPP Board Assurance Framework

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 5	**Failure to maintain a sustainable financial position** **NB In this context, a sustainable financial position means an in year AND underlying breakeven over next 2 years and sufficient cash headroom.**	• **Sustainability** ❖ **Balancing the books**	• *Poor financial management by budget holders.* • *Inadequate financial controls.* • *Cost pressures are not managed effectively.* • *Savings plans are not implemented.*	• Trust not meeting its financial targets limiting available funds for investment in patient pathways.	FPP	Executive Director of Finance	SR6 SR7

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
Open: Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels. **Target risk score range 9-10.**			5	5	25
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact: 5 x Likelihood 4= 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 5 * Likelihood 2 = 10**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	16th April 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• 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. • Savings Policy • Sustainability Board review. • ICS expectations and reporting requirements.	• Consequences of poor financial performance do not attract any further review. • Requests for cost pressure often made without following agreed process. • Attendance at Sustainability Board variable.

			• Trust has not been able to develop a pipeline for delivery of savings.
ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
To roll out of new finance reports – work is ongoing to identify the capability within the ledger system, the training and resource requirement including specialist expertise.	Deputy Director of Finance	30th September 2025	Finance teams have adjusted their local level reporting, and have a session with an external partner to share learning around Power BI finance tools. The changes to the ledger, and chart of accounts from the imminent changes as a result of BSMHFT receiving services currently provided by BWCH means that all financial reporting arrangements will need to be reviewed.
To develop a pricing policy to ensure that new services and developments cover all of the relevant costs, eliminating the risk that the Trust would need to cover unplanned costs.	Deputy Director of Finance	30th June 2025	The financial management team are currently developing the draft policy, with input from the business development team, PMO and other teams.
To change the focus of Sustainability Board to ensure that operational ADs are required to present feedback on their own financial performance as well as updates on savings plan delivery.	Deputy Director of Finance	30th April 2025	Agenda amended for Sustainability Board to be held on 24th April 2025.

POSITIVE ASSURANCES	**NEGATIVE ASSURANCES**	**PLANNED ASSURANCE**	**GAPS IN ASSURANCE**
• Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations, including any shortfall in savings delivery.	•	• 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 to 24/25.	• 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. • HFMA sustainability audit has identified a number of development areas that would improve controls and performance.

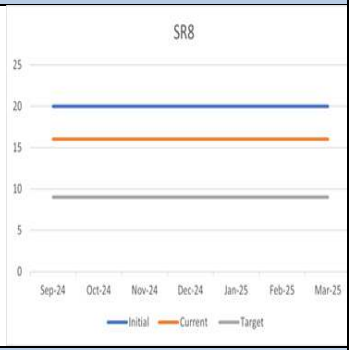
LINKED TO RISK REGISTERS/CRR RISKS	
108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.
112	The Trust does not secure the growth funding we require.

Update since last review:
21st October 2024 Risk newly assessed with inputs from the team and presented for Exec sign-off.
16th April 2025 Risk has been reviewed, a completed action closed and removed following approval at the RMG and two new actions added.

Appendix 5: Details of the QPES Board Assurance Framework – continuation

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES		CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.**		• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience. ❖ Using our time more effectively	• Inability to effectively use time resource in driving learning and transforming services. • Inability to develop and embed an organizational learning and safety culture. • Failure to identify, harness, develop and embed learnings from deaths processes. • Lack of support for and involvement of families and careers. • Lack of effective understanding by staff of what the Recovery Model is about and its expectations. • Services that are not tailored to fit the needs of our local communities	• 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. • 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. • Some communities being disengaged and mistrustful of the Trust. • Negative impact on	QPES	Executive Medical Director	**SR3** **SR4** **SR9**

			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.	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.			
RISK APPETITE		**Open** - Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance. ***Target risk score range 9-10.***		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Risk Score 20
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 3x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	24th April 2025	
CONTROLS/MITIGATIONS			**GAPS IN CONTROL**	

• ~~SI oversight Group~~ • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels. • Culture of Care national QI and other pieces of QI projects that address health inequalities. • 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. • 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. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • 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 implementation. • Community caseload review and transition.	• 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 wide reporting of LFE metrics. • Family and carers pathway not consistently applied or suitable for all services. • Performance in these areas is not effectively measured. • Divisional inequalities plans not fully finalised for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day job. • Inability to identify milestones that reduce health inequalities and improve patient experience. • Inability to identify clear data metrics to demonstrate impact (Cause and effect) in reducing health inequalities.

• Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work. • Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighbourhood teams. • Development of community • Active by-stander training. • Culture, Humility and Safety training. • Community specific training by community assets.	

ACTIONS PLANNED

Action	Lead	Due date	Update
To audit health inequalities footprint within the Trust`s governance and reporting arrangements from `Ward to Board`.	AD Corporate Governance	30th November 2025	This will facilitate an evaluation and understanding of the extent to which governance reports are written and presented through the lens of health inequalities.
Review and refresh of the family and carer pathway.	AD for Allied Health Professions and Recovery	Request for action due date to be extended from March 31st, 2025, to 30th November 2025 to enable widening and completion of action.	The use of dialogue + and Think Family principles along with family and carer recovery college sessions will support the family and carer voice. This will be reviewed at quarterly intervals through PEAR meeting and Participation reports at local CGC
Ensure Divisional Health inequality Plan milestones are established and monitored.	Associate Directors of Operations	31st March 2026	On track
Dialogue+ roll out	Deputy Medical Director for Quality & Safety	31st March 2026	On track

Development and implementation of a health inequalities dashboard.	Associate Director Performance	31st March 2026	On track

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• 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. • New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. • Participation Experience and Recovery (PEAR) Group. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.	• Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	• Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering • Performance Delivery Group "deep dives". • Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feed to Inequalities 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. • Senior leader session/Board meeting- to discuss how to use QI methodology- driver diagrams, plan, and risk asses, etc. Check knowledge. New First line manager QI training now in place: QI methodology in day-to-day leadership- using process mapping, driver diagrams, read data etc. • The Safety Summits are in their early conception and may not be adopted well by Divisions/services. • Work to be undertaken to embed human factors/just culture. • Inability to engage with all parts of the Trust.

LINKED TO RISK REGISTERS/CRR RISKS	
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.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments.
Update since last review:	

21st October 2024 Risk newly assessed with inputs from the team and presented for Exec sign-off.
24th October 2024 *Divisions have now completed their divisional health inequalities plans.*
24th April 2025 Risk reviewed and new controls and actions have been added.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 9	**Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.**	**Clinical Services** • Community transformation • Inpatient transformation • Improving access • Patient flow improvement programme • Partnership working • Urgent care transformation • Children and Young People new model of care.	• Demand for services exceeding our capacity including increase in demand for inpatient services. • Increased demand in the community. • Limited capacity in social service provisions. • Lack of partnership and effective system working. • Organisation delivering transformation but not joined-up. • Long waiting times to access services. • Inadequate support for our service users with mental health co-morbidities. • Not thinking as a system in developing priorities and pathways. • Fragmented pathways and interfaces. • Lack of service user voice in informing	• Service users being cared for in inappropriate environments when in crisis. • Increased OOA and the financial consequences. • Increased pressure on A&E in acute hospitals. • Increased waiting times/waiting list and backlog. • Negative impact on recovery and length of stay/time in service. • Negative impact on service user access, experience and outcomes. • Lack of joined up pathways and care. • Service users falling between gaps. • Inferior and poor care. • Increased risk of incidents. • Provision in the community not available.	QPES	Executive Director of Operations.	SR3 SR4 SR8

			service transformation. • Lack of support for and involvement of families and careers. • The difficult financial landscape.				
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. **Target risk score range 9-10.**		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Total score 20
				DATE RISK WAS ADDED	September 2024		
CURRENT RISK SCORE	**RATIONALE**		**TARGET RISK SCORE**	**RATIONALE**		**RISK HISTORY**	
Impact 4 x Likelihood 3 = 12	Current score demonstrates the controls in place and level of assurance evidenced.		**Impact 3 x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.			
			DATE OF LAST REVIEW	6th May 2025			
CONTROLS/MITIGATIONS				**GAPS IN CONTROL**			
• Inpatient Bed Strategy and Inpatient quality transformation programme. • Digital transformation programme. • Partnership working with the Voluntary Sector. • Inpatient flow improvement programme. • Patient initiative follow-up work. • Urgent care and Community transformation. • Better prioritisation and triaging of patients of waiting lists. • System approaches to improving and developing services. • Solihull Children and Young People Transformation. • System approaches to improving and developing services. • Solihull Children and Young People Transformation.				• Not enough beds for population when compared nationally. • Lack of the right model of care that is suitable for our patients. • Capacity within teams to deliver transformation and service developments alongside day job. • Family and carers pathway not consistently applied or suitable for all services. • Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about our population and needs.			

• EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Partnership working re dual diagnosis processes and pathways. • Plans in place around transformation and implementation of Community transformation. • Use of multi-disciplinary triage hubs in the South in delivering patient benefits through joint working with Talking Therapies colleagues. • Use of new referrals coming through via SPOA for PCNs without ARRs in ensuring timely access to Mental Health support for those that previously would not have been suitable for Secondary Care. • Implementation of work around Patient Initiated Follow Up (PIFU). • Implementation of locality working model. • Implementation of clinical activities for 24/7 NMHC team. • Proactive reduction of waiting times through identification of service users with open referrals for CMHT and NMHT that are still awaiting first contact, starting with those with longest waits.	

ACTIONS PLANNED

Action	Lead	Due date	Update
Implementation of the 1st phase of the Urgent Care transformation and Winter Plan.	Associate Director of Operations- Acute and Urgent Care	31st March 2025	Completed
Transformation of the Urgent Care Pathway	Associate Director of Operations- Acute and Urgent Care	31st March 2028	On track
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31st Dec 2025	On track
Implementation of pilot 24/7 service in East Birmingham.	Akilah Duffus 24/7 Programme Lead	30th June 2026	On track
To deliver the recovery business case to support the repatriation of out-of-contract & OOA service users to in area in contract beds. Phase 1	AD for ICCR	30th Sept 2025	On track

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR) Group. • Highlight and escalation reporting to Strategy and Transformation Board. • BSMHFT is one of six pilot sites working with NHSE in developing a new 24/7 MH neighbourhood Community service. • Evidence that the Community transformation is working as people are getting better access.	• The new 24/7 MH neighbourhood Community service is still in its early stages.	• Two weeks wait review. • Piece of work around Clinical Governance. • Financial plans that have just been signed. • Reports to the Strategy & Transformation Boards. • System trajectory around 104 and 78 weeks wait. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • Reports to QPES Committee. • Co-produced Trauma informed recovery focussed training rolled out (NMHT). • Physical health connectors pilot.	• Having a strong service user/carer voice across all of our governance forums. • Variations in inputs across pathways. • Gaps in the CYP Pathways.

LINKED TO RISK REGISTERS/CRR RISKS

CRR Risk IDs	Risk Descriptions
CRR02/1924	Potential insufficient capacity across Acute Care pathway to manage patient demand.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments

Update since last review:

21st October 2024 - Risk newly assessed with inputs from the team and presented for Exec sign-off.

4TH Feb 2025

Implementation Plan of 1st Phase of Inpatient Bed Strategy – this has been completed as Policy has been developed and shared with NHSE. New entries have been captured.

12th March 2025

Risk updated and new controls added noting the following progress:

- Multi-disciplinary triage hubs now in place in the South and we have already seen benefits of service users being supported to link with the most appropriate teas, especially joint working with colleagues in Talking Therapies.

• NMHT now managing new referrals coming through via SPOA for PCNs without ARRs roles ensuring timely access to Mental Health support for those that previously would not have been suitable for Secondary Care. • Arrangements agreed with two of the nine GPs in scope to commence receiving new referrals for the team. • Discussions with Neighbourhood Mental Health Team (NMHT) to start redirecting new referrals for individuals within pilot catchment area to 24/7 team that would otherwise be allocated to CMHT or NMHT.
11th April 2025 • Both transformations have progressed in their next phases (i.e. Community transformation – 4th phase & Urgent Care transformation – 2nd phase) work continues. • Recommending reduction of risk score from Impact 4 by Likelihood 4 = 16 to Impact 4 by Likelihood 3 = 12.
6th May 2025 Significant improvements in mitigating and managing this BAF risk have been noted. New actions have also been added.

9. Integrated Performance Report

Report to Board of Directors

Agenda item:	**9**
Date	4 June 2025
Title	Integrated Performance Report
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive Director	Dave Tomlinson, Director of Finance

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:

- Trajectories for the improvement metrics outlined in Appendix 1have all been updated for 2025/26 by relevant Leads. The 2025/26 trajectories for the workforce metrics have been approved via People Committee.
- Talking Therapies - As requested via March 2025 FPPC, a summary of the detailed recovery plan provided by service leads to address activity, recovery rates and reducing DNA rates is attached as Appendix Ia.
- In line with 2025/26 NHSE guidance, Length of Stay improvement trajectories have been submitted for adult and older adult inpatient services. These are outlined in Appendix 1.
- Both Talking Therapies waiting times targets for 6 and 18 weeks are sustainably being achieved.
- Inappropriate and Appropriate Out of area placements, remain a key priority area for improvement. To note that inappropriate out of area placements have been on a downward trend since end March 2025.
- Clinically ready for discharge remains a major contributor to this and remains high. System level escalations being undertaken.
- CPA 3 day follow below 80% target this month, improvements in late data entry required, this is being followed up with service managers to improve timeliness of recording contacts on RIO.
- Formal review within last 12 months now reliably upper 90s.
- Referrals over 3 months with no contact remains high, but mitigations are in place to avoid risks, focus on reducing long waits and waiting times are being covered at the service area deep dive meetings.
- Dashboard now contains links to relevant measures for each Division and services.
- Two new metrics have been added under the Sustainability Domain at the request of the Deputy Director of Finance covering bank and agency spend.
- Vacancies – Vacancy rate at 7.8%, a reduction from last month
- Fundamental Training maintained - 95% target for third month in a row
- Incidents of Self Harm have decreased from 223 to 214
- Ligature incidents with anchor point – 4 incidents this month
- Physical patient harm incidents – increasing trend in month from 21 to 23
- Physical Restraints have decreased from 347 to 277 in last month
- Prone restraints have decreased from 77 to 57 this month
- Rolling programme of service area deep dives continuing, covering benchmarking and waiting times where appropriate.

Being supplemented by review of leadership team approach.

FPPC members are asked to note the improvements made to the Trust's Performance Management Framework, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement through the service area deep dives and more recently the introduction of divisional leadership review meetings.

FPPC is asked to note that the service area deep dive framework has been in place since March 2024 and supports the implementation of a more granular level service specific approach focusing on the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance. A service line RAG rating assessment covering each of the domain areas is also agreed with the service area senior leadership team at each meeting.

In addition, and building on the service line review meetings, from November 2024 Divisional Leadership review meetings have been introduced. These take place with the Executive Team on a quarterly basis. The discussions focus on jointly reviewing team-working, management and delivery of the Trust's finance, people, quality and performance priorities and understanding dependencies across the team to support.

Since the last FPPC meeting in March 2025, there has been no Performance Delivery Group meeting, and three Service area deep dive meetings held. Updates and outcomes are provided in the report (Appendix II).

Members are reminded that at the request of FPPC, there is a continued focus on selected metrics for improvement. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the relevant service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is either a deteriorating trend or a requires improvement trend.

Relevant Leads have provided an update on each area. The detailed summary of progress against action plans is included as Appendix I.

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

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Inappropriate out of area Number of placements			Improvement in last month but remains just above trajectory	2, 10-12
National Waiting times – Long waits – Adult CMHTs			104 week waits trajectory achieved.	3
National Waiting Times – Long waits - CYP			104 and 78-weeks waits have reduced but a small volume of patients above trajectory.	3
People				
Vacancies			Decrease in last month to 7.8%	4
Sickness			Small increase in last month. April at 5.18%.	4, 19-20
Appraisals			Small reduction in month at 79.12% and remains below trajectory and 90% Trust standard	4, 21-22
Sustainability				
Monthly Agency costs				9

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving trend in last month (49.2%) and below national 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last month (44.99%) and below national target of 48%	3, 17-18
Talking Therapies Reliable improvement rate			Improving trend in last month (66.80%) but below national target of 67%	3, 15-16
Clinically Ready for Discharge: percentage of bed days			Improving trend in last month. April 2025 at 15.2%.	3, 13-14
Clinically Ready for Discharge: Number of delayed days			Improving trend in last month. April 2025 at 2405 bed days.	3, 13-14
3-day Follow Up			Deteriorating trend in last month to 78.26% below target of 80%	4

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 6 months (95.61%) above trust target of 95% for last 3 months.	4, 23-24

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incidents resulting in self harm			Decreasing trend in last month. Reviewed at QPES.	4, 25
Physical Patient harm incidents (New metric)			Increased to 23 from 21 this month	4,26
Psychological patient harm incidents (new metric)			Increase in last month. April at 17 (from 16)	4,27
Psychological harm Staff/third party			Has remained at 2 for last 2 months	4
Physical staff/ third party harm incidents (new metric)			Has increased to 6 from 5 in last month	4,28
Ligature with anchor point			Has increased to 4 from at 2 cases this month	4, 29
Physical restraints			Decreased from 347 to 277 in last month	4,30
Prone restraints			Decreased from 77 to 57 in last month	4,31

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	
People	✓	
Quality	✓	

Sustainability	✓	

Recommendation

The Board of Directors are asked to note the latest performance position, update on areas identified for improvement and feedback from the service area deep dive meetings held over the last month.

Enclosures

FPPC May 2025 Performance Report and Integrated Performance Dashboard

Appendix I FPPC May 2025 FPPC Performance Improvement Metrics

Appendix Ia FPPC May 2025 Talking Therapies Recovery Action Plan Summary

Appendix II FPPC May 2025 Performance Framework update

Appendix IIa Acute and Urgent care (South Inpatients)

Appendix IIb Specialties (MAS and Older Adult CMHT)

Integrated Performance Report

Context

The Integrated Performance Report, the associated Dashboard and supporting detailed reports, including the background to all, were discussed at the Board development session in July 2024 and committee chairs were asked to consider how best to use and develop them to support their committees in providing assurance to the Board. If they require any further discussion or support, they should contact Dave Tomlinson or Tasnim Kiddy.

All SPC-related charts and detailed commentaries can be accessed via 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.

It was agreed that more detailed updates will be provided on the key themes, factors affecting performance, actions and improvement trajectories relating to a number of metrics which require improvement.

- Active Inappropriate Adult Mental Health Out of Area Placements (Previously Inappropriate Out of Area Bed Days)
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

Committees are asked to note that the improvement plan metrics are discussed at service area deep dive meetings to assess progress and action plans to support delivery. Appendix 1 outlines an update on improvement plans provided by relevant KPI Leads. This includes an update on the 2025/26 trajectories and related action plans.

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

Since the last FPPC there has been no Performance Delivery Group meeting and three service area deep dive meetings held focusing on Specialties, Acute and urgent care and Secure and Offender Health (Appendix 2).

Performance in April 2025

FPPC is asked to note that new metrics were added in February 2025 to the quality and Sustainability Domains as follows.

- Four new metrics have been added under the Quality Domain at the request of the Acting Deputy CNO covering physical patient harm, psychological patient harm, physical staff/third party harm incidents and Psychological staff/ third party harm incidents.

- Two new metrics have been added under the Sustainability Domain at the request of the Deputy Director of Finance covering bank and agency spend.

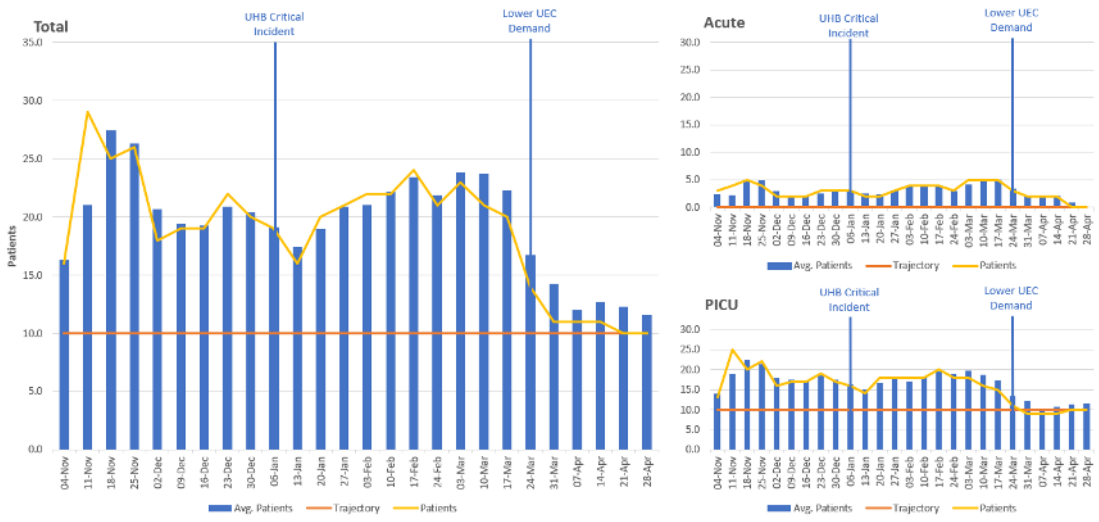
In summary, the key performance issues facing us as a Trust have changed little over the last 2 years, although there have been improvements against some of the metrics in recent months:

Active Inappropriate Out of Area placements

The Trust trajectory agreed with NHSE as part of the 2025/26 national planning requirements remains at zero acute inappropriate placements and to reduce and not exceed 10 PICU inappropriate placements.

Process improvements as part of the Productivity action plan are continuing to be implemented and have helped to address some underlying issues and reduced levels observed and maintained since end March 2025. However, the continuing number of service users requiring admission together with the ongoing pressures arising from Clinically Ready for Discharge patients continues to impair our ability to eliminate inappropriate out of area placements.

As at the end of April 2025, there were 0 acute (target 0) inappropriate placements and 12 PICU (target 10) patients, a total of 12 out of area placements. This is 5 lower than the previous month. The number of new inappropriate admissions during the month was 4, the lowest number in the last 12 months.



A more detailed update on the productivity plan and actions for 2025/26 will be provided to by the lead Associate Directors. This will include a review of the existing plans and focus on the following three workstreams, Admission Avoidance, Inpatient pathway and reducing LOS and Discharge planning to support the plans to improve patient flow across pathways and reduce out of area placements as a key outcome.

Reducing Length of Stay (LOS)

The 2025/26 national planning guidance sets out the objective of reducing length of stay for patients in adult and older adult inpatient services.

Trusts were required to submit improvement trajectories for 2025/26 using previous years as a baseline for improvement.

The Trust's submitted improvement trajectory is designed to deliver:

- 10% improvement by the end of the year compared with the NHSEs November 2024 national baseline data.
- 10% improvement (on average across the year) when compared with 2024-25 outturn based on local Trust figures.

The delivery of the improvement trajectories is reliant on progressing the Trust's inpatient bed strategy plan. FPPC have been provided with a separate operationally led report outlining the action plans in place with LOS reduction being one of the outcomes.

The LOS trajectories agreed and monthly performance to date have been added to Appendix 1.

Talking Therapies – 2025/26 Recovery action plan

As requested, at March 2025 FPPC, a summary of the detailed action plan developed by the Talking Therapies service Leads is attached as appendix Ia. The key areas of focus include:

- Meeting 2025/26 Activity and Income Trajectory
- Addressing the under-performance for 2 + completed treatment contacts
- Increasing the number of referrals the service receives
- Improving Recovery rates
- Reduce DNA rates
- Reduction of in-treatment waits
- Maintaining the national waiting times standards, 75% of service users seen within 6 weeks and 95% of service users seen within 18 weeks.

Update on national plan to reduce long waits in community teams –

Both Adult and Older Adult CMHTs have made progress against their improvement plans which have focussed on reducing long waits. Challenges in both services remain in-particular around managing high caseload levels and pressures arising from staffing levels.

It should be noted that the 2025/26 national guidance did not include any national requirement for continued improvement plans. However, local trust improvement plans will continue to focus on reducing long waits.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 15.21%. The main drivers for this are delays in both adult and older adult acute services. CRFD in April 2025 in Adult Acute & Urgent Care was at 17.7% (51 patients) and in Older Adult Services at 37% (29 patients).

The main reasons for the delays in adult acute care are delays in allocation of a social worker, supported accommodation and lack of public funding and in older adults is due to waits for nursing home placements and social worker allocation.

Trust and partnership wide discussions to support the identification of plans to assist discharge continue to be prioritised by weekly meetings and daily reviews discussing individual patient needs, however, traction to improve the position remains challenging. Barriers have also been escalated to senior system wide level discussions. A number of social workers have now been allocated to areas of the trust to support discharge and interagency meetings are taking place to escalate discussions.

3 Day Follow up

There has been a marginal decline this month to 78.2%, below the national 80% standard.

Quality the detailed position on these metric areas is discussed at QPES committee. For information, a summary of the metric changes is outlined below. This month, performance on the new metrics relating to harm:

- Incidents of Self harm have decreased from 223 to 214 this month (decrease in Secure Women's inpatients).
- New metric: Physical patient harm incidents – small increase from 21 to 23 in last month
- New metric: Physical staff/ third party harm incidents – Increased from 5 to 6 in last month.
- New metric: Psychological patient harm incidents – small increase in last month. April at 17 (from 16)
- New metric: Psychological harm staff/third party incidents – has remained at 2 for last 2 months
- Ligature with anchor point – has increased to 4 (from 2) this month
- Physical restraints fallen from 347 to 277 in last month (decrease in Acute inpatients, secure inpatient men and eating disorders
- Prone restraints have fallen from 77 to 57 in last month (decrease in acute inpatients)

People workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there is an adverse variance against most of the set performance standards although there have been improving trends in fundamental training and reduction in staff turnover.

2025/26 action plans - The HR Leads have reviewed the metrics and provided updated trajectories and action plans for 2025/26 which have been approved via People Committee. These are detailed in Appendix 1.

- Bank and Agency WTE reduction – The figures for April were not available at the time of writing the report.
- Staff Appraisals at 79.12% as at April 2025, just below improvement trajectory and below the 90% Trust standard.

  L&D have contacted hot spot areas directly and Executive leads of those services to highlight current compliance levels and offer of support e.g. VBA training sessions. Low take up of dates being offered to services and the team is identifying additional methods of communication to support.

- Staff vacancy levels Vacancy rate at 7.8% and below trajectory.

- Mandatory Training at 95.59%, continued improved position and above the 95% target for the third month in a row.

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Sustainability – (details in finance report)

Integrated Performance Dashboard

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR | Corporate | Specialties | Secure Services & Offender Health

Performance

Bed Occupancy (%)	93
Clinically Ready for Discharge: Bed Days	2405 ↓
Clinically Ready for Discharge: Bed Days (%)	15 ↓
CPA 3 Day Follow Up (%)	78
CPA 7 Day Follow Up (%)	90
Eating Disorders: Waiting Time - Routine (%)	100
First Episode Psychosis: Waiting Time (%)	100
Out of Area: Inappropriate Placement Bed Days	379
Out of Area: Inappropriate Placements Active	12
People on CPA with a Formal Review in last 12 Months (%)	97 ↑
Referrals over 3 Months with no Contact	3758 ↓
Talking Therapies: Reliable Improvement Rate (%)	67
Talking Therapies: Moving to Recovery (%)	49
Talking Therapies: Reliable Recovery Rate (%)	45
Talking Therapies: Seen in 18 Weeks (%)	100 ↑
Talking Therapies: Seen in 6 weeks (%)	94 ↑

People

Bank & Agency Fill Rate (%)	96 ↑
Fundamental Training (%)	96 ↑
Staff Appraisals (%)	79 ↑
Staff Sickness (%)	5
Staff Turnover: Rolling 12m (%)	6 ↑
Staff Vacancies (%)	8 ↑

Quality

Abscondions from Inpatient Units	2
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	3 ↓
Failure to Return	9 ↑
Harm (physical) – patients (%)	23
Harm (physical) – staff/third party (%)	6 ↑
Harm (psychological) – patients (%)	17 ↓
Harm (psychological) – staff/third party (%)	2 ↘
Incidents of Self Harm	214 ↓
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	20
Ligature with Anchor Point	4 ↓
Patient Assaults	27 ↑
Patient Assaults / 1000 OBDs	1.4 ↑
Physical Restraints	277 ↓
Physical Restraints / 1000 OBDs	14.8
Prone restraints	57
Prone restraints / 1000 OBDs	3.1
Reported Incidents	2417
Staff Assaults	112
Staff Assaults / 1000 OBDs	6.0

Sustainability

Agency as % of Pay Spend	3 ↗
Agency Staff Spend	£348k ↑
Bank as % of Pay Spend	13 ↓
Capital Expenditure	£56k ↓
Cost Improvement Programmes	£1,263k ↘
Group Cash Balance	£76,375k ↓
Info Governance (%)	95
Operating Surplus	-£1,070k ↓

Last refreshed 14th May 2025

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

Integrated Performance Dashboard

April 2025

HOME


PERFORMANCE


PEOPLE


QUALITY


SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Clinically Ready for Discharge: Bed Days		2117	2300	2140	1968	2716	2405 ↓
Clinically Ready for Discharge: Bed Days (%)		13	14	13	13	17	15 ↓
CPA 3 Day Follow Up (%)	80	80	84	80	81	89	78
CPA 7 Day Follow Up (%)	95	88	91	87	92	96	90
Eating Disorders: Waiting Time - Routine (%)	95	88	100	92	88	100	100
Eating Disorders: Waiting Time - Urgent (%)	95			100	100		
First Episode Psychosis: Waiting Time (%)	60	100	100	50	100	100	100
Out of Area: Inappropriate Placement Bed Days	328	658	631	591	646	765	379
Out of Area: Inappropriate Placements Active	10	27	21	20	25	20	12
PDU Referrals in month		100	99	132	100	114	108 ↓
People on CPA with a Formal Review in last 12 Months (%)	95	96	97	97	97	97	97 ↑
Referrals over 3 Months with no Contact		3707	3851	3920	3959	3893	3758 ↓
Talking Therapies: Reliable Improvement Rate (%)	67	63	61	61	59	65	67
Talking Therapies: Moving to Recovery (%)	50	48	50	48	50	48	49
Talking Therapies: Reliable Recovery Rate (%)	48	44	45	45	46	44	45
Talking Therapies: Seen in 18 Weeks (%)	95	98	98	98	100	99	100 ↑
Talking Therapies: Seen in 6 weeks (%)	75	93	93	92	93	95	94 ↑

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Integrated Performance Dashboard

April 2025

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Bank & Agency Fill Rate (%)		91	91	91	94	94	96 ↑
Fundamental Training (%)	95	94	94	95	95	96	96 ↑
Staff Appraisals (%)	90	80	80	80	81	79	79 ↑
Staff Sickness (%)	4	7	7	6	6	5	5
Staff Turnover: Rolling 12m (%)		6	6	6	6	6	6 ↑
Staff Vacancies (%)		10	9	9	9	8	8 ↑

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Integrated Performance Dashboard

April 2025

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	
Absconsions from Inpatient Units		1	3	5	2	2	2	
Commissioner Reportable Incidents		0	0	0	0	0	0	
Community Confirmed Suicides		0	0	0	0	0	0	
Community Suspected Suicides		1	2	4	2	2	3	↓
Failure to Return		17	16	15	13	16	9	↑
Harm (physical) – patients (%)		22	16	21	21	21	23	
Harm (physical) – staff/third party (%)		6	6	5	6	5	6	↑
Harm (psychological) – patients (%)		18	14	17	19	16	17	↓
Harm (psychological) – staff/third party (%)		2	2	1	1	2	2	↘
Incidents of Self Harm		192	114	224	205	223	214	↓
Inpatient Confirmed Suicides		0	0	0	0	0	0	
Inpatient Suspected Suicides		0	0	1	0	0	0	
Ligature no Anchor Point		23	14	20	11	25	20	
Ligature with Anchor Point		0	1	0	2	2	4	↓
Patient Assaults		52	36	33	27	26	27	↑
Patient Assaults / 1000 OBDs		2.7	1.9	1.7	1.5	1.4	1.4	↑
Physical Restraints		266	232	227	293	347	277	↓
Physical Restraints / 1000 OBDs		14.0	12.1	11.7	16.8	18.2	14.8	
Prone restraints		49	42	56	67	77	57	
Prone restraints / 1000 OBDs		2.6	2.2	2.9	3.8	4.0	3.1	
Reported Incidents		2707	2401	2631	2347	2537	2414	
Staff Assaults		123	128	91	79	94	112	
Staff Assaults / 1000 OBDs		6.5	6.7	4.7	4.5	4.9	6.0	

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Integrated Performance Dashboard

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR | Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Agency as % of Pay Spend		2	1	2	2	2	3
Agency Staff Spend		£416k	£323k	£372k	£372k	£482k	£348k
Bank as % of Pay Spend		12	12	11	11	9	13
Capital Expenditure		£342k	£874k	£1,333k	£1,705k	£3,620k	£56k
Cost Improvement Programmes		£1,201k	£1,449k	£2,586k	£2,102k	£1,732k	£1,263k
Group Cash Balance		£94,821k	£91,629k	£88,234k	£87,860k	£86,352k	£76,375k
Info Governance (%)		86	94	94	96	86	95
Operating Surplus		£127k	£458k	£378k	£1,016k	£7,864k	-£1,070k
System Oversight Framework (SOF) Rating		3					

	Not meeting target
↑	Significant IMPROVEMENT
↓	Significant CONCERN
↗	Possible improvement
↘	Possible concern

Out of Area: Inappropriate Placements Active

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

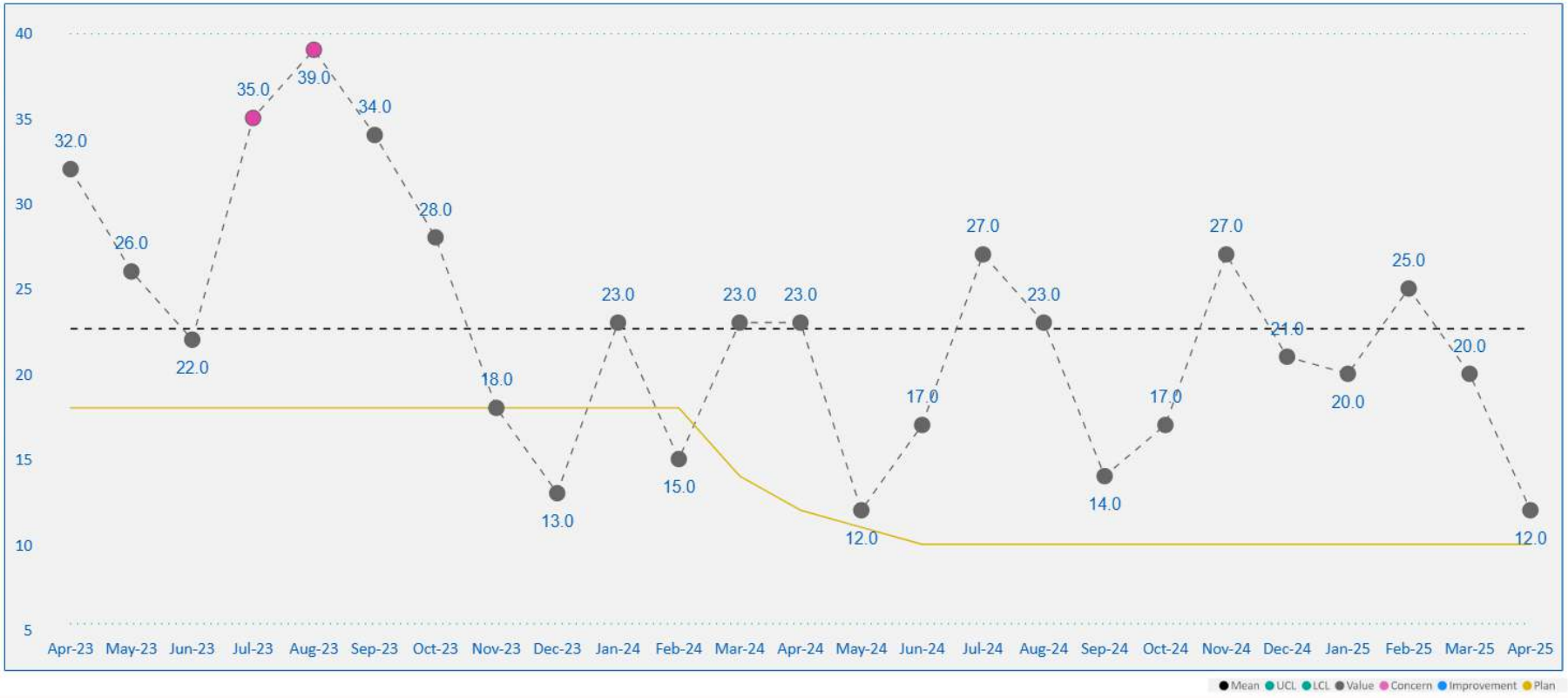
Trust

Divisions

Services

Commentary

*All means and SPC control limit calculations are based on data for the last 25 months



Question	Answers
A: What has happened?	The number of inappropriate out of area placements at each month end remains a metric in the 2025/26 national planning guidance. A Trust trajectory agreed with NHSE as part of the 2024/25 national planning requirements will continue in 2025/26 with zero acute inappropriate placements and to reduce and not exceed 10 PICU inappropriate placements each month. Inappropriate out of area placements has fluctuated since January 2024 with large peaks and troughs. April is showing an decrease in the last month at 12 placements with 0 in acute beds and 12 in PICU beds just above the trajectory of 10 for April 2025. These all relate to adult PICU patients. There were 5 inappropriate admissions during April, the lowest number in the last 12 months with 0 acute and 5 PICU a decrease compared to March. The 2025/26 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting reflects those currently identified as 'appropriate'. 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 for 2023/24 confirms that BSMHFT has a low number of inpatient beds per 100,000 weighted population indicating the need for additional capacity to meet the needs of the BSOL population. 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 are above the national average due to high levels of acuity requiring a higher number of observations. The number of patients clinically ready for discharge has been increasing over the 12 months with circa 86% delay reasons attributed to community which is not in the Trust's immediate control. CRFD at 2405 overall in April with adults at 1,182 lost bed days which equates to 17.8%, a reduction of 2.4%. Adult bed occupancy at 97.3% and length of stay has increased to an average of 113 days in April. A validation exercise has been undertaken which identified a number of unrecorded discharges which have been corrected and has contributed to an improved position in March and April. The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. The combination of these challenges and the 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.

D: What are we doing about it?	3 key workstreams are in place 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 • Managing demand, localities are now gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients. SDF funding has been secured to fund pilots in CMHT/HTT and urgent care High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral • 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 in area. • QI project to shift gatekeeping metrics from conversations recorded to measurable admission avoidance outcomes • Progressing the procurement of a Crisis House Locality model development • The locality model is now in place across all acute areas and a new bed management function to support the locality model being developed. CRFD Workstream and length of stay • Renewed focus on Clinically Ready for Discharge. Action plan in place, and suggestions of how to improve internal management of CRFD being presented via OOA Steering Group. • weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process (more proactive approach being taken for patients with longer Length of Stay. Reducing gaps in CRFD recording and plans to increase the usage of ICRT as an alternative to care packages • Social workers have been appointed who will work across adult acute/ older adults and with the homeless team. The first 2 will commence in January 2025 • Strategic level conversations are also being planned with the Local Authority Work has been undertaken to extend 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 A new trajectory has been agreed with commissioners for reductions in inappropriate out of area placements for 2024/25. This is based on the new national metric introduced in April which will look at the number of OOA placements at month end.
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 using only 10 or less PICU placements.
F: How will we know when we have addressed issues?	When the numbers of inappropriate OOA placements 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.

Clinically Ready for Discharge: Bed Days

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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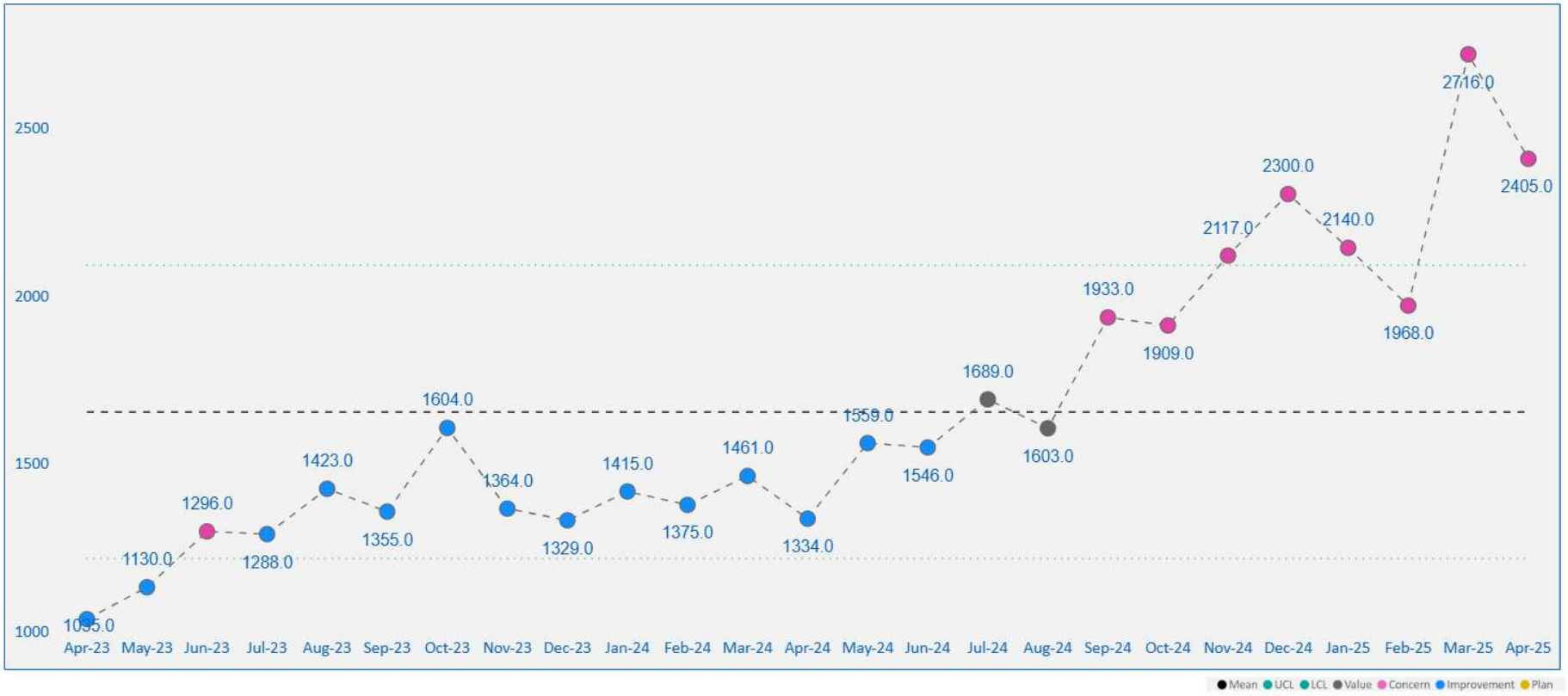

Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days has been on an increasing trend since May 24 and reaching a peak in March 2025 at 2716 bed days. April has reduced to 2405 days with Adults moved from 1,452 days in March to 1,182 days in April, which related to 51 patients, with a main delay reason of Social Worker allocation and awaiting public funding and older adults moved from 737 days in March to 758 in April and related to 29 patients, who were waiting for care home placements and social worker allocation.
B: Why has it happened?	The main reasons for the delays across both services include awaiting of a social worker, public funding and awaiting nursing home placements which 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.
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?	Fortnightly mental health CRFD Escalation meting are in palace with attendance from the ICS and Local Authority (Social care and housing) to review those with CRFD above 60 days or are complex. Key activites are to: Maximise joined up working between LA and BSMHFT, to reduce delays in LA processes, patient choice and assurance on CRFD processes. A priority Dischage team is being put in place with 1 Social Worker allocated to Older Adults 3.5WTE for adults (1 awaiting start date) and 1 Homeless social worker is being recruited to. In addition internally reviewing patient flow and activities as part of operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting is in place to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. There are some gaps in the current CRFD recording which the localities will be working with the discharge managers to address.
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.

Talking Therapies: Reliable Improvement Rate (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

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Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. April 2025 has shown an increase to 66.80% and rmarginally below the 67% target. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.
B: Why has it happened?	A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria. A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ medically unexplained symptoms measure have reduced by a reliable amount, whether or not they met caseness at the start of treatment. The service is providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to.
C: What are the implications and consequences?	Service users needs are not being met and the national 67% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate. An Action Plan is in place to explore ways that recovery rates can be increased. This includes a range of actions including: learning from other serices in the country, undertaking a deep dive into recovery rates between teams, identifying cohorts of service users which have lower recovery rates, increasing the number of treatment sessions with each service user and reducing DNA rates within the service by engaging proactively with service users. The plans are being monitored monthly by the ICS Lead and quarterly with the Talking Therapies system wide forum.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid reliable Improvement.
F: How will we know when we have addressed issues?	Maintain/exceed the 67% Reliable Improvement rate.

Talking Therapies: Reliable Recovery Rate (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2025

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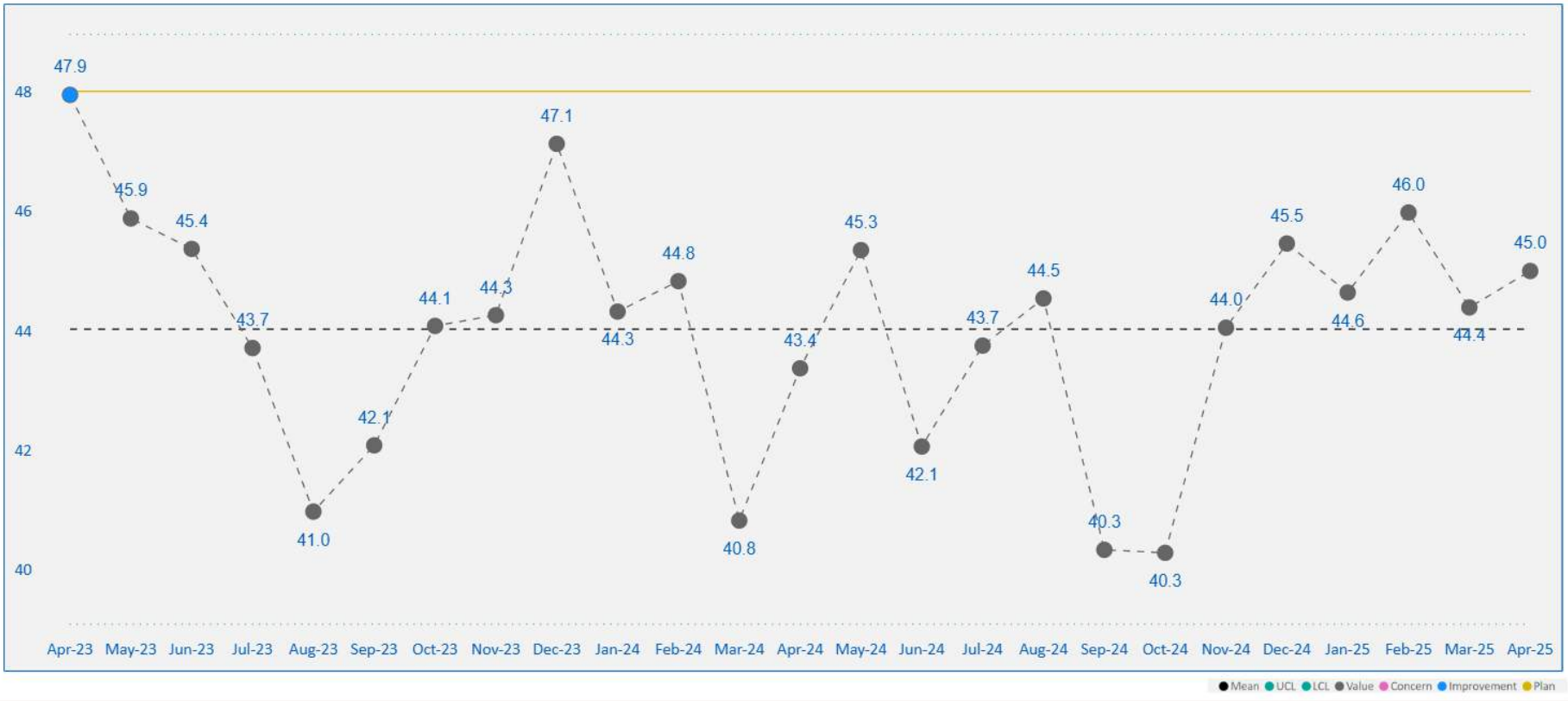

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. April 2025 position has increased to 44.99% and remains below target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment.
B: Why has it happened?	The target for recovery is 48% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria that met caseness at the start of treatment. Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery. The service is providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to.
C: What are the implications and consequences?	Service users needs are not being met and the national 48% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable recovery rate. An Action Plan is in place to explore ways that recovery rates can be increased. This includes a range of actions including: learning from other serices in the country, undertaking a deep dive into recovery rates between teams, identifying cohorts of service users which have lower recovery rates, increasing the number of treatment sessions with each service user and reducing DNA rates within the service by engaging proactively with service users. The plans are being monitored monthly by the ICS Lead and quarterly with the Talking Therapies system wide forum.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid Reliable recovery
F: How will we know when we have addressed issues?	Maintain/exceed the 48% Reliable Recovery rate.

Staff Sickness (%)

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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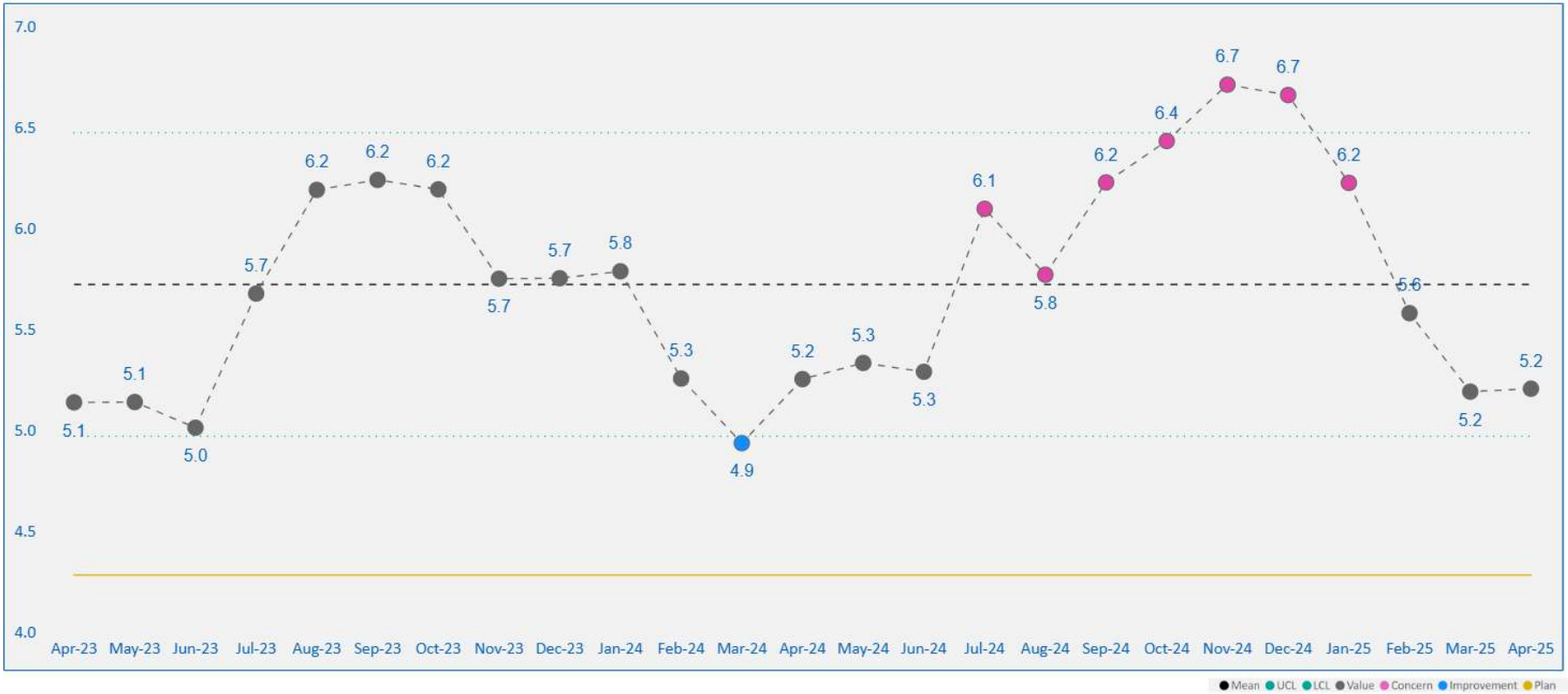

Question	Answers
A: What has happened?	Trust wide sickness absence rate for April 2025 was 5.18% against 5.1% in March 2025 and 5.5% in February 2025. This represents an increase on the previous month of 0.08% and was accounted for by an increase in long term absence.. Across the divisions, the following services had the highest absence rates: - Secure Services and Offender Health 6.4% (0.1% increase on previous month, 2.4% Short Term and 4% Long Term) - Primary Care and Dementia Specialties 5.4% (0.7% reduction on previou smonth, 1.9% Short-Term and 3.5% Long-Term) - A significant improvement in absence was noted in Strategy, People and Partnerships, which observed 4.9% across the period (a drop of 1% on the previous month). Integrated Community Care and Recovery 5.2% (1.6% Short-Term and 3.6% Long-Term) All divisions were showing as having a below target rate of Return to Work Interview completion, standing at 65.4% across the Trust.
B: Why has it happened?	Proactive ongoing management, combined with seasonality, has resulted in a reduction in short-term absence .
C: What are the implications and consequences?	Operational Inefficiencies: High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. Operational Costs: Sickness rates, particularly long-term, present a significant cost to the Trust in the opportunity lost, skill drift and backfill (including bank and agency spend). Increased Risk of Burnout: Ongoing vacancies and low RTW contact rates mean that some employees may experience greater strain, increasing burnout risk and potentially leading to a cycle of recurring sickness.
D: What are we doing about it?	Occupational Health: The new provider is now active and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management. Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling. Return to Work Focus: Key activities are ongoing to measure Return to Work and sickness support compliance, including divisionally targetted support.
E: What do we expect to happen?	Insight-driven targetted actions, led by divisonal teams and supported by the People Partners, will continue to support the management of sickness across the Trust and a net reduction will be observed.
F: How will we know when we have addressed issues?	Sickness absence levels will improve; outcomes will be achieved within parameters set by Trust Policies, reduction of high levels of stress and anxiety across the Trust.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals (%)

April 2025

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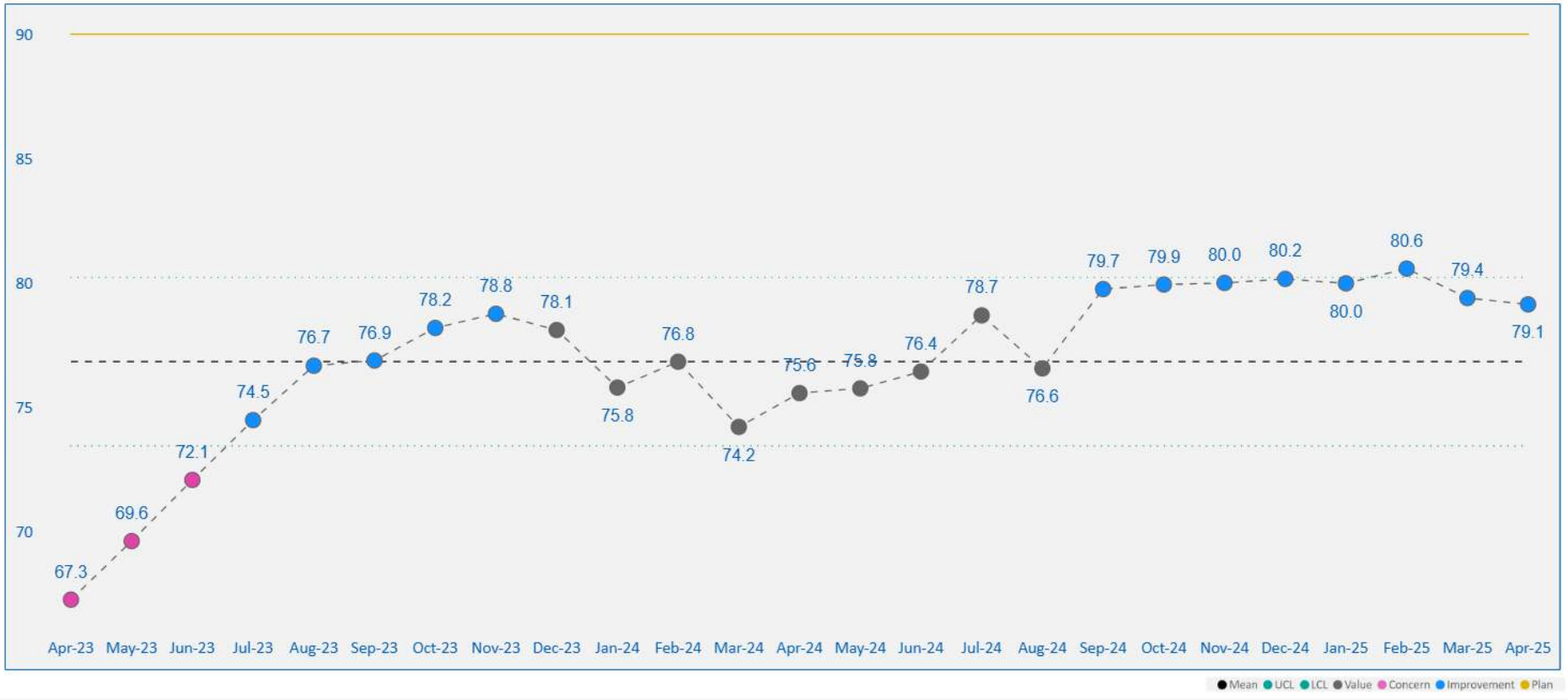

Question	Answers
A: What has happened?	The trust's Appraisal compliance is 79.1% which 0.35% below last month. The trust remains below the Trust target of 90% and commissioner's target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: Acute and Urgent Care 68.6%, Exec- Medical 50.3% Exec-Nursing 63.1%, Exec - Resources - 55.4% and New Care Models 40.4%. Please note we have understood that there are staff identified (trainee clinical psychologists) that are negatively impacting our compliance figures and will need to be excluded.
C: What are the implications and consequences?	We are not meeting our commissioner target of 85%
D: What are we doing about it?	Quality- The QI project has now completed with any outstanding actions for the project group in the process of completion e.g. video edits (Induction & Appraisal training) with the support of QI & L&D team. Compliance- In addition to BAU activities, L&D have contacted those hot spot areas listed above directly and Exec's of those services to highlight current compliance and offer of support e.g. VBA training sessions. In addition dates are being offered to services however we have identified low take up of sessions and therefore identifying additional methods to increase our communications e.g. newsletters and targeting of services specific comms.
E: What do we expect to happen?	The QI appraisal project and BAU appraisal work will continue to positively support staff in achieving quality values based appraisal conversations and also improve compliance.
F: How will we know when we have addressed issues?	The regular review of appraisal compliance data (Insights reports) and through our MS forms appraisal survey data. The appraisal QI project also provides staff feedback from a qualitative perspective from the working group including training evaluation data. Our aim is to ensure all staff will receive a values based appraisal, empowering staff to take ownership for their personal development and the trust will be able to demonstrate a holistic approach to staff members personal development.

Fundamental Training (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2025

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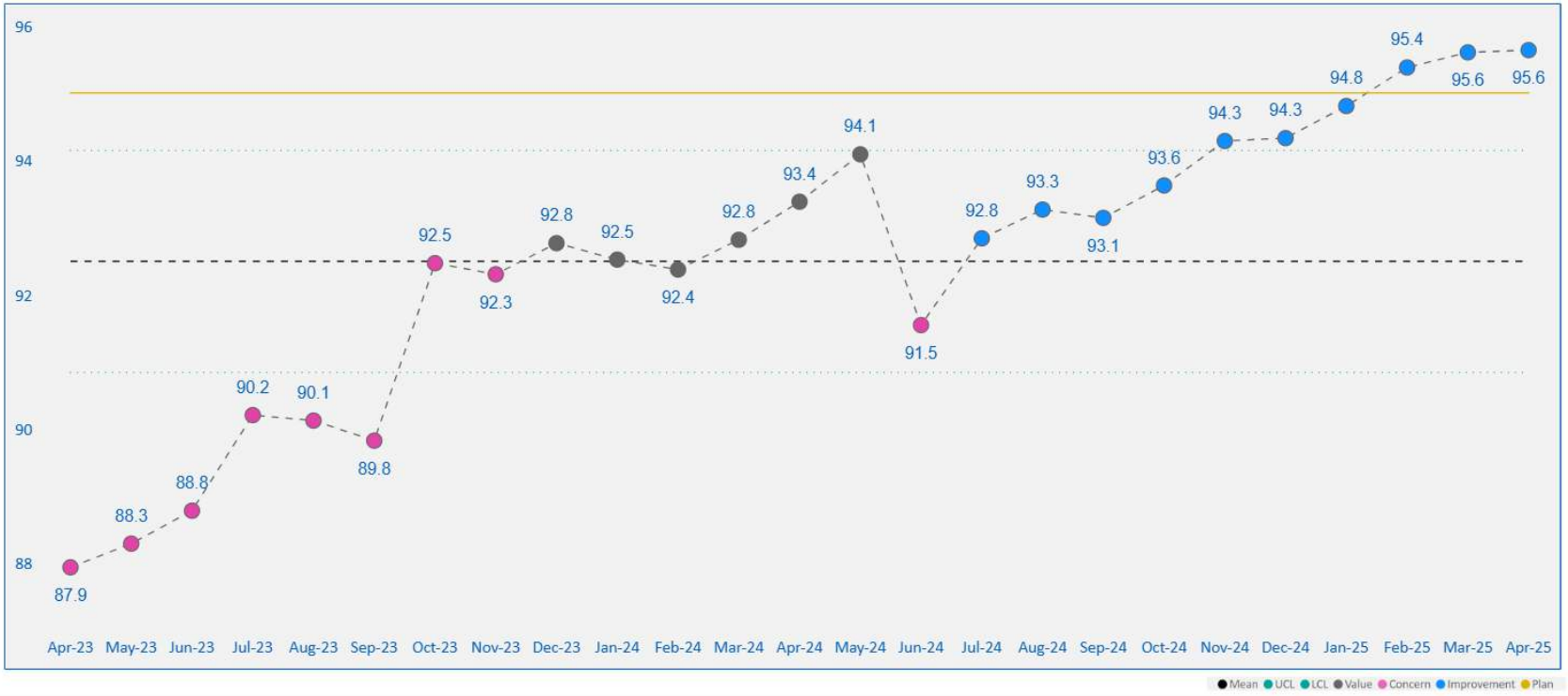

Question	Answers
A: What has happened?	The overall Fundamental Training compliance increased from 95.6% in March to 95.7% in April. Overall, the trust has surpassed the Commissioners' target and 95% Trust target for substantive staff. All areas remain above 95% except for: - Chief Exec - 84.1%, - Acute and Urgent Care- 94.8% - New Care Models - 91.7%, - Strategy, People and Partnerships - 93.1% Temporary Staffing Compliance has stayed the same at 91.5% and remains above the Trust Target of 75%
B: Why has it happened?	We continue to have a recovery plan in place for all courses that are below 95% and we have met the 95% target this month. We have a few subjects that are currently in their grace period but will effect compliance once the grace periods come to an end (Patient Safety Level and Level 2 May 2025, Dual Diagnosis in June 2025, Oliver McGowan Tier 1 and 2 August 2025). The following subjects are below 90% : ELS, ILS and SRS.
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. • The Trust is adding more FT training on the traffic light amd this can impact on the overall Trust compliance. Oliver McGowan Tier 1 and Tier 2 - there is currently no dates available past April • 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?	• For Fundamental Subjects with less than 95% compliance, a recovery plan with monthly trajectories is in place. • ILS spaces have been purchased for April - June 2025, we have placed a number of courses out in the areas (Oleaster, Northcroft, Reaside, Tamarind, Barberry, etc) as well as the Uffculme Centre to support compliance. • Business as usual activities are in place such as o emailing employees and managers to inform them of DNAs and requesting they re-book o reminder emails to both employees and managers regarding training that is booked. o All DNA's are sent on a monthly basis to the Clinical Directors and Heads of Services for them to follow up with their teams o Monthly chase up emails to those who have expired or approaching expiry to book onto training • At least one month prior to the new training going live, the FT team sends out an email to each staff member allocated to complete it. The training will also have a six-month grace period on the traffic light to enable staff members sufficient time to complete it.
E: What do we expect to happen?	Based on recovery plans we expect to stay above 95% compliance until May when the grace period for Patient Safety ends. Increasing the grace period for the new Fundamental Training subjects will not affect the overall Trust compliance in that give period as it will enable staff to become compliant before the grace period expires.
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight Reporting System

Incidents of Self Harm

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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*All means and SPC control limit calculations are based on data for the last 25 months

Harm (physical) – patients (%)

March 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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Harm (psychological) – patients (%)

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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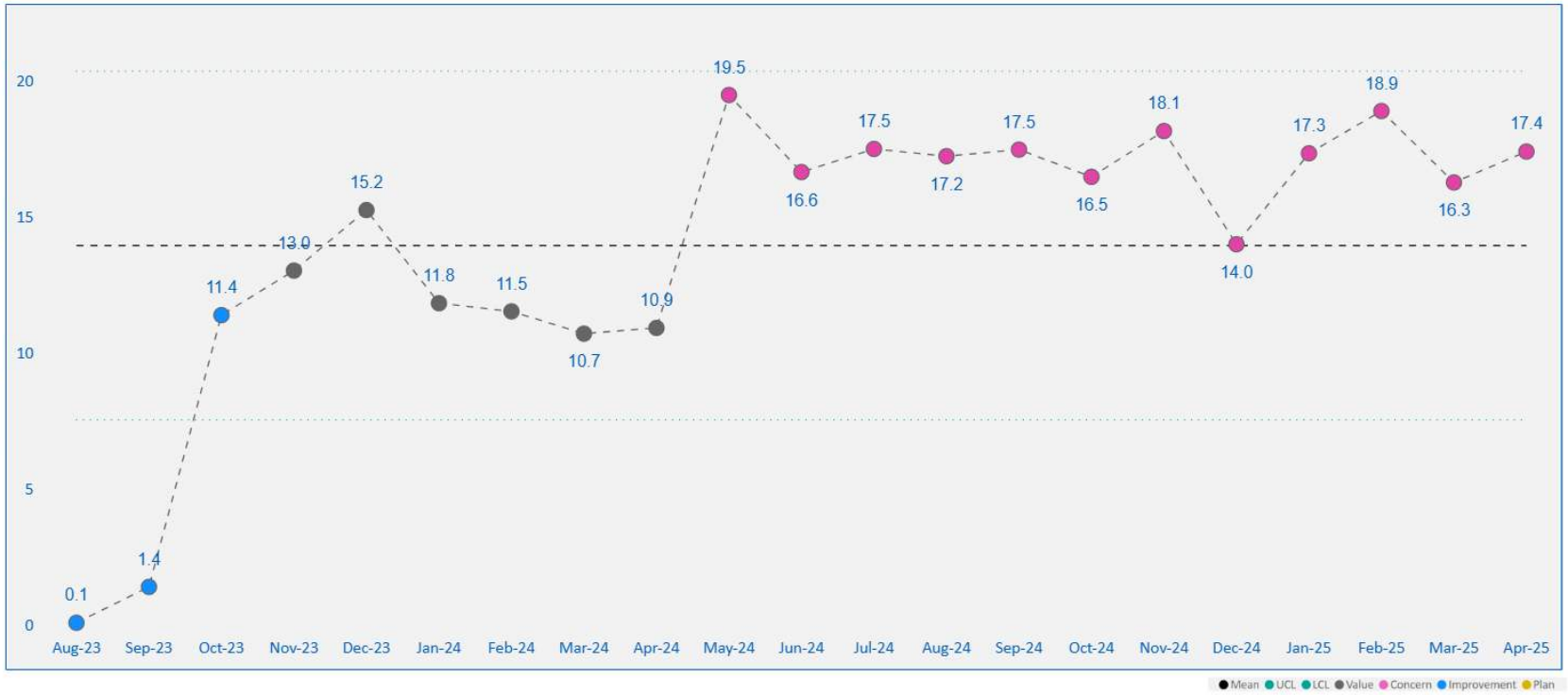

Harm (physical) – staff/third party (%)

March 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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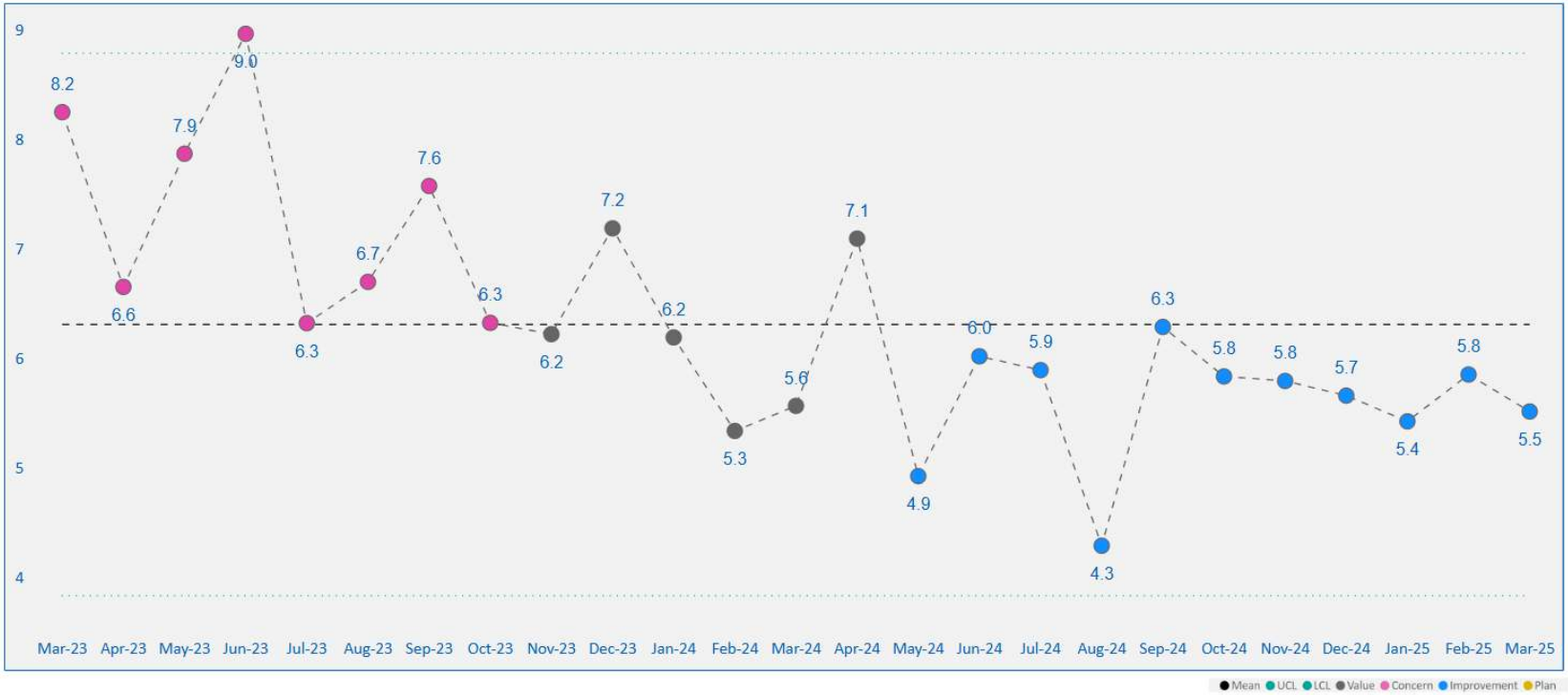

Ligature with Anchor Point

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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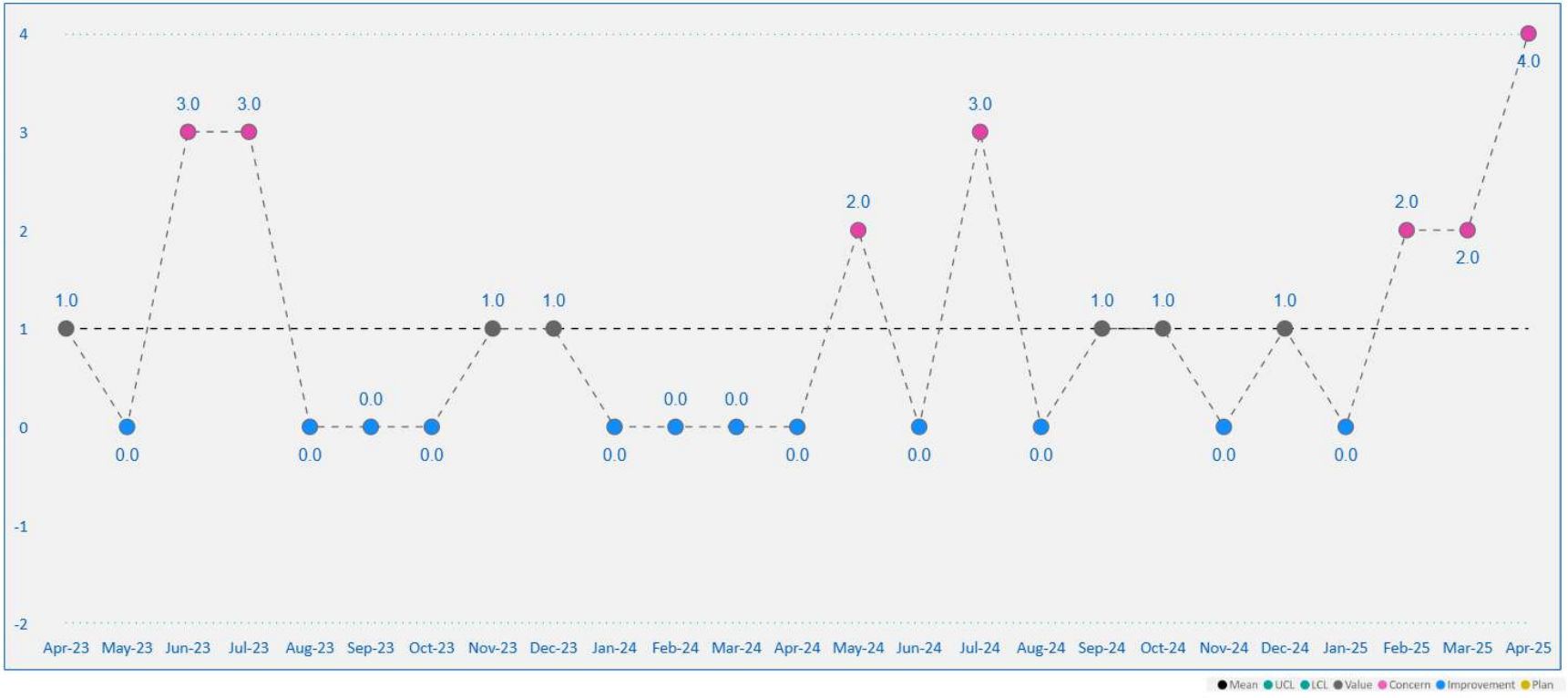

Physical Restraints

April 2025

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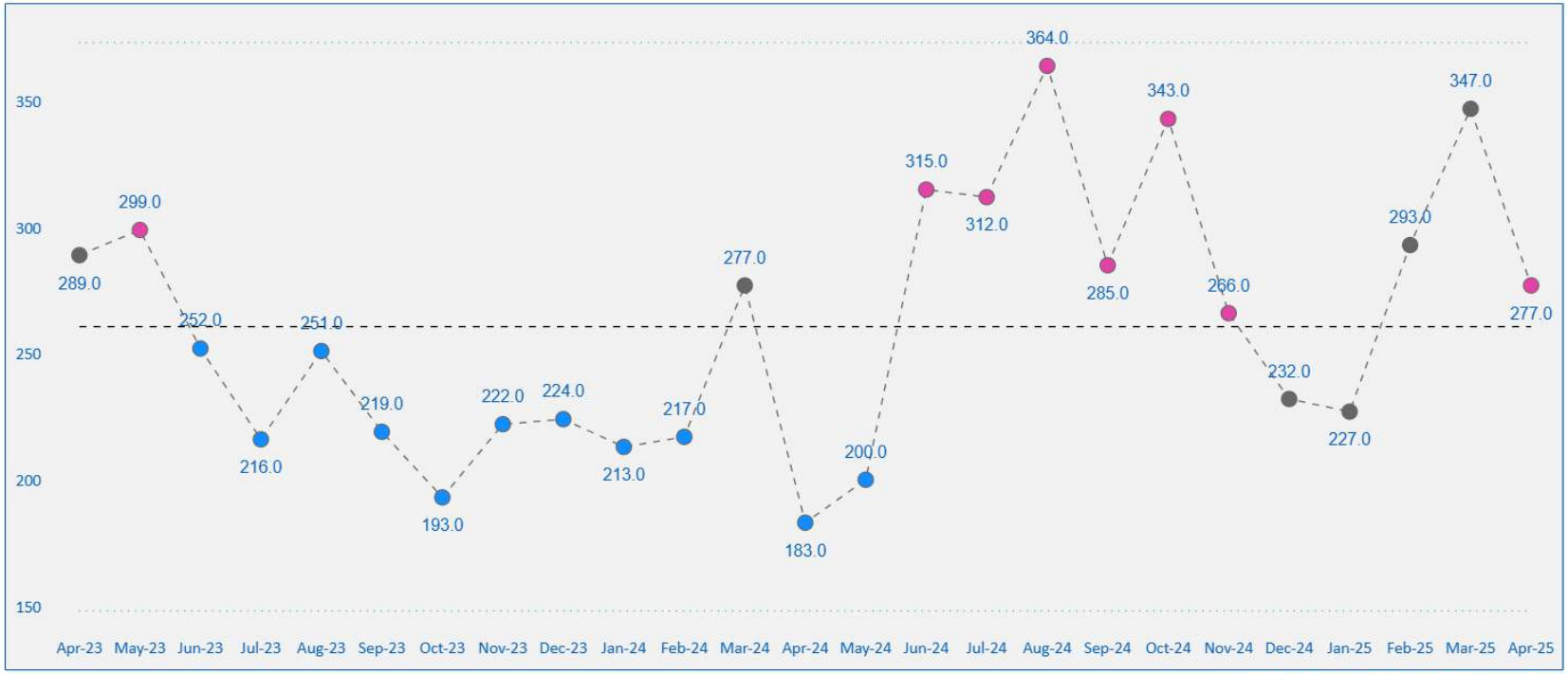

Prone restraints

April 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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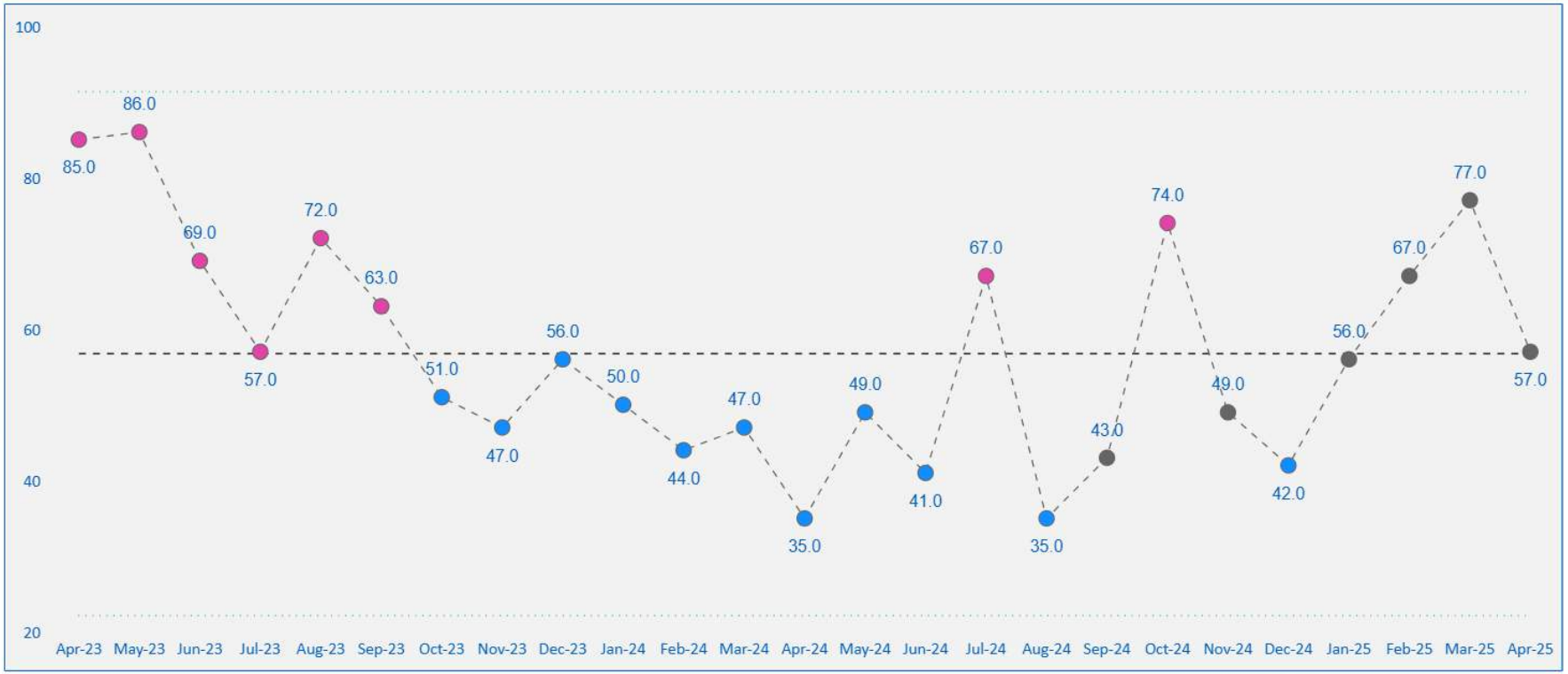


Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 22nd May 2025

2025/26 Performance metric Improvement Trajectory update

NHSE - Length of Stay Reduction Plans – Adults & Older Adults

The 2025/26 planning guidance sets out the objective of reducing length of stay for patients in adult and older adult inpatient services.

Trusts were required to submit improvement trajectories for 2025/26 using previous years as a baseline for improvement.

The Trust's submitted improvement trajectory is designed to deliver:

- 10% improvement by the end of the year compared with the NHSEs November 2024 national baseline data.
- 10% improvement (on average across the year) when compared with 2024-25 outturn based on local Trust figures.

NHSE methodology – Factors to note:

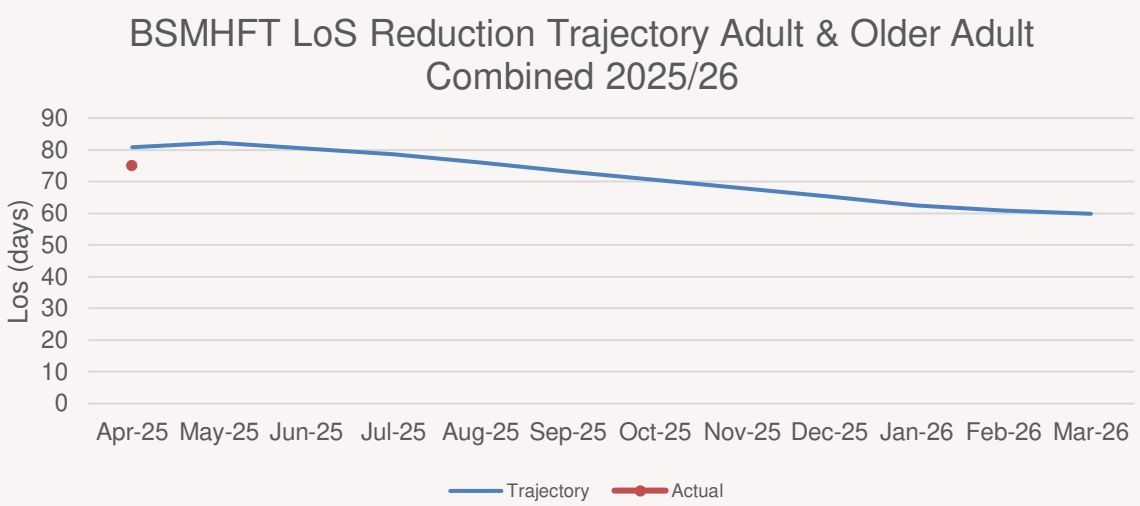
- As the methodology is based on discharge, discharging service users with long lengths of stay will have a negative impact on performance against trajectory.
- Achieving significant length of stay reductions on this methodology will require more discharges of people with longer lengths of stay during the early part of the year, which will mean we initially see raised average lengths of stay.
- Performance is assessed on the average of twelve 3-month rolling periods eg, April position includes the average of Feb, March and April data.

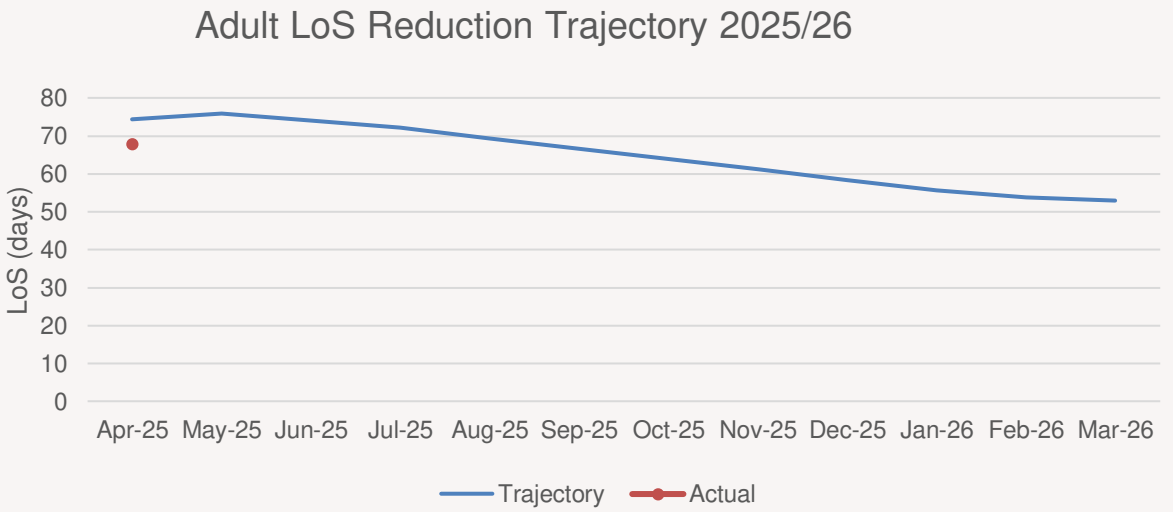
The slide below outlines the improvement trajectories agreed, and monthly update on performance to be provided to FPPC.

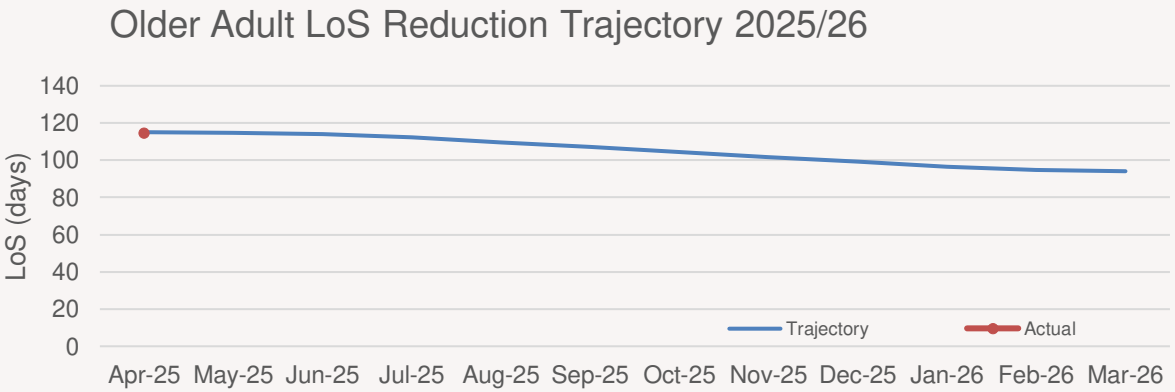
The delivery of the improvement trajectories are reliant on progressing the Trust's inpatient bed strategy action plan. FPPC have been provided with a separate operationally led report outlining the action plans in place with LOS reduction being one of the outcomes.

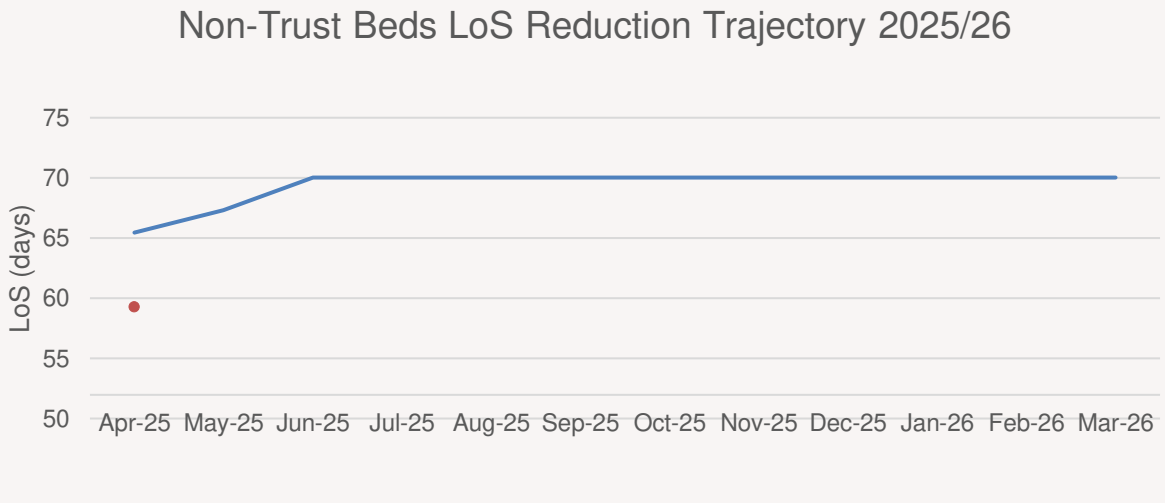
NHSE length of Stay reduction Trajectories

Birmingham and Solihull Mental Health NHS Foundation Trust









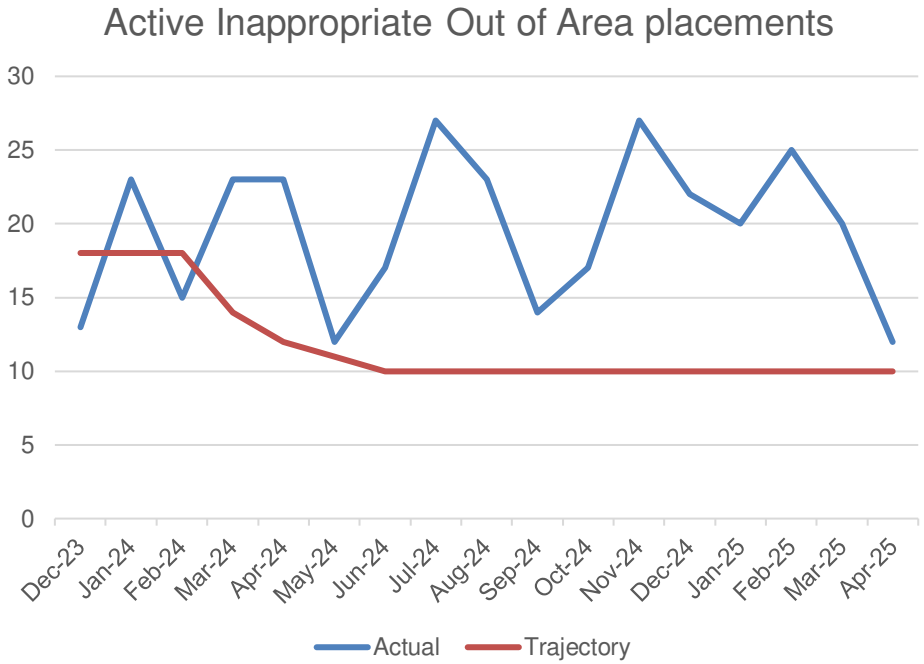
compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

During 2023/24 the following metrics were identified by FPPC for improvement.
These metrics remain areas for improvement.

Action plan updates and trajectories for improvement in 2025/26 have been provided by the relevant KPI owners. Please see below.

Active Inappropriate Out of Area Placements

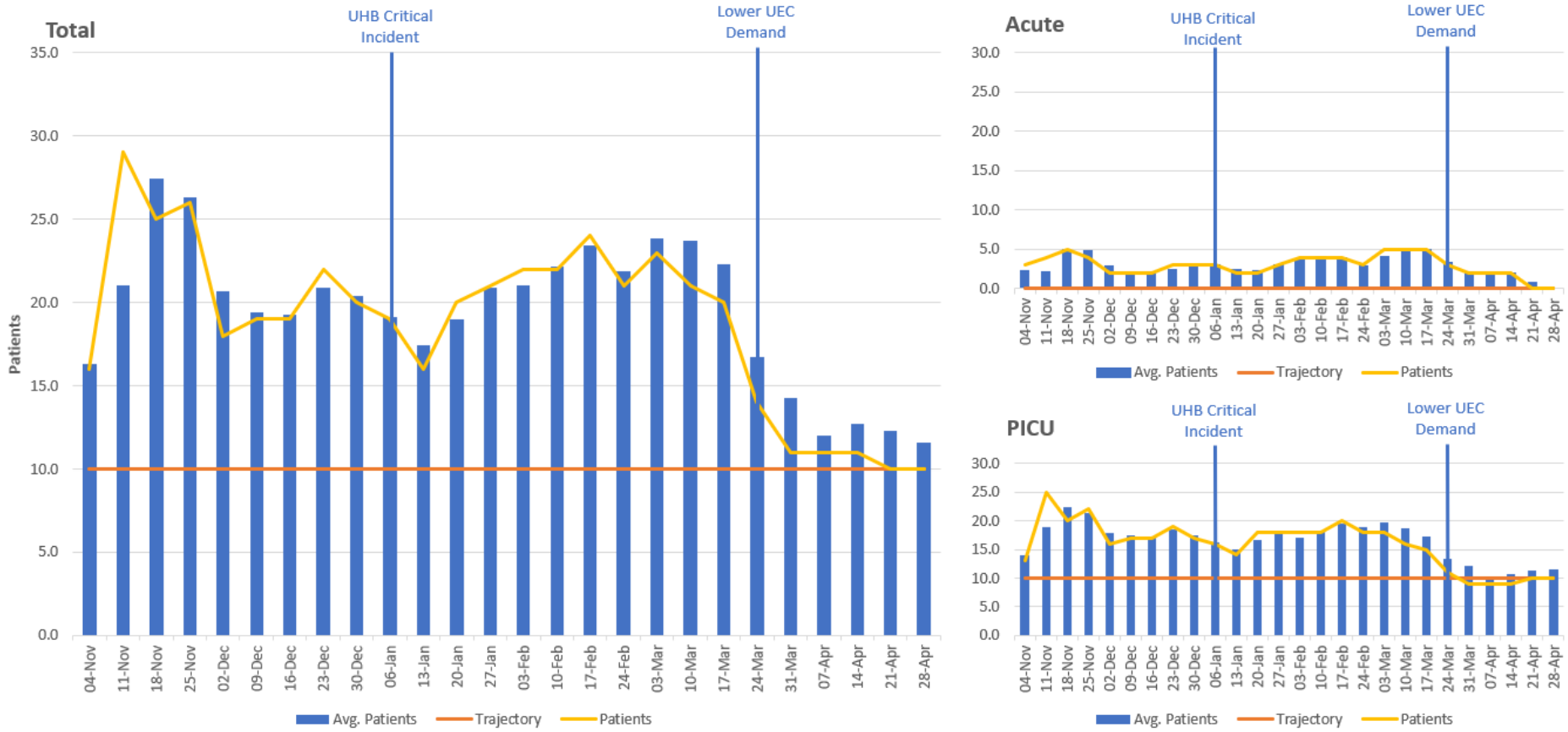


The Trust trajectory agreed NHSE as part of the 2025/26 national planning requirements remains at zero acute inappropriate placements and to not exceed 10 PICU placements.
April 2025 shows improved performance – Total inappropriate number of placements at 12 (target 10), 0 acute (target 0) and 12 PICU (target 10).

The Trust's productivity action plan continues to focus on workstreams to better manage demand, focus on reducing CRFD patients, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available.

Slide 6 below highlights the weekly progress being achieved, monitored via the Patient Flow Steering Group.
A key pressure point remains the impact of Clinically Ready for Discharge (CRFD) patients that are not within Trust control, particularly social care and housing impacting on reducing the available Trust capacity to support repatriation and reduce the number of all out of area placements.

Inappropriate Out of Area Placements - BSMHFT



Slides 4 outlines next steps for the productivity plan.

Productivity Plan – update

FPPC is asked to note that a detailed update on the Productivity Plan was been provided by the AD for Acute & Urgent Care at January 2025 FPPC.

Next Steps:

Clinical Oversight

- Establishing a Clinical Oversight Group to lead assertive case management, improve flow for high volume users, and create diversion pathways for CMHT patients.
- Focused actions to reduce bed usage from 160+ to 110 beds.
- Embed Quality Improvement into the Clinical Oversight Group to support tracking of performance at locality level and reporting into the Patient Flow Improvement Programme governance structure.

Gatekeeping

- QI project to shift gatekeeping metrics from conversations recorded to measurable admission avoidance outcomes.

Pathway improvements

- Develop and enhance pathways for earlier intervention within urgent care. Service Development funding has been secured which will support admission avoidance, ensure purposeful admission and that the discharge is effective. Pilots include:
    - CMHT pilot- responsive support for known patients attending ED.
    - Urgent Care pilot - Dedicated medical support in Bed Management and PDU.
    - Psychological support in HTT for patients on the bed waiting list.

System Collaboration

Address external challenges by engaging with local authorities and progressing the procurement of a Crisis House (recovery house) to reduce socially driven crisis overwhelming ED.

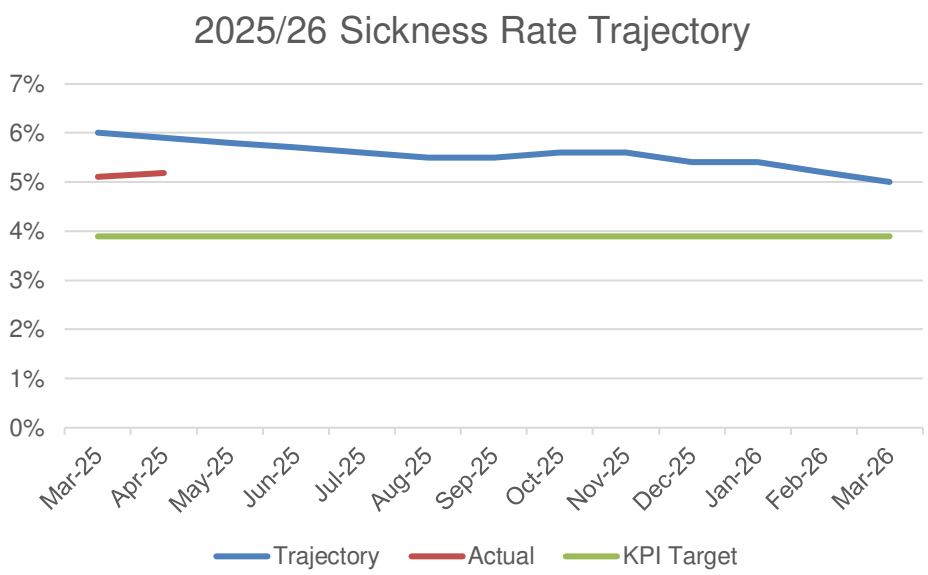
Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2025/26 update.

The trajectories for improvement have been signed off via the People Committee.

Sickness Absence

Updated 2025/26 Sickness trajectory in line with the workforce plan



A revised trajectory has been provided for 2025/26 to reduce sickness levels by 1% reaching 5% by March 2026.
April 2025 at 5.18% below the improvement trajectory of 6%. Long-term sickness has increased to 3.38% and short-term sickness remained at 1.8%.

Action Plan:
Occupational Health: The new provider is now active, and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management.

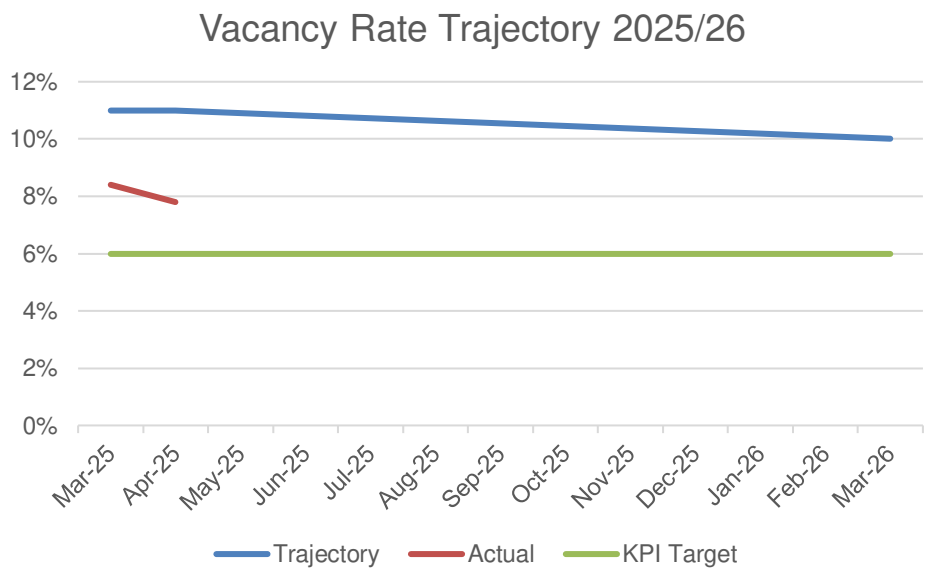
Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling.

Return to Work Focus: Key activities are ongoing to measure Return to Work and sickness support compliance, including divisionally targeted support.

Note - Trajectory agreed by the People Committee commentary provided by People team leads

Vacancies

Updated 2025/26 vacancy trajectory in line with the workforce plan



Note – 2025/26 trajectory approved by People Committee and commentary provided by People team

The target to reduce the vacancy rate for 2025/26 is based on a reduction of 1% to reach 10% by March 2026. The KPI target is 6%. April at 7.8% below the trajectory.

Following on from presenting to Nursing Students at the University of Birmingham and hosting stands over the last year at the Birmingham City University Nursing Careers event, University of Wolverhampton Nursing Careers Recruitment Event, and the RCNI Birmingham Recruitment event, the students in their final year who had offers made to them pending completion of their studies and them acquiring of their PIN's, are being slotted into our vacancies successfully. Furthermore, following a considerable centralised recruitment event for band 5 nurses across the year and international recruitment, multiple offers have been made, again with them being manoeuvred into our vacancies successfully.

BCU and UOB events have also been attended in Q1 of 2025 with a view of 50-70 students being sent a generic trust offer of an interview in September once qualified.

Vacancies

Action Plan update cont:

The trust, in conjunction with universities and with assistance of ICB is currently rolling out actions for the Careers Event Process for Psychological Professions.

The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel 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.

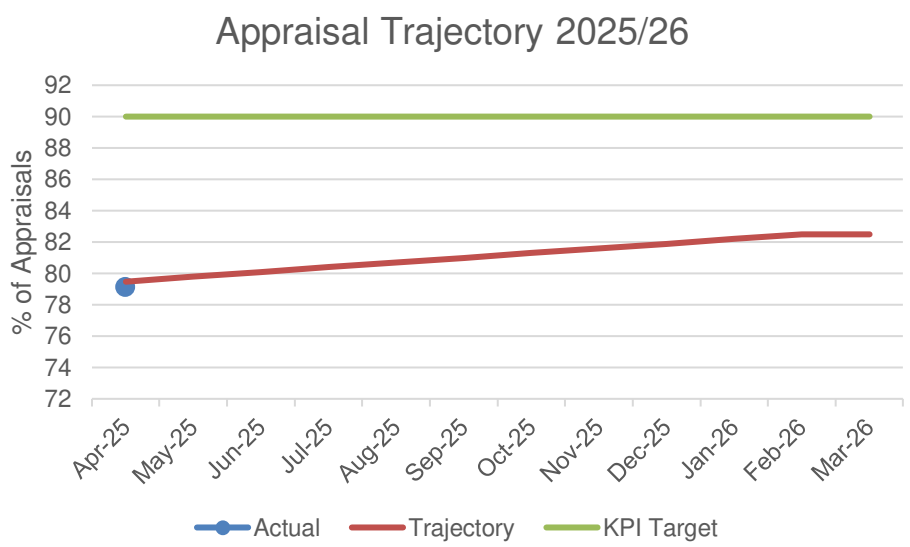
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 arrangements 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 vacancy packs.
- Start monitoring number of new joiners who are recruited flexibly and collate this centrally.

A Recruitment Initiatives and Strategy meeting will be held at the end of April 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.
A bespoke band 6 Recruitment event held by the RCN, specifically targeting band 6 and 7 RMN's is currently in the planning stages.

Appraisals

Updated 2025/26 Appraisal trajectory



Note - Trajectory agreed by People Committee and commentary provided by People team leads

A revised trajectory has been agreed for 2025/26 to increase appraisal performance as a minimum by 3% moving from 79.5% to 82.5% by March 2026.

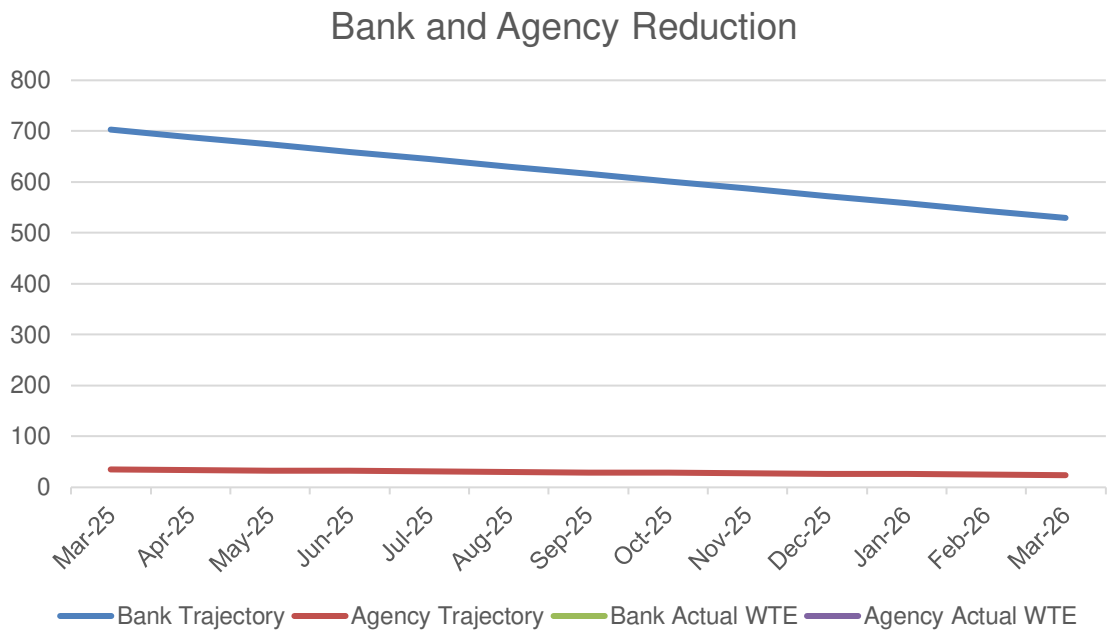
April 2025 appraisal performance shows small decrease to 79.1% just below trajectory.

<u>Summary of actions planned to support improvement:</u>

The QI project has now completed with any outstanding actions for the project group in the process of completion e.g. video edits (Induction & Appraisal training) with the support of QI & L&D team. .

Compliance- In addition to BAU activities, L&D have contacted those hot spot areas listed above directly and Exec's of those services to highlight current compliance and offer of support e.g. VBA training sessions. In addition, dates are being offered to services however we have identified low take up of sessions and therefore identifying additional methods to increase our communications e.g. newsletters and targeting of services specific comms.

Bank and Agency Reduction



The focus for 2025/26 remains on reducing the numbers of bank and agency staff used within the Trust. The target is to reduce the use of bank workers by 174 WTE and 10 WTE in agency workers by March 2026.

April data is not yet available

Note - Trajectory agreed by people Committee
Commentary provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- A detailed agency reduction programme mentioned above is in progress working in conjunction with ICB / NHSE 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 finishing of agency block bookings. Currently all HCA agency requests require Exec approval. The NHSE Midlands above cap improvement workgroup requirements ensured that all agency standard nursing bookings were fully compliant with cap rates as at the end of January 2025.

- As mentioned above, the TSS function has gone live with NHS Professionals – who have considerably less charge rates than agency – and are transferring over high cost and long-term block bookings, which can be recorded as bank spend, rather than agency. A deadline of the end of March 2025 was given to areas to transfer over their non-medical agency block bookings and regulars to NHSP otherwise they would not be able to use them in their areas. This has also stimulated the areas to organise and put out any vacancies (either perm or fixed term) that were outstanding, plus encourage the updating of their rota's long-term, which is of course the preferred option than simply transferring agency block booking's over to NHSP.

- Direct Engagement for Medical Agency is also live, 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.

- In April 26 bank workers started with the trust, helping to alleviate the need for agency.

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 22nd May 2025

2025/26 Talking Therapies Recovery Action Plan Summary

Birmingham and Solihull Mental Health NHS Foundation Trust

Introduction

At the March 2025 FPPC meeting the Talking Therapies Recovery Plan was requested.

A detailed action plan has been developed by the Talking Therapies service Leads (can be provided on request).

In summary, there are seven key areas of improvement:

- Addressing the under performance in the number of 2+ completed treatment contacts
- Increasing the number of referrals the service receives
- Improving Recovery and outcome rates
- Reduce DNA rates
- Reduction of in-treatment waits
- Achieving contract Activity and Income trajectories for 2025/26
- Maintain national waiting times standards

Activity and Performance

- To improve trajectory for 2+ completed contacts
  - Recruiting to vacancies
  - OD work with teams
  - Supporting staff in supervision
  - Introduction of new step 2 webinar
  - Guidance on the number of people who should be discharged each week
- Maintain national waiting time standards of 6 (75%) and 18 weeks (95%)
- Ensure number of people accessing service increases -
  - BHM attendance at joint triage meetings with CMHT/NMHT
- Reduction of in-treatment waits - reduces below 10%
  - Offering other support whilst service users are waiting for a specific intervention

Improving DNA Rates

January 2025 baseline DNA rate at 12% - Plan to reduce below 10% by May 2025.

- Introduction of Automated Booking System (ABS) which allows choice of appointments.
- Link for telephone Triage appointments
- Reviewing the use of automated text message service.
- Service wide sessions to discuss DNA rates and promoting patient attendance being held on quarterly basis
- To review DNA/ cancellation policy.
- Discussions with service users setting out expectations at beginning of treatment
- Overbook appointments where there are high DNA rates

Recovery rates

- Ensure clinicians are aware of their recovery rates
- Share good practice in high performing teams
- Organisational Development – promote team cohesion & help teams to perform to their optimum
- Analysing data to understand root causes impacting negatively on recovery rates i.e. complex trauma, newly qualified staff
- Arranging additional drop-in sessions for staff working with complex trauma
- Review contact methodology to understand impact on recovery rates

Activity and Income Trajectory

2025/2026 Activity and Income Trajectory (based on £637 per case)							
Month Y25/26	ICB Activity plan	BHM Activity trajectory	BHM Actual activity	Estimated income (in line with activity trajectory)	Actual Income received	Income received if total activity is achieved	Total deficit or over achieved income
Apr	812	670	734	£426,790	£467,558	£517,244	-£49,686
May	812	710		£452,270		£517,244	
Jun	812	710		£452,270		£517,244	
Jul	812	750		£477,750		£517,244	
Aug	812	670		£426,790		£517,244	
Sep	812	760		£484,120		£517,244	
Oct	812	800		£509,600		£517,244	
Nov	812	800		£509,600		£517,244	
Dec	812	800		£509,600		£517,244	
Jan	812	812		£517,244		£517,244	
Feb	812	812		£517,244		£517,244	
Mar	804	812		£517,244		£512,148	
Total	9,736	9,106		£5,800,522		£6,201,832	

FPPC is asked to note that from March 2024 a revised performance framework has been implemented with a monthly Performance Delivery Group meeting and granular level service area deep dive meetings. As part of this framework, a service line RAG rating assessment covering each of the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance is agreed with the service area senior leadership team.

FPPC members are asked to note that since the last FPPC meeting in April 2025, no Performance Delivery Group meeting was held but the following service area deep dives have taken place:

- Acute and Urgent care – 24th April 2025 focusing on South inpatients
- Specialties – 1st May 2025 – focusing on Older Adult CMHTs and Memory Assessment Service
- Secure and Offender health – 12th May 2025 focusing on Men's secure and FIRST

Service Area Deep Dive Meetings – Update

1. Acute and Urgent Care – 24th April 2025

The service focused their deep dive on South inpatient service. The related service area presentation is included as Appendix IIa. A summary of the agreed service line RAG rating is outlined in the table below:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
South Inpatient Psychology	Amber	Amber	Amber	Amber	Green	Amber
The following RAG ratings were agreed at the deep dive meeting						
Melissa ward	Amber	Amber	Amber	Green	Red	Green
Japonica	Amber	Amber	Amber	Amber	Red	Amber
Tazetta	Green	Green	Green	Green	Red	Green
Magnolia	Green	Green	Green	Green	Red	Amber
Caffra (PICU)	Green	Green	Green	Green	Red	Green

Areas raised by service leads for discussion/support:

Finance

- Red RAG Rating for finance due to overall overspend across wards.
- Caffra ward part of the reducing bank and agency pilot and reduction in spend noted.
- Now 0% spend on agency across all wards.
- March 2025 usage of bank staff was lower than other divisions.
- Drugs spend higher on Magnolia due to complexity of patients.

Quality and Safety

- Experts by experience are supporting work plans to reduce restrictive practices, including establishment of a patient council.
- Anti Barricade doors to be added to bedrooms. Noted that all the doors could not be

changed, risks escalated to the Director of Nursing for review.
- Issue with drugs coming into the building – service leads working with police using sniffer dogs. Plan to add barrier control for drivers to help restrict traffic coming through.
- Melissa ward placed on enhanced monitoring for a period due to a period of high sickness levels impacting on staff capacity and management of complex patients on wards.

People

- One psychology post recruited and a second vacancy advertised.
- Wards with low RMS levels noted with plan in place to improve over next couple of months
- Appraisal levels show improvement.
- Recruitment to vacancies improved over the last 3 months including recruitment of internationally educated nurses. Service leads working with the people team to offer posts to upcoming newly qualifying B5 nurses to bring wards up to full compliment.
- Staff survey feedback - people feeling more valued, areas for further work include violence by patients, abuse by patients and relatives and discrimination towards staff. Survey is discussed in action learning sets and leadership forum.
  Action: Link into the work being undertaken at Meadowcroft with the EDI leads.

Patient flow management

- Difficult to step down patients from PICU to acute wards due to unavailability of acute beds, has led to direct discharges where clinically appropriate.
- Home treatment teams supporting in wards to aid discharge planning.
- Interface challenges when people are referred from prison as this disrupts flow, as many are on restrictions, requiring Ministry of Justice (MOJ) involvement and also results in delays to discharge. Issues escalated and agreed that future patients will be reviewed by Clinical Directors for Acute and Urgent Care and Secure and Offender Health jointly to ensure appropriate placements.
- Noted Japonica ward has AOT and acute patients which have different needs and therefore require input from a number of consultants. High number of CRFD patients also being managed.

  Action: Medical Director to explore review of AOT inpatient and community model.

2. Specialties – 1st May 2025

The service leads focused their deep dive on Older Adult CMHTs and the Memory Assessment Service MAS). The related service area presentation is included as Appendix IIb. A summary of the agreed service line RAG rating is outlined in the table below:

. Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Memory Assessment service	Amber	Amber	Red	Green	Red	Amber
Older Adult CMHTs		Red	Amber	Amber	Green	Green

<u>Memory Assessment service</u>

Operational Performance

- Demand, rising population and capacity challenges/constraints to support and manage.
- Challenges with long waits for Memory Assessment. Pathway review and improvements introduced but capacity to manage demand remains a challenge.

- Waits for scans also a contributory pressure – pilot commenced to request scans earlier in the pathway to reduce impact on total length of wait.
- Improvement in the Dementia Diagnosis rate (DDR) noted, will also impact on demand.

Quality and safety

- To support service users on the waiting list, a 'waiting well' programme established, working well and received positively.
- 'Reading Well in dementia' - pilot in place.

Workforce

- Noted exceptional performance and compliance with workforce metrics.

Finance

- Overspend is linked to scanning invoices issue with UHB rather than pay (this is currently being resolved by respective finance colleagues)

Older Adult CMHTs

Operational performance

- Older Adult CMHTs have high caseloads and long waits for assessment. Increase in care homes and retirement villages particularly in Solihull and North Birmingham leading to increased demand with no additional resource.
- Focus on reducing long waits – first month with no waits over 52 weeks, maintenance impacted by capacity.
- South Team – commenced caseload stratification, outcomes/learning to be shared.
- Impact of neighbourhood mental health teams on managing/aiding demand limited as majority of referrals question dementia presentation which are forwarded to older adults CMHTs, further increasing demand on the service.

ESCA's (Essential Shared care Agreements)

- Birmingham GPs are a national outlier in not agreeing ESCAs relating to dementia medication, resulting in retaining service users on the OA CMHT caseload, requiring staff capacity to support with annual reviews.
- NHSE has removed the clinical lead for dementia and the ICB did not appoint a lead for dementia highlighting leadership gaps in this area at time of increased population demand/pressure.

Action: Service Leads requested Executive support to strengthen conversations with ICB in this field.

Quality and safety

- An increase in suicide in the older adult group, structured debriefs taking place in line with PSIRF.
- Noted an increase in referrals from GPs for service users requiring end-of-life care.
- Number of QI initiatives in place, the DNA reduction programme has been nominated for an HSJ award.

Workforce

- Clinical supervision and safeguarding supervision being promoted due to higher acuity levels.
- Long term team manager vacancy in Solihull recently appointed to.
- Working with Head of Nursing on career development and retention plans.

- Staff Survey results – Teams have developed plans and are addressing these in their business meetings or away days.
- Higher level of staff turnover in West Team who are experiencing higher number of SIs, ensuring team is being supported.

3. Secure and Offender Health- 12th May 2025

The service leads focused their deep dive on Secure Men's and FIRST community team. A summary of the agreed service line RAG rating is outlined in the table below:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Reaside	Amber	Amber	Green	Amber	Green	
Tamarind	Green	Amber	Green	Green	Green	
FIRST community	Green	Amber	Green	Green	Green	

Overall: Discussion summary

Clinically Ready for Discharge (CRFD)

Service leads reported an increase in the number of patients who are Clinically Ready for discharge but constrained by ability of Birmingham City Council (BCC) to support, with delays in social worker allocation and Care Act Assessments and progression to accommodation placements. Issues have been escalated and meeting scheduled with BCC leads.

Service leads have submitted a proposal for Reach Out to employ social workers, who can carry out trusted assessments in order to speed up the process as it was felt that accommodation is available, but funding approval required from BCC.

Action: Service Leads would like Executive support for this proposal.

Action: Director of Nursing to raise with Director of Operations the need to clarify and potentially streamline meetings being held with BCC across services and via the Mental Health Provider Collaborative.

Reaside: Discussion Summary:

- Very high bed occupancy levels requiring risk management and mitigation.
- Environment challenges remain.
- CQC revisited recently with positive feedback provided regarding Trust response to actions, and confidence in team to deliver the Culture of Care programme.
  There were 2 actions the CQC highlighted:
  - ELS/ILS training - progress has been good and noted a small of staff could not complete due to pregnancy or long terms sickness absence.
  - Patients care planning - To address, DIALOG+ has now been introduced and will support this action. In addition, PREOM (Patient Reported Outcomes and Experiences) data will be analysed and discussed at Clinical Governance meetings. This will enable feedback to inform service changes.

- Staff survey – improved uptake level (64%), action planning on six areas including quality of appraisals, inequalities and civility at work, culture of care and health and safety.

- Medical Staffing – some external challenges to appoint to a consultant vacancy being worked through.
- Co-produced trauma informed care training package for staff and service users to influence the culture is being rolled out at Reaside.
- Estate plan to start replacing the shower rooms and toilets in 2025/26.

Tamarind: Discussion summary

- Commenced work on culture of care programme.
- Positive engagement of Experts by Experience, trained and embedded and attend the local clinical governance meetings.
- Developing sustainable communities and reducing health inequalities - linking with organisations to provide a range of activities including music production, sport and podcast use.
- Estates team working to resolve the alarm staff response system issues, requiring resolution.
- Work being undertaken to support staff during night shifts - additional checks are being made and senior managers coming in to increase leadership visibility.
- Staff survey feedback trends consistently positive – areas of action include staff development, health and wellbeing of staff and focus on quality improvement areas. External support has been commissioned from Birmingham University in relation to feedback on misogyny behaviours and to inform and strengthen plans to address.
- Bank usage – reduced requests noted. However, continued use explained due to staff escorts which can be either 3:1 or 4:1 and also staff capacity required to support EPCs (Exceptional Packages of Care) to maintain quality of care.
- Tamarind was the only forensic unit in the country to be chosen by the European Training Network, to review training and the services provided. Feedback was excellent.

FIRST: Discussion Summary

- Positive CQC feedback.
- Service focus and review of model of community care support including efficiency and value for money objectives - increased investment for additional staff in community made to support planned increase in caseload from appropriate discharge of inpatients, however further work required to implement.
- Base for FIRST Team remains current issue but plans to move to Main House when building work has been completed in place.
- Undertaking QI work related to prevent readmissions.
- Patient voice and involvement/participation noted as a lead exemplar for the Trust.

4. Deep Dive Summary RAG ratings across all service areas

The overall RAG ratings summary across all service areas that have taken place to date has been updated for the above deep dive meetings and outlined below for reference.

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
31-May-24	Acute & Urgent care	Eden Acute		Red	Amber	Red	Red	
31-May-24		Eden PICU		Amber	Amber	Amber	Red	
31-May-24		Endeavour House		Green	Amber	Green	Red	
31-May-24		George ward		Red	Green	Red	Red	
31-May-24		Larimar		TBC	Green	Amber	Red	
20-Sep-24		Central & East Inpatients	Amber	Amber	Amber	Amber	Red	Green
17-Jan-25		Urgent Care: Psychiatric Liaison/Bed Management	Amber	Amber	Amber	Amber	Green	Amber
21-Mar-25		Home Treatment	Amber	Amber	Amber	Red	Amber	Amber
21-Mar-25		HTT West	Green	Amber	Green	Amber	Green	Amber
21-Mar-25		HTT North	Green	Green	Green	Amber	Amber	Amber
21-Mar-25		HTT South	Red	Red	Red	Red	Red	Amber
21-Mar-25		HTT Zinnia	Amber	Amber	Amber	Amber	Red	Amber
21-Mar-25		HTT Solihull	Red	Red	Amber	Red	Red	Amber
24-Apr-25		South inpatient Psychology	Amber	Amber	Amber	Amber	Green	Amber
24-Apr-25		Melissa ward	Amber	Amber	Amber	Green	Red	Green
24-Apr-25		Japonica	Amber	Amber	Amber	Amber	Red	Amber
24-Apr-25		Tazetta	Green	Green	Green	Green	Red	Green
24-Apr-25		Magnolia	Green	Green	Green	Green	Red	Amber
24-Apr-25		Caffra (PICU)	Green	Green	Green	Green	Red	Green
12-Mar-24	ICCR	SOLAR						
4-Jun-24		Homeless CMHT	Green	Green	Amber	Amber	Green	Green
4-Jun-24		Rough Sleeper MH Team	Green	Green	Green	Amber	Green	Amber
4-Jun-24		Health Exchange	Amber	Green	Amber	Amber	Green	Amber
20-Aug-24		Neighbourhood MH Teams	Amber	Amber	Amber	Amber	Amber	Green
20-Aug-24		Adult CMHTs	Amber	Amber	Amber	Amber	Amber	Amber
10-Sep-24		SIAS	Green	Green	Amber	Amber	Green	Amber
10-Sep-24		Recovery Near You	Green	Green	Amber	Amber	Green	Green
10-Sep-24		COMPASS	Green	Green	Green	Green	Amber	Green
1-Nov-24		S2R Wards	Amber	Green	Green	Green	Amber	Green
14-Jan-25		SPS	Green	Green	Green	Green	Green	Green
11-Mar-25		AOT	Amber	Amber	Green	Amber	Green	Green

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
11-Mar-25		AOT	Amber	Amber	Green	Amber	Green	Green
11-May-25		Enhanced Team for Personality Disorder						
2-Apr-25	Secure	Secure CAMHS	Amber	Red	Green	Amber	Green	Red
2-Apr-25		Womens Secure Blended Service	Amber	Amber	Green	Amber	Green	Amber
2-Apr-25		Youth First	Amber	Amber	Amber	Amber	Green	Amber
2-Apr-25		Offender Health	Amber	Red	Green	Amber	Green	Amber
2-Apr-25		Health Justice Vulnerability Service	Amber	Amber	Amber	Amber	Green	Amber
12-May-25		Reaside	Amber	Amber	Green	Amber	Green	
12-May-25		Tamarind	Green	Amber	Green	Green	Green	
12-May-25		FIRST	Green	Amber	Green	Green	Green	
20-Jun-25		Ardenleigh/Offender Health/Liasion and Diversion						
15-Aug-25		Reaside/ Tamarind/FIRST						
17-Oct-25		Ardenleigh/Offender Health/Liasion and Diversion						
19-Dec-25		Reaside/ Tamarind/FIRST						
7-Mar-24	Specialties	Clinical Health Psychology	Red	Amber	Amber	Red	Red	Red
2-May-24		Deaf		Amber	Amber	Amber	Red	Red
2-May-24		Neuropsychiatry		Amber	Amber	Green	Red	Amber
25-Jul-24		Perinatal		Green	Amber	Green	Amber	Green
25-Jul-24		Mother and Baby & Outreach		Green	Amber	Green	Green	Green
5-Sep-24		Eating Disorders	Green	Green	Green	Amber	Green	Green
7-Nov-24		Art Psychotherapy	Green	Green	Green	Green	Green	Green
7-Nov-24		Veterans	Green	Green	Green	Green	Green	Green
21-Jan-25		Dementia and Frailty Inpatients		Amber	Red	Amber	Red	Green
6-Mar-25		Care Home Liasion/CERTS	Green	Green	Green	Green	Green	Green
1-May-25		MAS	Amber	Amber	Red	Green	Red	Amber
1-May-25		Older Adult CMHT		Red	Amber	Amber	Green	Green

Acute and Urgent Care Directorate Accountability Framework domains self assessment

South Acute inpatients (19/04/2025)

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Psychology	X1 Psychologist & X 1Assistant currently appointed. 2nd vacancy advertised	Reduction of following – ▪ MDT working ▪ Staff wellbeing ▪ Reduces Quality/ patient care	Position was red earlier in year . Full recruitment supports MDT working and patient flow	Impacts on debriefs and consultation and group work.	Green although increases LOS. Underspend due to inability to fully recruit	○ Vacant posts out to advert . ○ In meantime plans to support with additional Psycholgy Assistant (fixed term contract) Mitigation Plan ○ Access to personality disorder service ○ Sign post to Community DBT service sign ○ Increase of OT activity workers
Mellissa Ward	December-January High acuity, high sickness, Psychology x1. RC`s job share. Currently interim Manager .OT successfully recruited .	Reduction in – ○ MDT working ○ Female wards mostly affected with EUPD patients ○ Reduction in staff well being	○ Improving (move from red to amber). ○ Mitigation plan successful. ○ Daily touchpoint meetings now stepped down but have opportunity to restart should there be any deterioration.	Staffing deficits addressed as discussed (psychology, activity worker and sickness improvement). Moved from red to amber December-January.	Recent improvement on LOS, however increased demand for beds % variance -drugs -127.16% and YTD variance is -33.07%	Recruited to Managers Post (interim) + OT Fully to Psychology Increase ward activity. Improvement in LOS /OBD (patient flow meetings) Manage sickness through sickness policy once manager in place. Adherence to RMS and Clinical supervision and training.

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Japonica	Female Mixed Acute / AOT	Good patient outcomes. Positive Quality Metrics. Increased LOS due to complexity of AOT patients.	See matron Audit updates – requires improvement in IPPC audits. Increased LOS due to AOT Complexity	Historically high. vacancy now recruited wit IENS and new staff therefore Team inexperienced but bedding in	Increased LOS/OBD /Bed Demand YTD variance Jan 25 –-- 17.06% - robust plan for Roster management and bank agency use.	Overall – New staff – Mitigation Plan, inclusive of team events, Clinical /Regular Management Supervision, shadowing & rotation opportunities. Review of inpatient female AOT Efficacy .(AOT females rarely above 50%)
Tazetta	Acute Male	Fully recruited + 1	See matron Audit updates	Fully recruited + 1 Acuity evident therefore increased observation levels CRFD + MOJ being reviewed daily. Good team morale	Increased LOS/OBD /Bed Demand Male acuity and comorbidity complexity drives costs % variance – drugs 13.56%	Review observation and staffing requirements daily in GH. Patient flow improving

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
				Supply of contraband especially illicit drugs a concern	YTD variance is -41.92% related to high observations	○ Mitigation incudes SMT Roster oversight. ○ Enhanced observations + confirm and challenge ○ Mitigation plan in place inclusive of increased vigilance, use of drug dogs, restriction of leave where applicable and Capital Bids for Barrier control and concierge service and escalation to Police.
Magnolia	AOT Male	Fully recruited + 1	See matron Audit updates	Consistently work within allocated numbers Increased LOS / AOT complexity & appropriate placement availability	Supply of contraband especially illicit drugs a concern YTD variance is -8.57% % variance -drugs -213.41%	○ Mitigation plan in place inclusive of increased vigilance, use of drug dogs, restriction of leave where applicable and Capital Bids for Barrier control and concierge service and escalation to Police. ○Drug spend – cost not reducing – plan with pharmacy to reduce spend and over prescription.

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Caffra	**(PICU)**	Fully recruited + 1	See matron Audit updates Increased CRFD stepdown due unavailability of Acute beds. More direct discharges	OT started this week ,MDT working affected by no psychologist as other wards . Much improved finance management- underutilized hours for September following work in agency spend pilot Increased property damage compared to other wards + racist violence towards staff .	Much improved finance management- underutilized hours for September following work in agency spend pilot % variance -drugs 8.52% YTD variance is -33.58% relates to high observations	Better working with bed management and other PICU enabling support across division 50% patients MOJ s37/41 That reduces Picu capacity . Plan in place with forensics to support. Racial violence – improving with plan to involve Police & Trust Diversity leads

Please indicate whether each domain for the service is Red/Amber or Green and provide an overall RAG rating for the service. Short notes should be added to each box with the rationale for the RAG rating

If you add notes that are different ratings within the same domain, please give an overall RAG Rating by adding a note in the box i.e. 'Overall: Amber'

YTD Staffing RAG Rating Summary

December 2024 (improvements from Dec – April)

CentresLevel Description	Bank % of Pay	Agency % of Pay	Substantive % of Pay
CAFFRA PICU	45.33%	0.03%	54.65%
JAPONICA INPATIENT UNIT	30.08%	0.10%	69.82%
MAGNOLIA INPATIENT UNIT	21.38%	0.05%	78.58%
MELISSA INPATIENTS UNIT	44.20%	0.20%	55.60%
TAZETTA INPATIENTS UNIT	30.46%	0.05%	69.49%
Grand Total	35.67%	0.09%	64.25%

April 2025

CentresLevel Description	Bank % of Pay	Agency %	Substantive % of
CAFFRA PICU	36.10%	0.01%	63.89%
JAPONICA INPATIENT UNIT	23.81%	0.05%	76.14%
MAGNOLIA INPATIENT UNIT	15.96%	0.02%	84.01%
MELISSA INPATIENTS UNIT	40.41%	0.10%	59.49%
TAZETTA INPATIENTS UNIT	29.52%	0.02%	70.45%
Grand Total	30.40%	0.04%	69.56%

Agency

Green = 0 – 2%

Amber = 2 – 3.7%

Red = Above 3.7%

Bank

Green = 0 – 10%

Amber = 10 – 20%

Red = Above 20%

- Plan in place for oversight and confirm and challenge of observations and bank use daily at Grand Huddle

Support requested at time of report

- Progress anti barricade system, all wards have different doors. This increases risk
- Decision on closed bathrooms – empty clinical space costs money
- Contraband and Parking at front of oleaster concerning – request to support funding for barrier control

NB overall excellent feedback from patient council

South Inpatients Admissions /Discharges (Ambition 0 OOA)

- Increase flow by addressing CRFD (= 4) , Length of Stay and OBD.
- Reduce spot bed OOA = Dec 2024 total = 12 April 2025 - total 4
- Adherence to best practice length of stays (28 days) by robust regular pathway discussion with RCs and for this to be confirmed in new Standard Operating Procedure.

Staff Survey

South Inpatients

- 22 scores improved, 27 fallen back.
- People feeling more valued and less burnt out but more scope to improve
- Teamwork a likely focus. 3/8 scores below Trust average and 5 falling year on year . Action learning set support workstream and engagement (You said we did)

Metric	Organisation	Acute - South Inpatients Section '24	Acute - South Inpatients Section '23	Change Year on Year (6%)
	2,650	80	80	YoY
I am enthusiastic about my job (Often/Always).	70.9%	73.4%	73.4%	
Time passes quickly when I am working (Often/Always).	70.0%	70.9%	61.5%	
I always know what my work responsibilities are (Agree/Strongly agree).	87.0%	91.3%	87.5%	
I am trusted to do my job (Agree/Strongly agree).	90.2%	90.0%	93.8%	
There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	78.2%	85.0%	86.3%	
I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	77.2%	79.7%	85.0%	

Staff Survey South Inpatients – Responses requring action (Via Action learning learning sets)

Data Type	Metric		Organisation	Acute - South Inpatients Section
Question score	Q4c	My level of pay (Satisfied/Very satisfied).	36.2%	20.0%
Question score	Q5b	I have a choice in deciding how to do my work (Often/Always).	61.1%	46.3%
Question score	Q5c	Relationships at work are strained (Never/Rarely).	54.7%	43.8%
Question score	Q7b	The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	70.3%	57.7%
Question score	Q7e	I enjoy working with the colleagues in my team (Agree/Strongly agree).	81.0%	67.9%
Question score	Q10b	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours (0 hours).	62.4%	39.0%
Question score	Q12f	How often, if at all, do you feel that every working hour is tiring for you (Never/Rarely).	58.7%	48.7%
Question score	Q13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Never).	80.1%	33.8%
Question score	Q14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (Never).	68.4%	24.1%
Question score	Q16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (No).	83.6%	45.0%
Question score	Q16c01	On what grounds have you experienced discrimination? Ethnic background (No).	36.3%	9.1%
Question score	Q16c04	On what grounds have you experienced discrimination? Sexual orientation (No).	95.4%	86.4%
Question score	Q17a	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public (Never).	86.3%	58.8%
Question score	Q18	In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users (No).	67.8%	44.9%
Question score	Q22	I can eat nutritious and affordable food while I am working (Often/Always).	51.9%	33.8%
Question score	Q24a	This organisation offers me challenging work (Agree/Strongly agree).	69.9%	58.2%

Areas of improvement – Tazetta and Japonica (Return to work)

Remaining wards are green

Birmingham and Solihull Mental Health NHS Foundation Trust

Memory Assessment Service & Older Adult Community Deep Dive

May 2025

Lou Pickering, Community Service Manager
Tim Adams, Operational Lead

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality and Safety

Memory Assessment Service

- Challenges with significantly long waits for Memory Assessment Service, actively being address with work on digital pathway, capacity remains a challenge.
- MCI will need to be identified in the future in greater numbers, there is no capacity in the service to proactively address this.
- Lack of system working around Memory assessment.
- Waiting well programme now established with recovery college, received positive feedback on preparing for diagnostic assessment.
- Improved reporting re where SU is in pathway. Benchmark well against other services within the MSNAP.
- Initiation of MAS Implementation plan and steering group

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Operational Performance

Memory Assessment Service

- DDR slowly improving 62.6% against national target 66.7%, positive impact from data cleaning initiative although not sustainable
- Historical long waits for referral to assessment, a notable improvement in Q4 24/25, current average wait 31 weeks against a 6-week target
- The service has not met this target since it was established due to a range of factors, including higher than expected numbers of referrals, ongoing recruitment and retention challenges, long standing historical waits, impact on service delivery during covid and surge in referrals post covid.
- Capacity modelling supports a significant under establishment in workforce to met current need, likely to worsen with ageing population

MAS waiting times

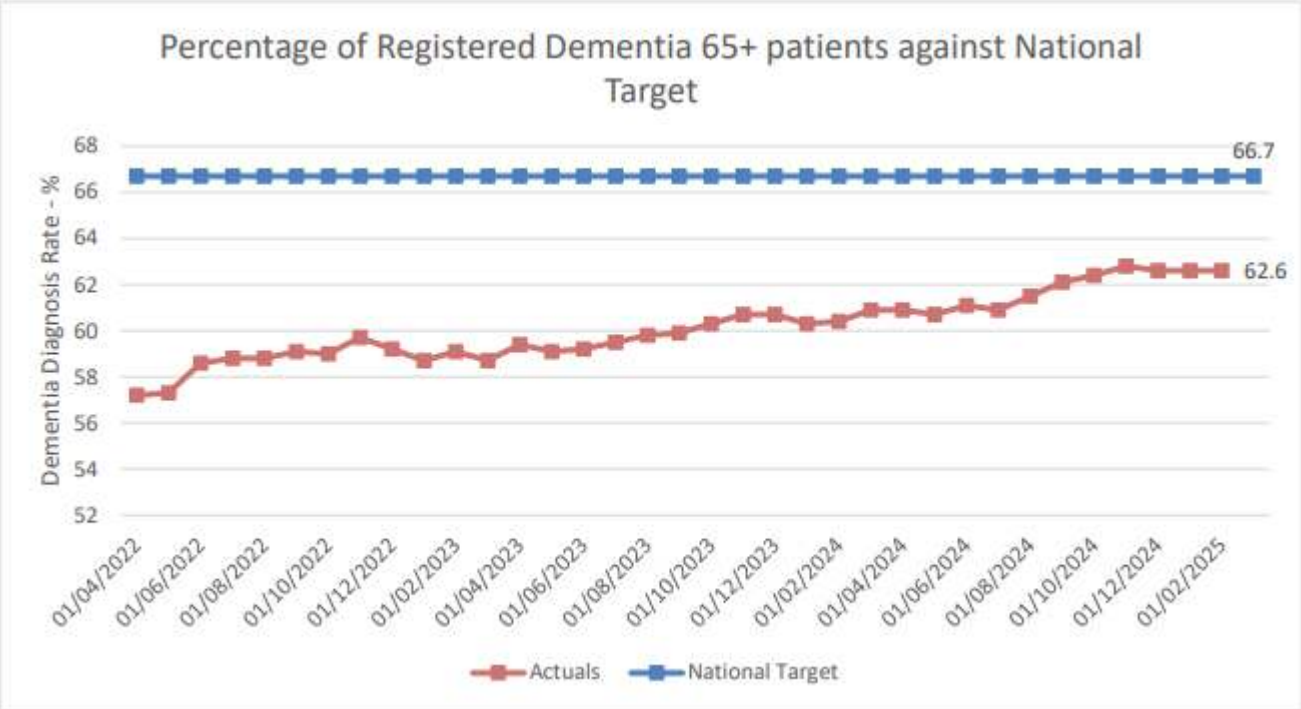
As at 15 April 2025

Team	0-1 Wks	1-2 Wks	2-3 Wks	3-6 Wks	6-10 Wks	10-14 Wks	14-18 Wks	18-26 Wks	26-52 Wks	52+ Wks	Total 15 Apr	Total 21 Feb
Service Total:	**42**	**38**	**57**	**147**	**171**	**180**	**121**	**254**	**407**	**5**	**1422**	1497
DIADEM Assessment Team	4	5	0	10	11	5	7	1	4	0	**47**	18
Memory Assessment- Complex Formulation	3	0	4	10	5	8	2	6	5	0	**43**	39
Memory Assessment- Complex Mainstream	5	17	28	59	80	77	58	111	216	2	**653**	714
Memory Assessment- Complex Psychology	2	2	6	8	5	11	3	11	44	3	**95**	105
Memory Assessment- Non Complex	8	13	19	60	70	79	51	125	138	0	**563**	608
Memory Assessment -TRIAGE	20	1	0	0	0	0	0	0	0	0	**21**	13

Reduction of 75 since 21st February

Referrals over 3 months with no contact has shown a steady decline in last 3 months

Dementia Diagnosis rate



Source: NHS England.

https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data

- The current Birmingham and Solihull CCG dementia diagnosis rate is **below** the target of 66.7%.
- Diagnosis rate based on the proportion of estimated over 65s in the population with dementia that have been diagnosed.

BSOL_0098

Measure	202403	202404	202405	202406	202407	202408	202409	202410	202411	202412	202501	202502
Actuals	8,799	8,815	8,804	8,877	8,855	8,975	9,069	9,119	9,189	9,183	9,176	9,179
Published Rate - %	**60.9**	**60.9**	**60.7**	**61.1**	**60.9**	**61.5**	**62.1**	**62.4**	**62.8**	**62.6**	**62.6**	**62.6**
Underlying Prevalence	14,450	14,481	14,502	14,534	14,543	14,587	14,615	14,623	14,637	14,675	14,662	14,673

Workforce and Culture Data

Appraisal Rate

- **MAS 96%**

Vacancy Rate

- **MAS 1.8%**
- Variance (WTE) 0.5

Sickness Absence

- **MAS 1.1%**
- Short term sickness 1.1%
- Long term sickness 0.0%

Clinical Supervision

- **MAS 100%**

Turnover Rate

- **MAS 3.3%**
- Leavers:in-month - 0
- Leavers:rolling 12 months - 1

Fundamental Training

- **MAS 97.7%**

RMS

- **MAS 100%,**

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Finance

- End of year 24/25 budget was overspent due:

- Staff pay award
- UHB invoice Scans £115K

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Strategy and Transformation

MAS

- Explore opportunities with system partners for more joined up thinking and partnership working including:
  - Active engagement with Dementia Leads across acute trusts
  - Engagement stands with Age UK and Alzheimer's Society
  - Regular meetings with ICB lead
  - GP leads to explore primary care diagnosis
  - Reading well.org, reading well in dementia pilot in mas Bsol

- Delivery of co-produced Waiting well programme running in conjunction with recovery college as part of waiting well initiative

- Digital transformation - identified leaner processes across pathway including; centralised booking system, updated clinical pathway, improving clinical systems recording and reporting (new screening, scan requests and new assessment summary forms), streamlined imaging requests and DNA management plan

- Data cleansing pilot - enhanced admin resource to increase the DDR rate.

Quality and Safety

- Red risk - long waits for assessment, high caseloads impacting team capacity to proactively respond to need of SU and carers.

- Increased levels of acuity and complexity across CMHT's.

1. Increase in new built large retirement villages and specialist nursing homes, predominantly solihull and north Birmingham and this is increasing the population of older adults within these areas.

- Dementia medication impacting service flow with increase in GP's declining ESCA's.

- Increase in number of suicides within the community- care homes and those in contact with CMHT – recognised importance of need for robust and structured de-briefs.

- Increase in safeguarding supervision uptake across teams with positive impact.

- Introduced managers touchpoint meetings to support with complexity and reflexivity.

- Lack of older adult knowledge in non specialist teams that we need to rely on in the pathway i.e. neighbourhood team, home treatment.

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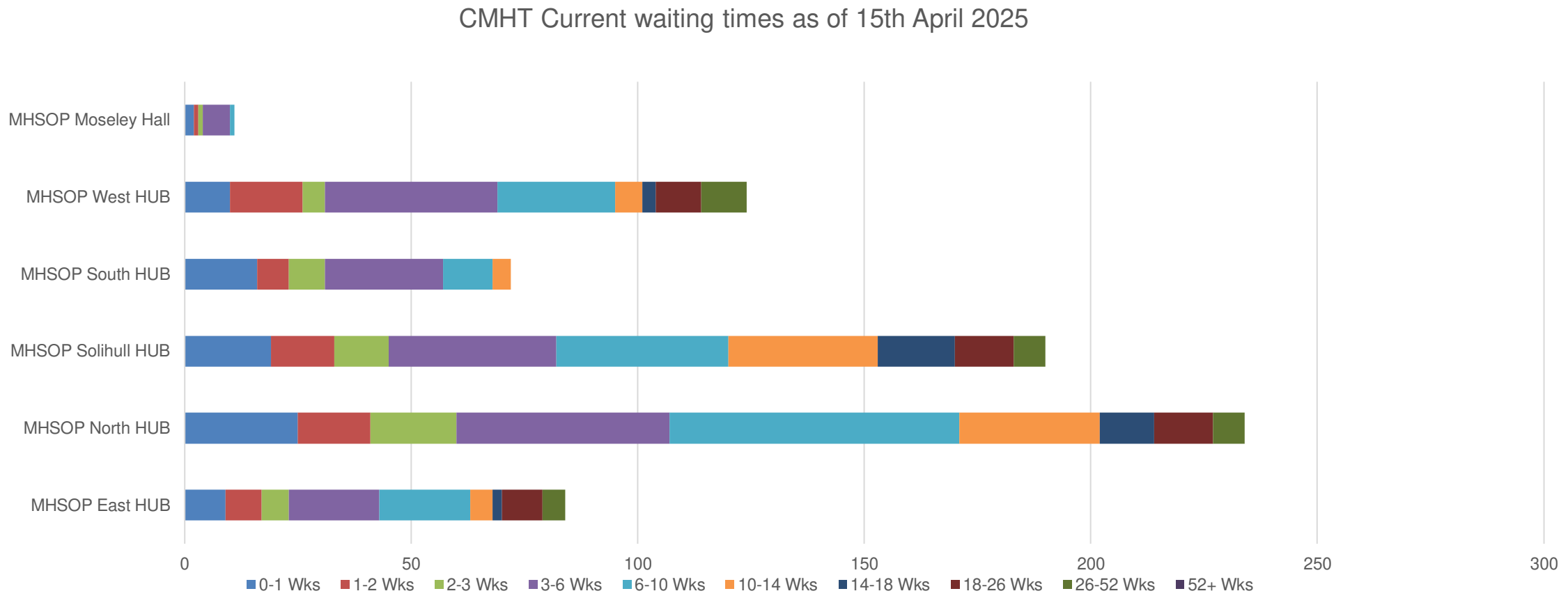
Operational Performance

CMHT

- Improvement in long wait management due to data cleansing exercise, team capacity to offer a timely appointment remains challenged in North, Solihull and West teams
- Caseloads are increasing year on year in line with ageing population.
- Dementia medication remains largely in secondary care impacted team's ability to discharge from service – particular challenge in North and Solihull where high levels of older age demographics
- National NHS Benchmarking across older Adult CMHTs rank BSMHFT 3rd highest caseload in 2024 based on weighted population at 1,743 compared to the national average of 754
- Caseload stratification for SMI population completed in South CMHT – identifying patients that have been on caseloads for a long time and challenging the need for service, strengthened relationships with NMHT but limited flow impact due to need

Waiting Times



As of 15th April 2025, there are 715 people waiting for a first appointment.

Waiting times for 1st Appointment as of 15th April 2025 have decreased by 44 since 20th February 2025. There are no people waiting for more than 52+ and 26-52 weeks has decreased by 1 to 29

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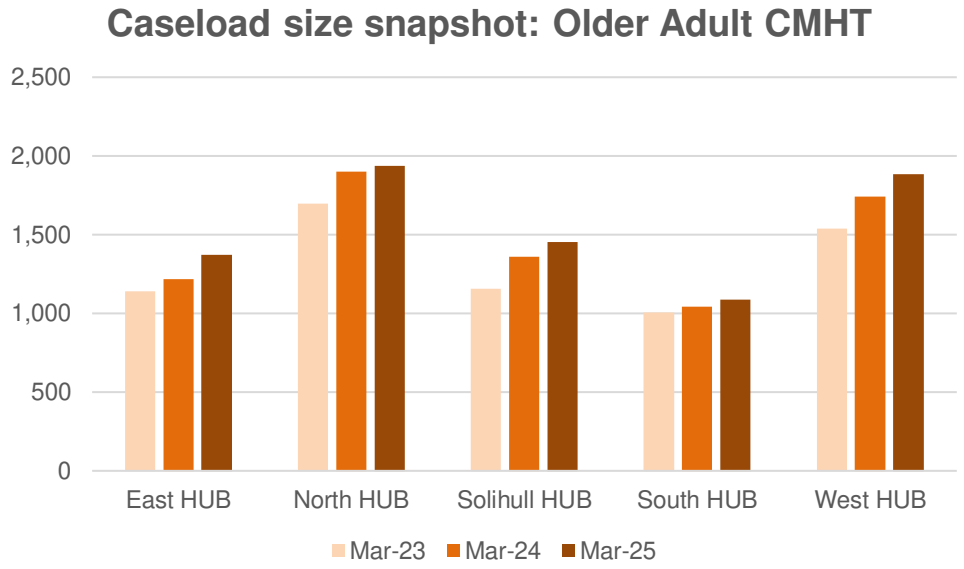
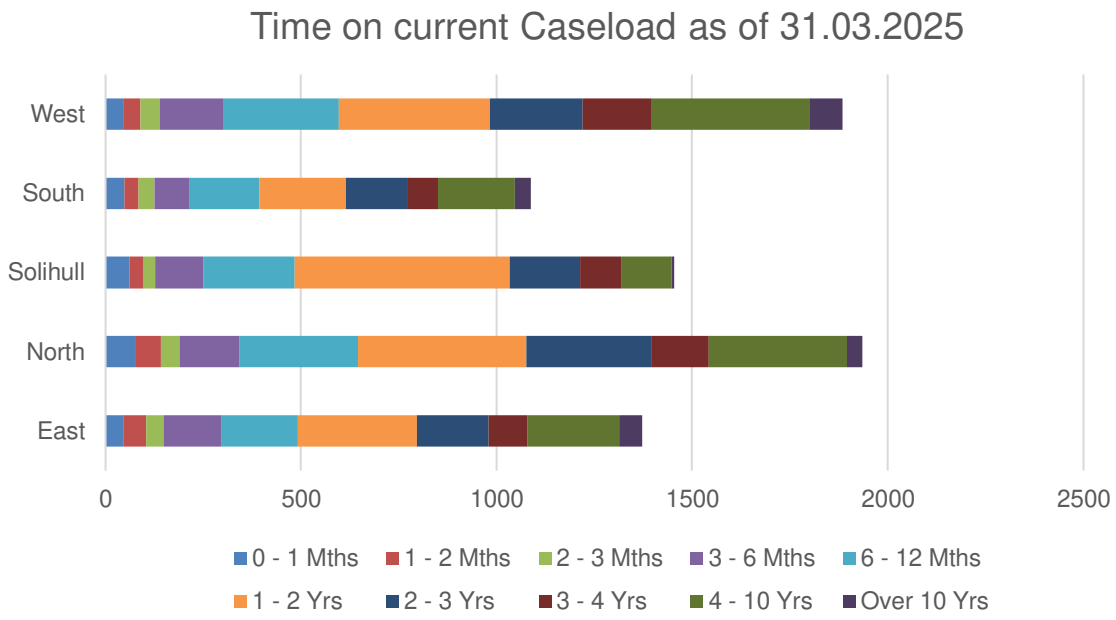
Caseload size and time on caseload: Older Adult CMHT



2024 NHS Benchmarking older Adult CMHTs are the 3rd highest based on weighted population at 1,743 compared to the national average of 754



CMHT NHS Benchmarking

Metric	Low – High	MH010	Mean	Median
Referrals received per 100,000 population		2,594	2,620	2,499
Referral acceptance rate		73%	86%	90%
Median waiting time referral to 1st appointment (weeks)		...	3.3	2.2
Median waiting time referral to 2nd appointment (weeks)		...	8.5	6.0
Community caseload per 100,000 resident population at 31st March 2024		2,717	1,174	916
Patients on caseload with no contact in 2023/24 per 100,000 population		318	111	46
Contacts delivered per 100,000 population		19,855	20,377	18,064
Proportion of contacts delivered face-to-face		71%	66%	64%
Proportion of contacts delivered non-face-to-face		29%	35%	36%
Proportion of contacts delivered digitally		2.0%	1.0%	0.6%
Community WTE per 100,000 population		57.4	71.4	66.4
Cost per contact		£359	£325	£270
Cost per patient on caseload (caseload at 31st March 2024)		£2,624	£6,263	£5,183

- 3rd highest Caseload above the mean and in the top quartile for weighted population at 1,743 compared to the national average of 754.
- The number of referrals we receive is just below the national average, the **acceptance rate** is **73%** against a national average of 86%
- Number of contacts at 12,473 is below the national average of 14,462
- **The numbers one the** the caseload not seen in previous 12 months based on weighted population is 318 compared the national average of 111(*note the definition is different to internal metric*)
- **71%** of patients were seen face to face compared to the national average of 66%
- Older Adult CMHT had 15th lowest total number of staff based on weighted population (36.8) at 31.03.2024 compared to a national average of 51.5

Workforce and Culture

- Team Manager for Solihull CMHT appointed following several rounds of recruitment, post vacant for 12 months
- CSM commenced Trust in September 2024
- Career development and retention workshop planned with Professional Education and Development Team
- Risk of burn out is high across CMHT's due to high case loads and MAS due to long waits
- Introduction of range of development initiatives, empowering staff to work autonomously. Comms around CEAG and NAC, more representation now at trust wide meetings
- Quarterly in person workshops to bring managers and professional leads together from across the service
- **Staff survey:** Year on Year there are some striking changes with people feeling more involved, recognised and valued.

  Areas of significant improvement:

  - 11% improvement on feeling valued by the organisation & 14% by team.
  - 17% improvement on being able to access learning opportunities and people much more likely to one to stay.

  Areas to develop:

  - Flexible working opportunities
  - Managing clinical incidences
- John Travers/Service Manager met with all Team Managers to support improvement plans at team/service level address through Team Meetings. Plan to improve Staff Survey in 25/26

Workforce and Culture Data

Appraisal Rate

- CMHT North, Solihull, South, East, all 100%
- CMHT West 91.9%

Vacancy Rate

CMHT vacancy rate -1.9% to 13.8%
Team with high vacancy rate:
- CMHT East 13.8%

Sickness Absence

CMHT sickness rate 0-11.5%.
Teams with highest sickness rate:
- Solihull CMHT 11.5%
- West CMHT 9.4%

Clinical Supervision

- CMHT West 93%, North 92%
- CMHT Solihull 62%
- CMHT: East , South100%

Turnover Rate

CMHT turnover rate 0-7.1%
Teams with high turnover:
- CMHT West 7.1%

Fundamental Training

- 100% East CMHT - 89.1% West CMHT

RMS

- CMHT West 94%, North 92%
- CMHT Solihull, South, East all 100%

Finance

- End of year 24/25 overspend across Dementia and Frailty Community was £1m, due to:
  - Pay Award
  - Community Medic Agency (432K)
  - FP10 overspend (£277 across IP/Community)
  - UHB invoice Scans £115K

- Non-pay overspend is forecasted to improve across 25/26 due to community medic recruitment into substantive posts and review of UHB scan SLA

- Extensive review of community budgets/skill mix completed by CSM and finance

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Strategy and Transformation

CMHT / Service wide

- FFF bid submitted which would address health inequalities, improve integrated working with primary care and community trust and align with locality working. This would also support the increase of DDR.
- Caseload stratification project for SMI cohort is being launched in June
- Increase in QI projects across service, South CMHT QI project on managing DNA Management recently nominated for HSJ award
- Focus on building networks and establishing relationships across BSMHFT to integrate pathways
- PCERF action plan: Holding a series of engagement events to identify actions to increase access and improve experience of people who access our services
- Concern arounds plans to appoint to ICB Clinical Lead for Dementia have been put on hold, impacting system wide buy in and impact

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Key Messages

- Current Dementia Service Delivery Model does not meet the needs of the local population and requires system wide transformation with wider partnership working across all parts of the Dementia Pathway
- Birmingham is an outlier nationally re: Dementia Medication Management remains in secondary care, with notable shift on declining ESCA's across primary care.
- Capacity challenges are seen across MAS and CMHT and will worsen with increase in new large retirement villages, demand increase is already seen in the caseload data with no additional staffing to support
- Passionate and skilled leadership team to support working differently
- Positive impact on Data cleansing on long waits and workforce KPI's

10. 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	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**23 April 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Culture of Care Progress Update • PEAR Update • Mental Health ED Summit • National Patient Survey Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Safer Staffing • Case for Closure- Adriatic • Integrated Performance Report • Clinical Governance Committee Assurance Report • Dialog+ update • Intensive & Assertive Community Mental Health Care Learning from Nottingham Case • Forward Planner
Alert:	The Committee wished to alert the Board of Directors to the following: • The Committee received the Closure of Adriatic ward proposal noting the proposal has been developed following a number of incidents that have been identified through quality impact assessments. There has been a high level of incidents that continue to create pressures for staff alongside the poor environment. The Committee noted the significant issues and concerns and need to consider strategic opportunities for better care before approving the closure of the ward. • Access issues for ADHD and Older People remains a high risk and focus for the Committee. • The Committee received the Safer staffing report and noted the significant risks associated with competency skills of staff being appointed into senior roles. The highest risk remains CMHT with significant gaps for senior nurses, the lack of skills and expertise are a key component to the risks.
Assure:	The Committee was assured on the following areas: • Committee visit feedback following a recent visit to HMP Birmingham was positive and improvements noted. A full scheduled of Committee visits is in place for 2025.

	• Board Assurance Framework developments continue to provide assurance. Joint Executive led risks will now triangulate across Committees to ensure full oversight. • Culture of care at Reaside reported significant improvements for both staff and service users with collaboration and co- production a key focus. Expert by experience engagement has supported the design of the framework with a family culture approach embedded with 'live, life, love' as the values in place. • Patient Councils have been developed and embedded across in patient units, they showcase the service users voice in real time and promotes positive engagement. Feedback has been positive and meetings are well attended. • Safer staffing retention has improved significantly. The current overall position is positive with the number of leavers reducing and retention remaining stable at over 70% in nursing. There is an established pipeline from the University and the attraction strategy is supporting positive recruitment.
Advise:	The Committee were advised: • Culture of care programme will be launched at Ardenleigh. • Mental Health ED summit scheduled for 24 April 2025 with representatives from across the system. The objective of the summit is to understand and reduce the long wait times for mental health patients in emergency departments and it will address a number of questions in relation to successful initiatives and ongoing improvements. • National patient survey benchmarking report was received. A deep dive into results is scheduled and will include benchmarking comparisons. A low response rate of 19% is a key risk to data validation. This is a slight improvement on last year by 2%. Respect, dignity and compassion is the top score. Crisis care support was the worst score. Planned improvements are being developed to address access to crisis support, this will include engagement with family and carers. • Learning from Nottingham report was received and highlighted the requirement to review community mental health services for patients with serious mental illness who require intensive community treatment and follow-up but where engagement is a challenge and implement improvements in public safety, risk management and care. Work is in progress to review pathways with potential investment available from Reach Out colleagues. A business case is being developed to support clinical improvements and outcomes will be shared with Committee when available. • Dialog+ implementation has been underway in the Trust for a number of years and following the Community Teams phase of implementation, the Inpatient Dialog+ Implementation phase will be complete by 28 April 2025. This is in line with national approach.
Board Assurance Framework	The Committee were assured the Board Assurance Framework is reflective of the associated Committee risks.
	New risks identified: no additional risks were identified.
Report compiled by:	Linda Cullen Non-Executive Director
Minutes available from:	

		Hannah Sullivan, Corporate Governance Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**21 May 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Culture of Care Progress Update • PEAR Update • Mental Health ED Summit Update • Patient Safety Report • Safeguarding Management Board Assurance Report • Infection Prevention & Control Team Report Q4 • Integrated Performance Report • Clinical Governance Committee Assurance Report • Mental Health Legislation Committee Assurance Report • Quality Account • Clinical Effectiveness and CEAG Escalations
Alert:	The Committee wished to alert the Board of Directors to the following: • The Committee noted the number of overall complaints as a concern as there is a continual increase. They noted partial assurance in relation to improvement plans. • Clinically ready for discharge remains a major contributor to this and remains high. System level escalations being undertaken. • Waiting times and delays in accessing services remains a key concern. • The Committee discussed in detail concerns in relation to FTB and the impact on Parkview. The Committee noted their concerns in relation to the potential impact on services users pathways and highlighted the need for continued oversight for assurance.
Assure:	The Committee was assured on the following areas: • The Committee were assured with the significant improvements and transformation of culture at Reaside and the roll out across the Trust. The Committee noted the positive patient voice initiatives and highlighted the impact at Reaside • The Committee were assured the PEAR Group continues to develop with co-production with experts by experience at the forefront. The Committee noted a number of quick wins for continued improvement with oversight from the Clinical Governance Committee.

	• The Committee received a detailed presentation for Clinical Effectiveness and were assured there have been many clinical audits opened and completed over the past year with the decision to include local clinical audits into the Quality Account. • The Committee noted overall assurance for the Quality Account with the significant improvements highlighted to include the voice of the service user and clarified priorities. • The Committee received the Safeguarding Management Board Assurance Report and were assured organisational training compliance exceeds to KPI. Deep dive work continues into the staff who are non-compliant, by the safeguarding team. • Following the re-inspection of CMHTs in June 2024, the Section 29s were removed as the CQC found enough evidence that the Trust had taken appropriate actions in the areas of concern. • Section 29 Environment and Governance Processes at Reaside (Focused Inspection August 2024) has now been removed following the recent inspection. •	
Advise:	• The Committee approved the Quality Account. • The Committee approved the revised terms of reference for the Mental Health Legislation Committee.	
Board Assurance Framework	The Committee was assured the Board Assurance Framework is reflective of the associated Committee risks.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Sue Bedward Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance Manager

11. Quality Improvement: A Year in QI Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to the Board of Directors							
Agenda item:	**11**						
Date	4 June 2025						
Title	A Year in Quality Improvement 2024-2025						
Author/Presenter	Julie Romano, Head of Quality Improvement and Clinical Effectiveness						
Executive Director	Lisa Stalley- Green, Chief Nursing Officer.	**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**	

The document is an Overview of Quality Improvement activity across the Trust in the past 12 months, provided as an informative and interactive Year in QI document.

The document covers a range of elements that the QI Team support and champion with highlights of continuous improvement work over the last year in a holistic viewing approach. It is inclusive of:

- EBE progress
- Training status and QI training offers internally and now inclusive of ICB colleagues
- QI Project Status
- QI Communications update
- Good news and positive reputational updates, inclusive of finalists, winners and shortlisted entries across the year.
- LCGC and Corporate QI project overviews
- QI Team infrastructure changes
- NHS Impact Update inclusive of QMS approaches

With all Quality Improvement work there is a strong commitment to involve our service users/EBE's/families/staff, so work is truly coproduced. Many projects look at fundamental ways to improve the service user, pathway models and or staff well-being and in the report, you will see highlights of a few examples.

BSMHFT have participated in 2 National Quality Improvement Projects that have commenced in 2024. National Mental Health Act Quality Improvement Programme and the Culture of Care National Collaborative QI Programme. The programmes are designed to support inpatient ward staff to create psychologically safe, caring, and relationally strong ward environments. Through site visits, reflective practice, training, supervision, coaching, and skills-based development, the initiative aims to foster a sustainable culture of positive informal interactions and high-quality care this aligns to NHS England's 12 Culture of Care Standards and supports trauma-informed, autism-informed, and culturally competent care

and links to Trust strategic challenges. The plan is to do more of these strategic aligned bigger projects with roll out of the Culture of Care to all inpatient areas over the next 12 months.

The QI team support Listen Up live events regularly, attend and organise Workshop Events with teams and presentations to spread knowledge and support for continuous improvement. Collaborating with teams to develop a Quality Management System approach, inclusive of NHS Impact, to strengthen priority workstreams and how QI can be utilised across the system to the best effect. With plans to support the Strategy Team in the development of the next Trust Strategy in due course.

QI Team are working through new ways to bring through sustainability models and has been a focus over the last year and is one that we plan to strengthen and demonstrate over the coming 12 months.

Recommendation

The Board is asked to:

Note the great practice across the Trust with Quality Improvement methodology and projects supporting teams and individuals in a flexible approach.

Noting the new modules in the QI Academy to approach engagement with continuous improvement through a new lens and inclusive of peers in the wider ICB system. Providing leadership skills training, project training and QI methodology in a variety of accessible choices with more planned for the coming year.

Being a visible and accessible team, where our new Improvement Facilitators can in reach and support teams on a personal level and by having the resource, we have demonstrated the increase in training offers, uptake and able to be present at all inductions so new staff get a feel for involvement in improvement from day one in the Trust.

Awareness of the continued work with teams to develop Quality Management Systems at BSMHFT, with continued joined up thinking by combining QI and PSIRF collaboratively this has enabled Patient Safety to develop learning approaches together.

Many of the items included have hyperlinks to video links and team updates from our BSMHFT staff and EBEs. I would engage you to have a view as these are accounts of what it is like to be part of a QI Project or use QI methodology at BSMHFT.

Enclosures

Appendix 1: Year in QI 2024/2025 document

A Year In Quality Improvement 2024-2025

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

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**
SR4	✓	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
SR8	✓	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
SR9	✓	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Acronyms

A&E - Accident and Emergency
AMHP: Approved Mental Health Professional
AOT: Assertive Outreach Team
BCC: Birmingham City Council
BSMHFT: Birmingham and Solihull NHS Foundation Trust
CERTS: Community Enablement & Recovery Team
CHP: Clinical Health Psychology
CMHT: Community Mental Health Team
CPN: Community Psychiatric Nurse
CPS: Crime Prosecution Service
CQC: Care Quality Commission
C/YP: Child/Young Person
ECG: Electro-cardiogram
EDS: Eating Disorders Service
ELS: Emergency Life Support
ESCA: Enhanced Shared Care Agreement
GP: General Practitioners
HTT: Home Treatment Team
ICS: Integrated Care System
ILLY: A patient record software system
LCGC: Local Clinical Governance Committees
LD&A: Learning Disability and Autism
LP: Liaison Psychiatry
MBU: Mother & Baby Unit
MDT: Multi-Disciplinary Team
MHA: Mental Health Act
NACRO: A community substance misuse service
OT: Occupational Therapist

PDSA: Plan Do Study Act
PSIRF: Patient Safety Incident Response Framework
QI: Quality Improvement
QICE: Quality Improvement and Clinical Effectiveness Team
QMS: Quality Management System
RC: Responsible Clinician
RDS: Rare Dementia Service
RMN: Registered Mental Health Nurse
RNY: Recovery Near You
RT: Rapid Tranquilisation
SAS Dr: Specialty and Specialist doctor
SI: Serious Incident
SOP: Standard Operating Procedure
S2R: Steps to Recovery
TSS: Temporary Staffing Solutions
UHB: University Hospitals Birmingham
WTE: Whole Time Equivalent

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

A Year in Quality Improvement At BSMHFT 2024/25

Visit Quality Improvement on Connect

Contents

Please note links only work internally. For any queries, please contact the Quality Improvement inbox:
bsmhft.qualityimprovementteam@nhs.net

Julie Romano
Head of Quality Improvement and Clinical Effectiveness

“The heart of QI is collaboration - and this year, we’ve seen just how powerful we can be when we learn, lead, and improve together.”

Foreword

An Intro to Quality Improvement

It gives us great pride to introduce A Year in QI - a celebration of the energy, commitment and collective progress made across Birmingham and Solihull Mental Health NHS Foundation Trust through our Quality Improvement (QI) work over the past 12 months.

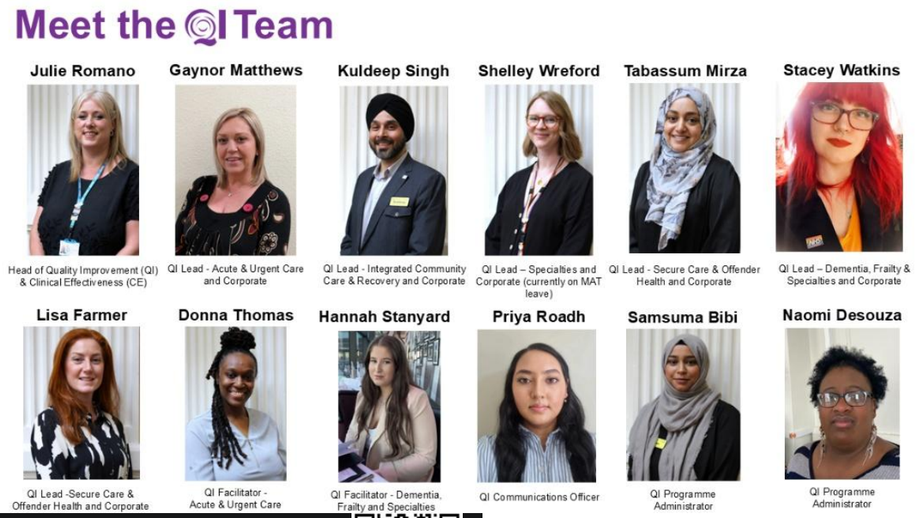
This year has been one of purpose and momentum. From reducing DNAs and unnecessary FP10s, improving mealtime experiences for our service users, and standardising lone working processes, to shaping a Culture of Care across our inpatient units -our QI efforts have spanned every corner of the Trust. At the heart of this work has been a steadfast focus on capability building, equipping both clinical and non-clinical teams with practical tools and knowledge to drive sustainable improvement using the Model for Improvement and our QI toolkit.

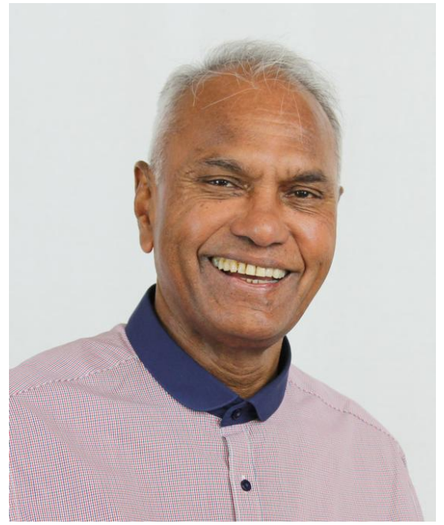
Co-production remains central to our ethos. Our partnerships with service users and Experts by Experience have ensured that improvement is never something we do to people, but with them. With an average of 30 - 40 live QI projects and over 1,200 staff trained in QI, we are embedding a culture of continuous learning and shared ownership - what we proudly call the QI way.

Our achievements have resonated far beyond the Trust. From national stages like the Royal College of Psychiatrists International Congress and the Mental Health Improve conference, to our own Values Awards, we have had much to celebrate. We also welcomed new team members whose perspectives and passion have brought fresh energy to our journey because, as we know, improvement thrives on new ideas, inclusion, and collaboration.
Thank you to everyone who has contributed, participated, or simply stayed curious. This report reflects your efforts, and the shared belief that by working together, we can always make care better.

What’s New?

Check out from **page 28** on the launch of new updates from the QI Training Academy! Learn more about the Quality Improvement (QI) sessions piloted at the Recovery College, and the first-ever QI session with service users piloted at Reaside on **page 10**.





Mustak Mirza, Deputy Lead Governor and Expert by Experience

We are deeply saddened by the passing of Mustak Mirza, Deputy Lead Governor and Expert by Experience. Mustak was a passionate advocate for Quality Improvement, always championing how the QI approach could support service users in their own recovery journeys.

Through the power of personal storytelling, Mustak brought people together, inspiring colleagues and service users alike to believe in a better way forward. As Chair of the Patient Experience and Recovery Forum, he played a pivotal role in shaping our Trust’s approach to co-production and lived experience leadership.

His compassion, vision, and unwavering dedication to improving lives leave an enduring legacy. Mustak was not only a valued leader and colleague, but a kind and courageous soul who will be sorely missed by all who had the privilege of working with him.

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QI Roadshows

QI IS OUT AND ABOUT

Bringing the power of Quality Improvement at Birmingham and Solihull Mental Health Foundation Trust to many sites for all to learn about the strategic and transformative structured approach.

Excellence in Psychological Professions Celebration Event 2024

On Thursday the 10th of October, 150 colleagues attended the Excellence in Psychological Professions Event at Birmingham City Football Ground. This event celebrated those within psychological professions on their inspiring work and commitment to their roles, with an emphasis on professional development and clinical practice. Team members of the Quality Improvement (QI) team collaborated with the event organisers Dr Newman Leung (Consultant Clinical Psychologist -Eating Disorders Service) and Samuel Molyneux (Senior Clinical Educator / Senior PWP), connecting with colleagues at the pop-up QI stand and engaging in the event activities.

Sunny Kalsy-Lillico, our Chief Psychological Professions Officer launched the event, highlighting the hard work and commitment of all staff at Birmingham and Solihull Mental Health Foundation Trust. Lisa Stalley-Green, our Chief Nurse gave an inspiring speech on her career journey that led to working at the Trust and emphasising the diverse array of exceptional services and departments within the organisation. Including a reference to QI, highlighting that “Quality Improvement is absolutely where we want to be.” Katherine Allen (Lead for Recovery, Service User and Carer Experience) gave valuable insight into coproduction and the importance of working collaboratively with support of informative videos.

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QI Day, November 2024

A delightful day of QI! QI Facilitator Amy Jowicz, QI Programme Admin Naomi Desouza & QI Comms Officer Priya Roadh co-led the engaging event of QI Day. Fantastic meeting many friendly faces & delve deep into great QI discussions. Theme of the day 'Involvement.'

QI Inspires Interest in Improvement at Possibilities Beyond Limits Event, December 2024

The programme is in collaboration with Birmingham and Solihull Integrated Care System (BSOL IC). a development programme to improve the identification, engagement, and retention of colleagues from diverse backgrounds has launched for staff across Birmingham and Solihull.

Organisers Ramal Royal (Talent Development Manager-BCHC) and Rabia Begum (Senior Project Manager-Birmingham and Solihull ICB) gave a great introduction to QI with QI Lead Kuldeep Singh (ICCR and Corporate) leading the QI session. Kuldeep Singh, QI Lead (ICCR and Corporate) encouraged members of the event to ask questions “QI is all about curiosity.” Exploring the QI approach of the Model For Improvement (MFI). Looking at the significant impact of measuring data reviewing run chart examples, which QI Lead Kuldeep highlighted that “data tells a story, it should give enough information about what’s happening. Without no measuring, there’s no improvement. What you’re changing is what you’re improving.”

BSMHFT Celebrates LGBTQ+ History Month, February 2025

On Friday 14th of February 2025, BSMHFT celebrated LGBTQ+ History Month with a spectacular event. Quality Improvement (QI) Team members QI Lead Stacey Watkins (Dementia Frailty and Specialties| Corporate), QI Facilitator Donna Thomas (Acute and Urgent Care), QI Programme Administrator Naomi Desouza and QI Communications Officer Priya Roadh attended the exciting event; connecting with colleagues, hosting a QI interactive word game at the QI stall and opening a discussion on inclusivity and QI within the Trust.

Key Events

NHS IMPACT National Improvement

On 19th September 2024, BSMHFT's Continuous Approach to Improvement was showcased at the NHS IMPACT National Improvement Event in London. BSMHFT was represented by Julie Romano (Head of QI and Clinical Effectiveness), Dr Renarta Rowe (Deputy Chief Medical Officer for BSOL ICB) and Dr Sadira Teeluckdharry (Deputy Medical Director for Quality and Safety).

This exciting and informative National Improvement Event was chaired by David Fillingham CBE, Chair of the National Improvement Board and Chair of Lancashire and South Cumbria NHS Foundation Trust. One of the key highlights of the day was NHS Chief Executive, Amanda Pritchard, joining for the morning session and providing critical national context for all the excellent improvement work happening across the country.

A variety of Improvement work and projects at a variety of system levels with population approaches were shared with excellent examples of collaboration and shared learning.

Julie Romano shared the excellent offer by our Quality Improvement Team – QI Training Academy and QI Project support strongly underpinned by EBE Co-production and showcased the incredible work the team has done. From 2022 to current, 3240 BSMHFT staff have had some form of QI Training and out of these 1095 staff went on to more in-depth training.

There were two inspiring sessions by Lived Experience speakers who truly demonstrated the powerful voice of our Lived Experience partners in driving continuous improvement. Significant key messages were shared regarding the involvement of lived experiences.

"EBEs have so much more to offer than just their lived experience."- EBE Amy Chidley

We were also able to share the use of Improvement methodology in a number of workstreams in the Trust including Enhanced Gatekeeping pilot, Community Mental Health Transformation, the Culture of Care National QI Collaborative, the Personalised Approach to Risk QI, Dialog+ Care Planning Implementation and Improvement of our Patient Safety processes.

As we continue on this Improvement journey, we remain committed to working closely and collaboratively with all system stakeholders, patients, carers, families, Experts by Experience and staff to inspire and embed positive change.

QI got involved in an incredible opportunity to share QI projects from each directorate. These were submitted as external case studies for **NHSE Impact**, following from the positive feedback from speaking at **National NHS Impact Conference** in September 2024.

Check out the links to the Quality Improvement BSMHFT NHS Impact case studies: NHS Impact QI Case Studies

National Mental Health Act Quality Improvement Programme.

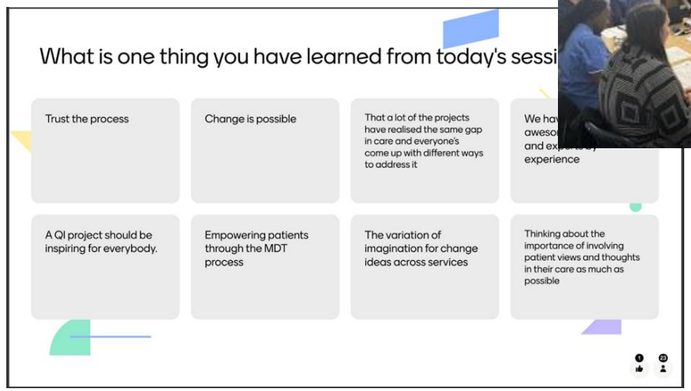
The aim of the programme is to improve the equity of experience for people from ethically diverse backgrounds and people with a learning disability and and autistic In 2021, the Government published a White Paper, Reforming the Mental Health Act, which accepted many of the recommendations from the 2018 Independent Review of the Mental Health Act. To support these improvements, one of the recommendations taken forward in the White Paper was a commitment for NHSE to deliver a national QI programme. This aims to Promote patient choice and autonomy to Apply the Mental Health Act in the least restrictive way possible and ensure care delivers therapeutic benefit also to ensure people are viewed and treated as individuals.

A fantastic first face to face workshop of the National Mental Health Act Quality Improvement Programme (MHA QI). Exploring data, process mapping and brainstorming for patient admission to the Eden Acute ward.

On the 25th of September, QI Lead Gaynor Matthews (Acute & Urgent Care and Corporate), QI Lead Stacey Watkins (Dementia, Frailty & Specialties and Corporate) and QI Facilitator Amy Jowicz (ICCR) supported colleagues from the Eden Acute ward, exploring data in the process mapping and brainstorming session for patient admission.

It was wonderful to bring everyone together in the engaging event to share the change ideas and learnings across teams, helping everyone find inspiration for the next steps in the continuation of their Quality Improvement journey!

The Mental Health Act National QI Programme (MHA QI) hosted a virtual Learning and Celebration Event to mark the end of the coaching for the main cohort of this programme and the successful implementation of impactful change ideas across the 36 wards nationwide that participated in this phase.



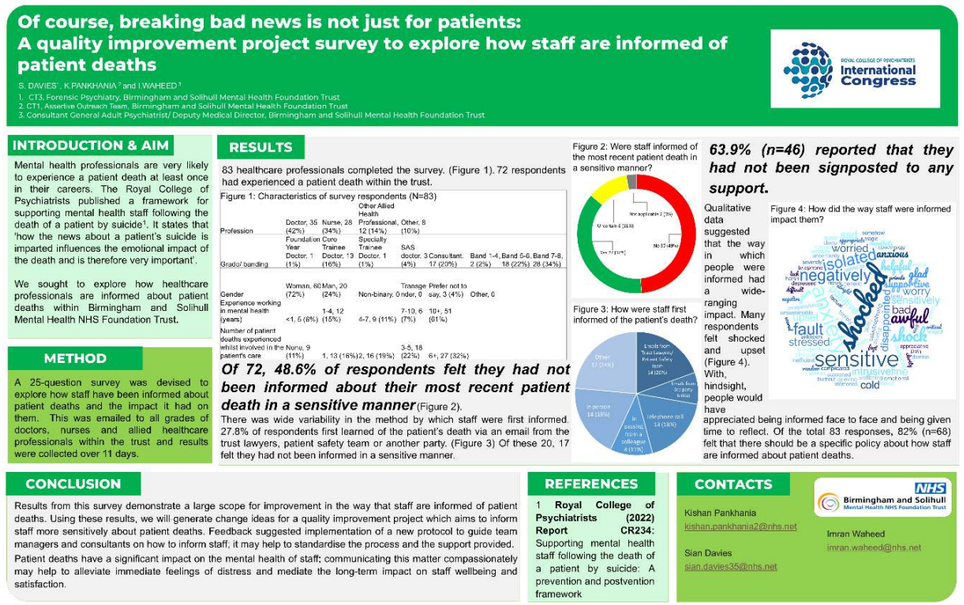
Visit Quality Improvement on Connect

RCPsych International Congress 2024

On the 17th-20th June 2024, Dr Kishan Pankhania attended the RCPscyh International Congress at Edinburgh to present their poster abstract, sharing the remarkable work of the Quality Improvement (QI) project on improving Initial Notification of Patient Deaths.

Patient deaths can have a huge impact on those who knew and supported them. Dr Kishan Pankhania and Dr Sian Davies started a QI project to look at how staff are informed about patient deaths to see if we can make the initial notification a compassionate and supportive process for those effected.
A staff survey was conducted to explore how staff are informed about the initial notification of patient deaths. The use of the qualitative data helps to inform change ideas that will impact compassionate contact, feedback suggestions included a new protocol to guide team managers and consultants on how to inform staff on the initial notification of patients death in a sensitive and compassionate manner. The long-term impact of this may help with alleviating distress, supporting staff mental health and wellbeing.

The below image showcases the poster abstract presented by Dr Kishan Pankhania at the RCPscyh International Congress Edinburgh, June 2024. Sharing the remarkable work of the Quality Improvement (QI) project on improving Initial Notification of Patient Deaths.



Click the following link to view the full poster: Informing staff of patient deaths Poster draft.pdf

IMG Doctors QI Project Receives Recognition of First Place at the RCPsych Annual Conference 2024

IMG Doctors represented the Trust at the RCPsych Annual Conference 2024 in Belfast and showcased their Quality Improvement (QI) project poster. The project poster was chosen as one of three from forty-five abstracts to present. On Thursday the 17th of October, Dr. Shahnila Sohail (Specialty Doctor-Erdington and Kingstanding Home Treatment Team) represented her project team and presented the Quality Improvement (QI) project at the RCPsych Annual conference for the Faculty of General Adult Psychiatry. This notable annual conference was hosted at ICC in Belfast, welcoming 200 delegates in attendance daily. The project poster was one of three selected for an oral presentation, from 45 poster abstracts that had been submitted.

The aim of the project is to improve the experience of International Medical Graduates (IMG) doctors within the Trust. The QI project has been recognised for the impressive improvements through a collation of great change ideas to ensure IMG Doctors working within the Trust feel supported. Some of the change ideas include a dedicated IMG email inbox, WhatsApp group and hosting IMG Forums where staff can interact and connect with colleagues.

Dr Shahnila Sohail (Specialty Doctor-Erdington and Kingstanding Home Treatment Team) , who is the Project Lead shared that she was "delighted to share the project and findings with the attendees of the conference, including the Chair of the general adult faculty, Dr Jon Van Niekerk." The oral presentation won first place! It generated engaging discussions and garnered praise from the audience.

International Medical Graduates - International Medical Graduates

Click the following link to view the full poster: V3 RCPsych International Congress IMG QI poster.pdf

RCPsych Awards 2024: BSMHFT Remarkable Nominations Receives Recognition

The notable awards returned for another year. On the 7th of November, the RCPsych Awards held the ceremony in London to celebrate the amazing achievements and recognition of the hard work of teams and individuals within psychiatry and healthcare. There were four nominations that represented Birmingham and Solihull Mental Health Trust in this year's awards. The following nominees were recognised for their incredible service within the mental health field. Grove Avenue Steps 2 Recovery was nominated for the Psychiatric Team of the Year: Quality Improvement category demonstrating coproduction with service users at the heart of the project whilst collecting preliminary data from surveys around choice in mealtime experiences. The team found that by improving access to equipment and the quality of ingredients provided, survey scores evidenced increased satisfaction and independence feedback from service users.

The Rare Dementia Service Team were nominated for the shortlisted for the Team of the Year Older-Age Adults Award. This community based, multi-disciplinary team specialise in rare dementia cases, supporting people of all ages. Their aim is to provide service users with comprehensive treatments and interventions, using the best available evidence. Mustak Mirza, Deputy Lead Governor shortlisted for Patient Contributor of the Year Award. Mustak was nominated for his substantial contributions across the Trust and Dr Mona Salim, Speciality Doctor was nominated for Speciality Doctor/Associate Specialist of the Year Award. Working in the Trust's old age psychiatry services, Dr Salim consistently goes beyond the call of duty to ensure patients' needs are met.

Dr Fabida Aria (role), QI Lead Kuldeep Singh (ICCR and Corporate), Mustak Mirza (role) and team members of the Grove Avenue Team attended the honourable event representing the Trust and celebrating the incredible work that has made impactful changes to service users and staff. The Grove Avenue Team in the ICCR directorate received recognition for their remarkable Quality Improvement (QI) work. The project group was successfully shortlisted in the RCPsych Awards 2024 for Psychiatric Team of the Year: Quality Improvement category. They accomplished outstanding work in improving mealtime experience for Service Users. The QI project work was coproduced with Service Users, embracing the Trust values to be inclusive by carrying out a family and carer survey for Service Users and family/carers to voice their thoughts on their mealtime experiences.

Grove Avenue Ward Manager and project team member Neil Edwards shared that "the team at Grove Avenue were delighted to be shortlisted for the RCPsych Team of the Year Award (QI category), and a few of the [team members] made the trip to London for the ceremony."

Neil Edwards stated that the "QI project focussed on improving choice and experience around mealtimes, but the broader objective was reducing restrictive practice" and believes that the "team's project was chosen for nomination mainly due to the presentation of data, and demonstrable adherence to the QI process."

The Grove Avenue team found the experience "very positive, and an encouragement to continue endeavouring for excellence. as well as seeing some of the country's best psychiatrists being recognised for their efforts and also some of the multidisciplinary teams. It is encouraging to see so many striving to improve our services."

QI Nominations Shine at the Values Awards 2024

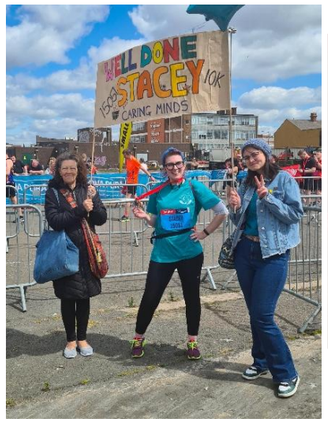
An ecstatic evening sharing the amazing achievements by fellow fantastic colleagues who are dedicated to providing the utmost care and service, upholding the Trust values.

The Trust Values Awards is a great opportunity to shine a light on the fantastic work from BMSHFT staff. Three Quality Improvement nominations were up on the podium for the Quality Improvement, Research and Innovation Award category for their remarkable work, which included two QI projects from ICCR and one QI nomination from Acute and Urgent Care. This award is for an individual or team who uses research and innovation in every element of their role to bring about service improvement for our service users and colleagues. Northcroft CMHT, Dr Katarina Lietavova & Steps 2 Recovery received great admiration for their amazing achievements in the Quality Improvement, Research & Innovation Award. A huge congratulations to all the nominees.

Chief Executive, Roisin Fallon-William shared that there is "really great quality improvement work." Chair Philip Gayle highlighted the "recognition [of] hard work" and everyone was moved by the analogy of the "gold stars" representing the incredible workforce at BSMHFT and recognising the importance of staff.
Northcroft CMHT won the Gold award for recognition of their incredible work in their QI project on *Reducing emergency FP10s (ECSA) issues by Northcroft*. Dr Katarina Lietavova won the Silver award, recognising her dedicated involvement alongside the project team on their fantastic work in their QI project on *Reducing DNAs (Did Not Attends) with Sutton Home Treatment Team medical review*. The S2R (Steps To Recovery) Service won the Bronze award for their incredible initiative, which includes 7 QI projects across the ICCR directorate.
To learn more about the QI projects follow this link:
Quality Improvement Nominations Values Awards 2024

My 10K Journey: QI's Stacey Watkins Race to the Finish Line

QI's Stacey Watkins (QI Lead for Dementia, Frailty, and Specialties) put on her running shoes for the Caring Minds Running Team and participated in the Great Birmingham Run on Sunday, May 4th, representing Caring Minds and the Trust. Stacey successfully broke her personal record with a time of 1 hour and 38 minutes. Stacey has raised an impressive £745 for Caring Minds and the BSMHFT running team collectively raised over £2000!



"It was an absolute honour to run for Caring Minds at the AJ Bell Great Birmingham Run on Sunday May 4th 2025. It was my first time running at an organised event; the buzz, energy, and support of fellow runners and spectators was phenomenal!
The run was a challenge for me, but I thoroughly enjoyed the event from start to finish; even when I found it tough, I was still running with a huge smile on my face because there was always someone on the side cheering me on. Caring Minds and Mental Health means so much to me, last year both my godparents passed away after battles with dementia and cancer. I accessed Mental Health services myself to see a grief counsellor (which I'd put off for some time) and I can't highlight enough the importance of erasing the stigma of accessing mental health services".

Well done to our colleagues who took part in the Great Birmingham Run, proudly representing the Trust to promote awareness for Caring Minds and Mental Health.

Culture of Care National Collaborative QI Programme

The Culture of Care Quality Improvement (QI) programme completed coaching sessions for project team members and the projects have started to take shape. The initiative is delivered in partnership with the Royal College of Psychiatrists, the National Collaborating Centre for Mental Health (NCCMH), and other specialist partners, aims to transform the culture within inpatient mental health, learning disability, and autism wards. The primary goal of the Culture of Care programme is to create environments that are safe, therapeutic, and equitable for both patients and staff. By fostering a culture where care is truly at the centre, the programme seeks to ensure that everyone feels cared for and is empowered to provide the level of care they aspire to deliver. In September 2024, a number of wards participated in the Culture of Care National Collaborative training, which involved 2 online training sessions provided by the Royal College of Psychiatrists and a face to face session.

There were great co-production efforts at the Culture of Care QI session at Reaside. Severn Ward and Forward House created a powerful project team CV, put PDSA into practice using chocolate coins and shared great change ideas to improve services for service users and staff.

The project team's finalisation, change ideas and increased co-production with EBEs were key focus of the day.

George Ward and Sage Ward joined forces in the Culture of Care session led by QI Coach Niamh Roberts, creating strong project team CVs and sharing innovative change ideas. Both the project teams tested PDSAs using chocolate coins. Sage Ward won with sweet success with a record time of 1.8 seconds! The project teams co-produced change ideas with EBEs present and a MDT project team formation was finalised.

The Trust launches Culture of Care: Staff Care and Development Programme

We are proud to be part of the recently launched National Culture of Care: Staff Care and Development Quality Improvement (QI) programme, one of six strands of the overarching Culture of Care iOver the next six months, four wards at our Trust – Cilantro Suite, Hertford House, Jasmine Suite, and Chamomile Suite – will take part in this exciting programme dedicated to strengthening staff wellbeing and development.

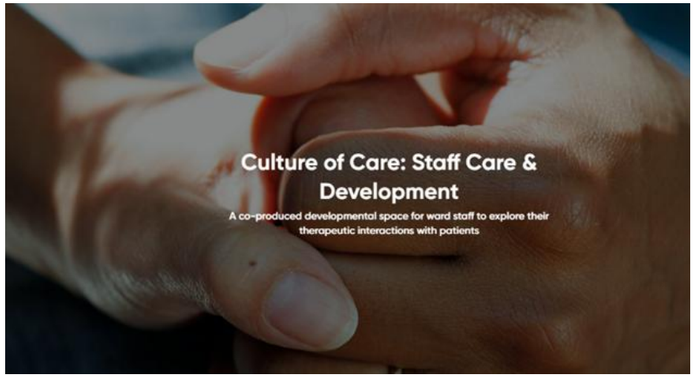
The programme is designed to support inpatient ward staff to create psychologically safe, caring, and relationally strong ward environments. Through site visits, reflective practice training, supervision, coaching, and skills-based development, the initiative aims to foster a sustainable culture of positive informal interactions and high-quality care.

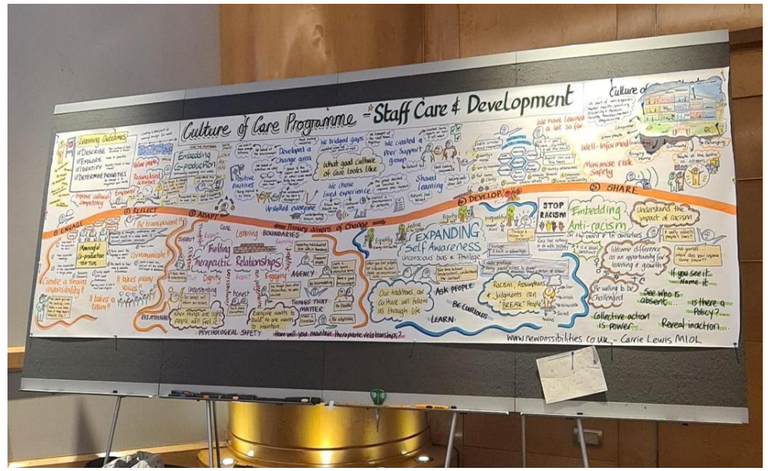
Running nationally, this programme will engage over 180 ward teams across England. Participating teams will co-produce cultural improvement projects, take part in structured learning and reflective forums, and receive tailored coaching support; including from people with lived experience–to help embed long-lasting change.
initiative.

Over the next six months, four wards at our Trust – Cilantro Suite, Hertford House, Jasmine Suite, and Chamomile Suite – will take part in this exciting programme dedicated to strengthening staff wellbeing and development.

The programme is designed to support inpatient ward staff to create psychologically safe, caring, and relationally strong ward environments. Through site visits, reflective practice training, supervision, coaching, and skills-based development, the initiative aims

Culture of Care **3 Specialties wards** starts Cohort **2! Specialties wards** (Jasmine Suite, Cilantro Suite, and Chamomile Suite) start Culture of Care national programme! On Friday 28th March specialties wards Jasmine Suite, Cilantro Suite, and Chamomile Suite completed a workshop covering topics such as co-production, building therapeutic relationships and embedding anti-racism practices.





Culture of Care: Live Love Life

The Culture of Care initiative looks at a therapeutic and transformation approach for people with the aim to enhance a better environment for all service users, staff and stakeholders.

The EBE's have been supporting the project, bringing their lived experience of life at Reaside along with plentiful energy and enthusiasm. When asked what they wanted the project to be called, they came up with several suggestions for the project name, that truly resonated with them. The ideas then evolved into a new project name; **Culture of Care: Live, Love, Life**. They went on to describe what each element meant to them, explaining that **Live** is about ideas to improve their time while they live at Reaside, **Love** was about inclusivity, respecting each other, also having culturally appropriate food options and coming together to celebrate all cultures. Finally, **Life** represents the opportunity to improve how they spend their time at Reaside to prepare for life outside.

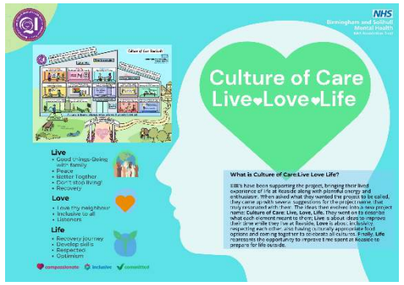
Since the start of the year, everyone at Reaside, including staff and service users have been taking time away from their desks, bedrooms and daily tasks, to really think creatively and collaboratively about what is great about Reaside and generating ideas to work on together, to make things even better for staff and service users.

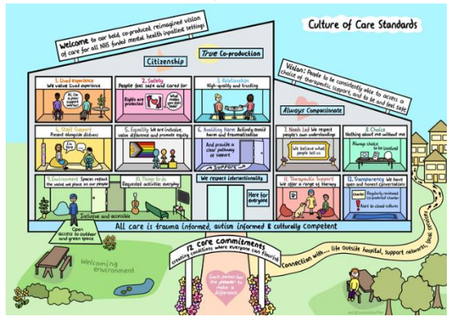
Service Users and Staff are sharing innovative change ideas in this collaborative work to foster positive changes and transformation.

One of the change ideas currently tested out involves using a labelled box based on staff experience of their day going either 'well' or 'could be better.' Staff will then deposit tokens to measure their daily experiences, which will help to identify any themes to review for improvement. Change ideas: Through the appreciative enquiry conversations, exploring what is working well and what could be better everyone has really stepped up and generated insightful opportunities for improvement.

Chief Nurse, Lisa Stalley-Green (Executive Director of Quality and Safety), Dr Helen Smith (Consultant Forensic Psychiatrist) and Jonathan Warren (Former Chief Executive and Chief Nurse) with support from QI Lead Tabassum Mirza (Secure Care and Offender Health and Corporate); have been supporting with the Culture of Care: Live Love Life initiative by creating a collaborative space for staff, service users and EBEs to share ideas and support with the positive changes discussed.

The **12** Culture of Care standards have been useful in creating change through innovation and coproduction. The vision aims for people to consistently be able to access a





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The 12 standards of Culture of Care include Lived experience, Safety, Relationships, Staff Support, Equality, Avoiding harm, Needs led, Choice, Environment, Things to do, Therapeutic support and Transparency.

The Big Reaside Clean Up Event

An epic event at Reaside and Hillis Lodge took place the week commencing the 7th of April 2025- The Big Reaside Clean Up Week! Staff, EBEs and stakeholders rolled up their sleeves and got stuck in to create a better environment for all with updated furniture and fixtures. This was also happening during the National Spring Clean Up, an opportunity to improve the quality of spaces and unite communities. Overall promoting a cleaner and more sustainable environment. The staff were enthusiastic about discussing the positive impact of the changes, especially the fresh coat of paint that brightened the store. One service user got creative and crafted an impressive money jar boat for the shop. At the heart of the event was co-production, emphasising inclusivity in making positive changes happen.

Katie Hollamby (Deputy Ward Manager-Severn Ward) and Michael Nti-Wireko (Ward Manager-Inpat Acute) from the Reaside Team shared remarkable changes that have been implemented such as working on a de-escalation room. Service users have expressed their thoughts on the name of the room called a 'chill-out room'. There are many change ideas that the team will be looking into further to improve the environment such as reducing blanket restrictions and reviewing the dining room layout. They are presently encouraging personal hygiene, reviewing activity requests, and making it a point to ask service users about their day. Service users were provided with a Patient Care Survey to express their thoughts on the existing processes and their experiences. Additionally, staff members completed a Staff Satisfaction Survey, which focused on how they could receive better support.

"Everyone is here for the same reason, to progress"- J.G. EBE

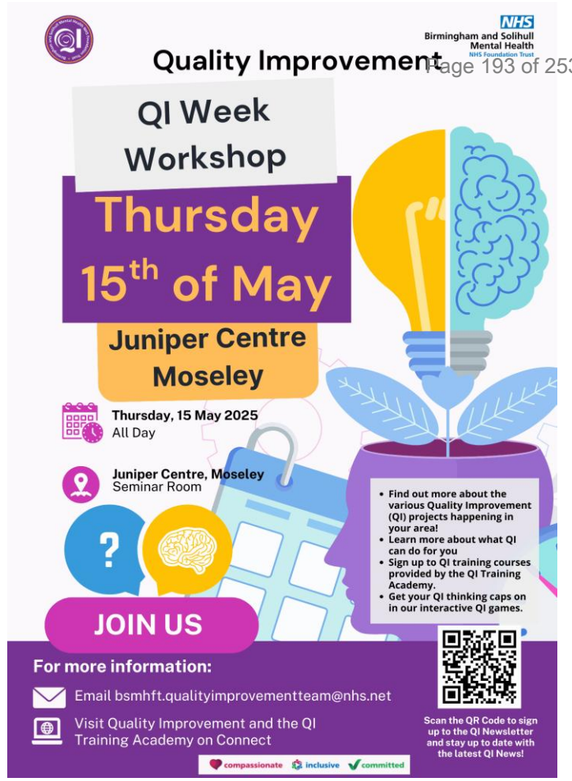
The QI Team have also created a Culture of Care survey for Reaside to gain insight into the ideas that staff and service users have to make Reaside great again.

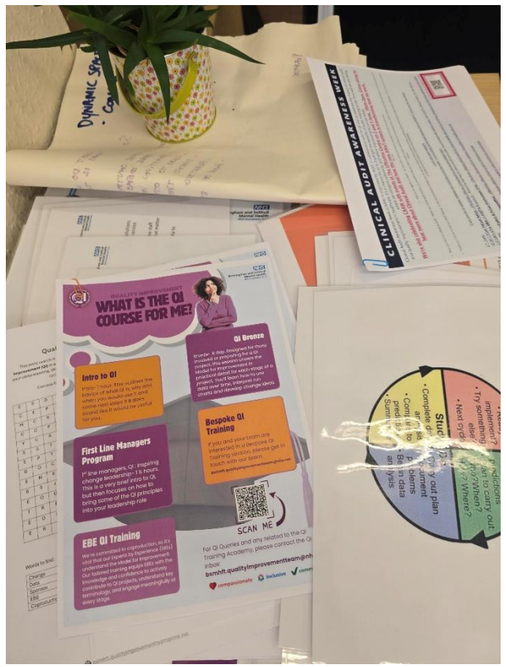
QI Week

Quality Improvement will be hosting a one-week event ‘QI Week’ commencing the 12th of May where the Quality Improvement (QI) Team will be visiting a number of sites and bringing the power of QI to different areas. This will give all the opportunity to visit local Quality Improvement stalls and join the team for engaging QI discussions and interactive sessions designed to spark innovation and collaboration. There will be fun filled QI activities, our amazing QI experts will be on hand to answer any QI questions! It’s a great opportunity to learn about a wide range of Quality Improvement projects and initiatives happening around the Trust. The event will enable staff, service users, EBEs and stakeholders to find out more about the innovative QI work happening in the areas. So that they can be a part of the continuous improvement movement and learn how they can get involved to make a positive difference.

The aim of the QI Event is to promote and enhance the engagement of the Quality Improvement brand within the Trust.

The QI event has been promoted via physical and digital copies of posters, articles have been consistently published to promote engagement with the event further and news of the event launch was also shared on the Trust Listen Up Live platform. The QI Team created multiple resources to support attendees in getting the most out of the event. The QI resources not only provides details of the event, but informs on how to get involved in Quality Improvement.





Service User, EBE and Carer Involvement

Within our team we recognise the need to include the people who receive our services, or care for those that do, is a fundamental part of Quality Improvement. Furthermore, we believe that this will greatly enhance the success of our QI projects as we can then measure improvements for staff, service users and carers. We are using the terms Little I and Big I to differentiate the level of participation.

- Little I – Means involving service users and carers at various points throughout the life of a project, the team may ask for ideas of what should be changed or about the impact changes have had to the services they receive.
- Big I – Means involving service users and carers directly and continuously throughout the whole life of the QI project.

Recovery College Pilots Quality Improvement Session

Flying start to the first Quality Improvement (QI) session at the Recovery College! QI Lead Kuldeep Singh used PDSA activity and Storytelling Circle to explore creating new healthy habits to aid recovery. Huge appreciation for our EBE partners for co-producing and co-delivering the session!

BSMHFT's Recovery College recently hosted its first-ever "Making a Difference: An Introduction to Quality Improvement (QI)" session. This groundbreaking event aimed to introduce the core concepts and principles of QI and explore how they can be used to enhance health and wellbeing outcomes for service users, with a strong emphasis on co-production.

The session was designed to engage participants in thinking differently about improvement and applying QI techniques, such as the Plan-Do-Study-Act (PDSA) cycle, within the context of recovery.
The session was co-produced and co-delivered by Experts by Experience (EBEs) currently engaged in QI projects. Leading the way were EBEs alongside QI Lead Kuldeep Singh (ICCR| Corporate). The session kicked off with a light-hearted "Duck Scale" icebreaker and then guided participants through the ladder of involvement, QI as "Kindness with a Strategy," and inspiring stories of lived experiences. The highlight of the day was the Aeroplane Building PDSA activity, which brought out the participants' creativity, innovation, and teamwork, all while adding a touch of friendly competition.

Steve Shaw from the Recovery, Participation, and Experience team, and Amy Jowicz, a QI Facilitator, enthusiastically supported the event. The session received positive feedback, with several Experts by Experience expressing curiosity about becoming QI EBE advisors.

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First Service User QI Training session

On Wednesday 16th of April, QI Team members QI Lead Kuldeep Singh (ICCR and Corporate) and QI Facilitator Donna Thomas (Acute and Urgent Care) co-delivered a superb Quality Improvement (QI) session to service users at Reaside.
The QI duo delivered an insightful session to service users on how QI is beneficial within a service and Trust. Service User involvement highlights the importance of inclusivity, enabling all voices to be heard and aligns with the QI approach of including all perspectives.

Service users were eager to get involved and learn more about the QI approach. QI Facilitator Donna Thomas highlighted the incredible work that's happening at the site to help improve the service for servicer users, staff and stakeholders, which includes the local Culture of Care: Live Love Life programme at Reaside. The Culture of Care: Live, Love, Life programme at Reaside is a collaborative transformation journey. The collaborative and transformative initiative looks at a therapeutic and transformation approach for people with the aim to enhance a better environment for all service users, staff and stakeholders. Over the past six weeks, colleagues and service users, have co-produced a project name and shared ideas for improvement at Reaside. 'Live' focuses on enhancing daily experiences, 'Love' on inclusivity and respect and 'Life' on preparing for the future. Check out the first edition of the Culture of Care: Live Love Life Newsletter: Culture of Care: Live, Love, Life newsletter
Building roots serves as a good foundation for change and enhancement, allowing great ideas to flourish.
"To make a change, have a vision, an aim"
-QI Lead Kuldeep Singh (ICCR and Corporate)
The session opened with a fun 'icebreaker' game of "Duck Scale." Everyone allowed their creativity to soar in the 'Airplane Building' PDSA (Plan Do Study Act cycle) activity as they customised and put their airplane to the test! Creating a safe and comfortable environment to put PDSA into practice where creativity, innovation and teamwork is encouraged, with a fun element of friendly competition.

Highlights of Completed QI Projects

QI Case Study: Lone Working QI Project

The Lone Working QI Project has successfully had their abstract accepted to present at the RCPsych International Congress 2025, which will be held at the ICC Wales in Newport from 23-26 of June 2025. QI Communications Officer; Priya Roadh help design the poster which has been submitted.

Despite the existence of a lone working policy at BSMHFT, gaps in implementation have raised concerns about the consistency and effectiveness of safety measures across different settings. Data from a baseline questionnaire showed that approximately **71% of Trainee Doctors** have engaged in lone working, yet only 30% felt they were adequately informed about the lone working policy. **57% of Trainee Doctors** reported they had not been provided with an alarm for lone working, and among those who had, 33% indicated they had not received proper training on how to use it. **50% of Trainee Doctors** had carried out lone work outside of clinical areas where access to colleagues is significantly restricted, 66% had not been provided with any other safety measures during lone working

The project group tested the following change ideas;

PDSA 1: Improve local Induction with Clinical Supervisors, including local lone working session

PDSA 2: Create a video for the Trust to improve awareness of lone working policy

PDSA 3: Create and include a slide on lone working during Induction

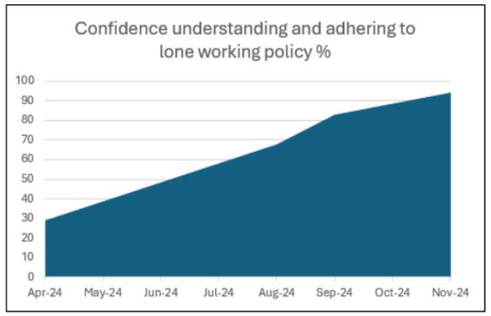
PDSA 4: Ensure orientation checklist is completed with Clinical Supervisor

Scan the QR Code to watch the informative video on the Lone Working process.

"I wanted to say thank you for working with us and all your hard work. We're extremely proud of the project and really pleased to be taking it to congress. We've had an incredible team including Gaynor and Lisa and now yourself. We're immensely grateful. Thank you."-**Dr Tooba Khan, Trainee Doctor**

Follow link: RCPsych International Congress 2025: Lone Working QI project successfully shortlisted

- 157 YouTube views of the lone working guide. 79% of respondents reported the lone working video guide was helpful in increasing their awareness of the lone working policy.
- 53% found the lone working presentation helpful in increasing awareness of the lone working policy during the Trust wide Induction.
- Completed orientation checklists and improved local Inductions with Clinical Supervisors were less effective in increasing awareness of lone working policy.
- The Local Security Management Specialist, has provided a template for local teams to use to record their lone working protocols and procedures, and given assurance of an investment in lone working devices for Trainee Doctors. 94% of respondents reported confidence understanding and adhering to the Lone Working policy.



QI Case Study: Reducing emergency FP10s (ESCA) with Northcroft CMHT.

An insightful Quality Improvement video interview with Project Lead Zora Bell (Clinical Hub Manager), Dr Alisha Bakshi (ST4 in Psychiatry) and Matthew Stafford (Clinical Lead) exploring insight into the QI project on Reducing emergency FP10s (ESCA) issued by North Hub (Northcroft).

The project team was multidisciplinary with Project Lead Zora Bell (Clinical Hub Manager), Dr Alisha Bakshi (ST4 in Psychiatry), Matthew Stafford (Clinical Lead), Sanna Ceesay (Advanced Nurse Practitioner), Kate Jennings-Cole (Clinical Lead), Emma Allsop (Support Services Manager), David Somers (Staff Nurse) & Aysha Chughtai (Clinic Nurse). The overall aim of the Quality Improvement project was to reduce the number of FP10's requiring ESCA (Electronic Shared Care Agreement) by 10% by end of the project. This aim was met and exceeded by achieving a 14% reduction. The team continued to sustain some of their change ideas and their overall aim sustainability data measure, checked after a gap of 3 months over December 2023. A reduction in numbers continued to fall and was at a remarkable 64% when compared to project baseline.

The project also showed immense improvement by reducing the number of weekly antipsychotics FP10's (out of total FP10's) issued. One of the other crucial issues for the project team was to reduce the significant 'time burden' on reception and medical secretaries when processing large number of last-minute requests for medication prescriptions from service users. ESCAs not being done, GPs/MHT not accepting transfer of prescribing or Service Users not wanting to go their GPs for their prescription needs were the contributing factors to this aspect. The project made a remarkable 27% reduction in number of calls for FP10s.

Clinical Lead, Matthew Stafford shared highlights in the latest QI project interview; sharing praises of project progress. One of the highlights shared was the 4-week system of managing FP10's at reception has now been included in the Medication Management's new procedures and guidance; after discussion with the Lead Pharmacist, Nigel Barnes, it is being introduced across all CMHT's.

The project team acknowledge there were significant barriers and challenges faced by them during the project, noticeably the staffing situation, entrenched ways of working culture, capacity for improvement work and limited sphere of influence on various system issues.

As FP10s and ESCAs continue to be an issue for the directorate, there is a recommendation to use learning from this project to widen the scope of this work and involve wider system stakeholders including Service Users for a potential multi-CMHT approach. Dr Alisha Bakshi shared in the QI interview that the QI project has been entered into the RCPsych International conference poster competition to share the amazing work of the QI project.

Scan the QR Code below to watch the informative video on how the project team worked together to reduce emergency FP10s at Northcroft CMHT.

QI Highlights

Staff Spotlight

A huge congratulations to our QI team member Lisa Farmer, who has been appointed to QI Lead (SCOH and Corporate services).

A huge well done to our QI team member Lisa Farmer on her new role as QI Lead for the SCOH directorate and Corporate services! Lisa started her role as QI Facilitator within the Quality Improvement (QI) team in April 2024. Let's hear from QI Lead Lisa on her experience in her new role.

"The 12 month secondment to the QI Lead role is a fantastic opportunity for me to develop my knowledge and skills of continuous quality improvement. It's an opportunity for growth and professional development. I am passionate about quality improvement, and I am excited about supporting teams across the Trust to make great improvement strides towards providing the best care we can for our Service Users and a great place to work for our colleagues."-**QI Lead, Lisa Farmer (SCOH and Corporate services).**

Digital Champions

A digital scheme started across the Trust. The QI Team announced their official Digital Champions in March 2024. Alongside their role, QI Communications Officer Priya Roadh and Quality Improvement Programme Administrator Samsuma Bibi are the official Digital Champions for the QICE (Quality Improvement and Clinical Effectiveness) Team. The incredible initiative aims to bring colleagues together across the Trust who are interested or passionate about digital technologies to enable a smoother digital transformation within BSMHFT. This role encourages to become a digital leader and voice for the department when it comes to adapting new technology and solutions. Digital champions will bridge the gap between the non-clinical IT staff who builds, develops, procures these technologies and the wider staffs who uses the technology for patient care. This digital development will explore current and new applications to utilise and cater these technological tools within the different departments.

An Interview with Stacey Watkins

Stacey Watkins joined the QI Team in July 2024 as a QI Lead for the Dementia, Frailty and Specialties directorate.

Why are you interested in Quality Improvement work?
I am passionate about collaboratively driving change forward and putting coproduction with our Trust staff, Experts by Experience and Service Users at the heart of what I do! I have a background in IT/Clinical Systems and have worked in the NHS for 7 years now; most of my roles have been both change-oriented and supportive in nature. I love working alongside others and Quality Improvement is a fantastic fusion of coproduction and data.

What did you do in your previous role?
I was a Project Manager in the Programme Management Office (PMO), implementing large-scale projects across the Trust. My proudest achievement in my PMO role was implementing the new Trust website with the comms team, we had such a short deadline; but working as part of a dedicated, committed team ensured the project's success.

What are you looking forward to in the role?
Working together with our Project Teams to achieve their aims and putting the Model for Improvement into practice. The "nerdy side" of me is excited to be analysing data and having been both an NHS and First Aid trainer in the past, I'm looking forward to sharing my passion and knowledge with others via our QI training courses.

QI Facilitators

QI Facilitator, Donna Thomas (Acute and Urgent Care)

“My name is Donna Thomas. I have been working within the QI team as a QI facilitator for just over a year. There were 4 of us that stared this new role, and we have embraced the role, and all have individual qualities that we have brought to the team.

With me personally I started the QI journey when I was working at Reaside as a Participation and Experience Worker. I was supporting the service users in a local Clinical Governance meeting. Tabassum Mirza the QI lead for Secure Care and Offender Health, was talking about QI and the benefits of having Experts By Experience (EBEs) involved in successful projects. My thoughts were that the service users that I work with would be ideal to be involved in Quality Improvement projects, with their first-hand wealth of experience and knowledge. I explored how I could get some training for the service users at Reaside but I was told that to be an EBE for the trust they could not be inpatient. I understood the reasons but I thought there must be a way they could have the training and get involved in local projects. Just over a year on, I continued to advocate for training on QI to be done in inpatient settings and I am proud to say that I was able to co-deliver training with QI lead Kuldeep Singh. My aspirations had come true!! I was so glad to see the service users and they were glad to know that I was still supporting them.

I have a passion to improve the service that we give to service users, families and staff that I work with, so I think I am with the right team to make that happen. I have proved that with determination and going to the right people you can be part of making a difference.

The Quality Improvement Team was right for me!!.”

QI Facilitator, Hannah Stanyard (Dementia, Frailty and Specialties)

“I am really interested in QI because I feel that staff, Experts By Experience and patients should be the heart of any change we make. I want to be more involved with teams across the Trust and collaborating with staff and experts by experience in order to make a difference and improve the care we provide, ultimately benefitting our patients, staff and the Trust.

Before becoming a Quality Improvement Facilitator I worked in the Programme Management Office (PMO) as a Project Support Officer, supporting the implementation of projects across the Trust. I have really enjoyed my time in QI so far, I have been involved in a number of great projects, working alongside our staff, patients and family to improve the care and services for our patients. I want to thank the staff I have worked with for all their hard work and dedication to quality improvement in their area. It is amazing to see how implementing changes following the model for improvement can lead to continuous improvement. Another focus of mine within the past year has been to raise awareness of QI and train staff. I am looking forward to the next year in QI!

Please get in touch with myself or Stacey Watkins to discuss QI in Dementia, Frailty & Specialties!”

QI Programme Administrators

QI Programme Administrator, Naomi Desouza

“As a QI Programme Administrator, I enjoy being at the heart of so many meaningful projects that aim to make real improvements for staff and patients. One of the highlights this year has been supporting the smooth running of training programmes and events—it is rewarding to know that even behind-the-scenes work contributes to real change. Working in QI is fast-paced and collaborative, and it is inspiring to see how small ideas can grow into impactful initiatives. I am looking forward to continuing to support teams as they turn their improvement ideas into action.”

QI Programme Administrator, Samsuma Bibi

“Working in Quality Improvement has been incredibly rewarding, as it enables me to contribute to meaningful initiatives that positively impact our organisation and colleagues. I thoroughly enjoy the collaborative environment and the chance to be part of projects that align with the Trust's principles of compassion, inclusivity, and commitment.

One of the key highlights for me has been the opportunity to actively engage in corporate projects aligned with the Trust values. Specifically, I’ve been deeply involved in the Values-Based Appraisal (VBA) project, which has allowed me to showcase my enthusiasm for enhancing the appraisal process as a subject matter expert. As part of this initiative, I took the lead in creating a video that illustrates the elements of a good appraisal, serving as a practical guide for colleagues. Additionally, I developed an offline tool to improve accessibility to appraisals, ensuring inclusivity and support for all team members. These contributions reflect my commitment to streamlining procedures and fostering meaningful, values-driven experiences.

Tip: In the fast-paced and high-pressure environment of the NHS, effective prioritisation is key. Focus on critical tasks, delegate where possible, and use digital tools to streamline administrative workflows, reducing unnecessary stress and delays.

Message: You are the backbone of a vital institution that saves lives every day. Your dedication ensures the NHS continues to function efficiently, supporting both patients and healthcare professionals. Remember, even in challenging times, your work makes a profound difference!”

Here are some Quality Improvement (QI) projects from each directorate detailed below and their impact of improvements.

Spotlight on Directorate QI Projects

Acute and Urgent Care

In Acute and Urgent, we have **6 Acute projects** and **2 Urgent projects**. We have recently **closed 2 projects**.

Mental Health Act QI project

This has been a national project that has be piloted at Eden, one of the acute wards at Northcroft.
The project team felt that better communication for new service users and their visitors where English may not be their first language or if there are difficulties reading or writing, was important so wanted to create a walk around video so that this can be access before visits to the ward. We looked at what was already available and most of it was out of date. We thought about ways that we could keep information current and accessible.

The Mental Health Act National QI Programme (MHA QI) hosted a virtual Learning and Celebration Event to mark the end of the coaching for the main cohort of this programme and the successful implementation of impactful change ideas across the 36 wards nationwide that participated in this phase.

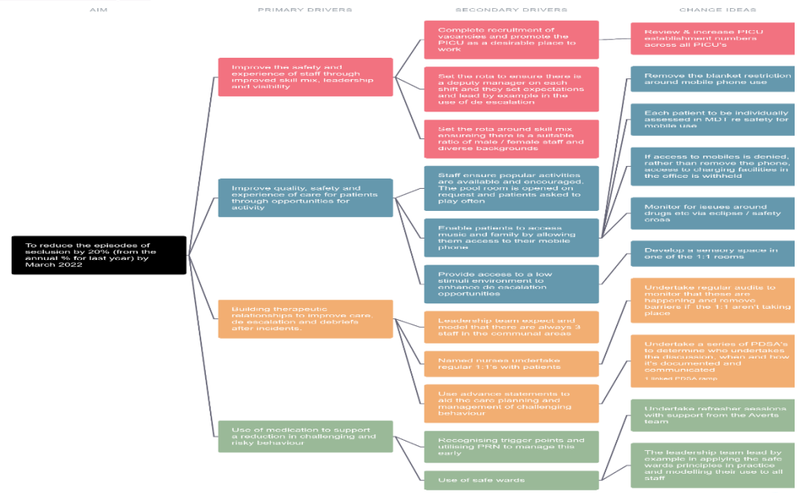
Bringing everyone together in the engaging event to share the change ideas and learnings across teams, helping everyone find inspiration for the next steps in the continuation of their Quality Improvement journey!

Visit Quality Improvement on Connect

Project Title: To Improve Ward Initial Reviews on PICS-UHB electronic system

Project Aim: To Improve documentation of initial reviews on the ward in line with PLAN standards which state that: Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes. PLAN standards are developed using recommendations in key literature, research and consultation with a range of stakeholders. By meeting these standards, it ensures that high quality liaison psychiatry services work to benefit patients with mental health needs- who are often in acute psychiatric crisis. If the outcome of assessments and treatment decisions aren't communicated effectively to all those involved with the patient it could delay and effect patient care.
The aim is to also meet UHB guidance by using PLAN standards. It will also hugely benefit quality care for our patients in order to have purposeful reviews.

Click the link to view the QI Project thumbnail:
PICS thumbnail.pdf



Mental Health Act Quality Improvement Programme

Trust Programme lead: Gaynor Matthews

AIM - "Improve the equity of experience for people from ethnically diverse backgrounds and people with a learning disability & autistic people when detained under the Mental Health Act in hospitals across England, including improving the cultural appropriateness of care for those detained under the MHA

Why? (1)

This programme will support improvements in culture and practice to meet the aims of the Mental Health Act reforms

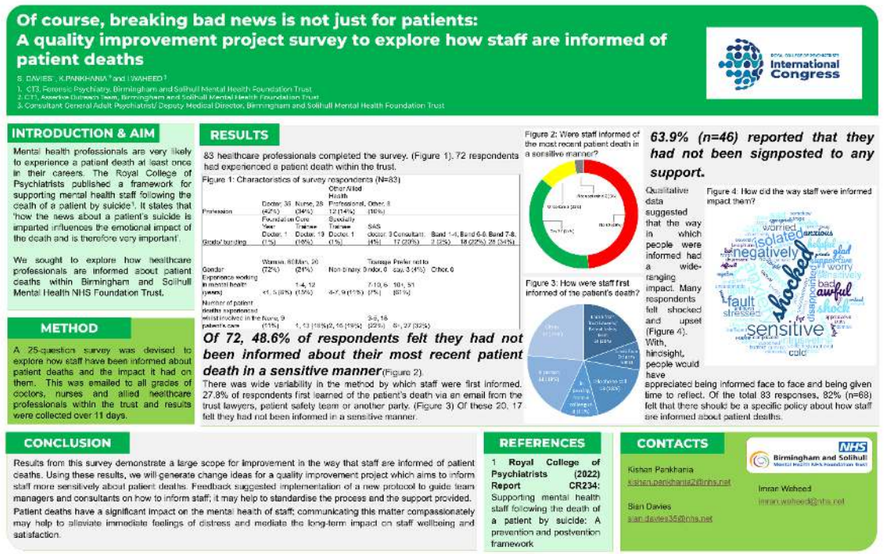
- In 2021, the Government published a White Paper, Reforming the Mental Health Act, which accepted many of the recommendations from the 2018 Independent Review of the Mental Health Act and set out a series of **ambitious reforms to care under the Act**.
- The four **guiding principles** of the reforms are:
  - Promote patient choice and autonomy
  - Apply the Mental Health Act in the least restrictive way possible
  - Ensure care delivers therapeutic benefit
  - Ensure people are viewed and treated as individuals
- The White Paper included proposals for significant legislative reform but acknowledged that legislation alone would not be sufficient to deliver the broader **improvements in culture and practice required to meet the aims of the reforms**.
- To support these improvements, one of the recommendations taken forward in the White Paper was a commitment for NHSE to deliver a **national QI programme**.

QI project on Initial Notification of Patient Deaths

Patient deaths can have a huge impact on those who knew and supported them. Dr Kishan Pankhania and Dr Sian Davies started a QI project to look at how staff are informed about patient deaths to see if we can make the initial notification a compassionate and supportive process for those effected.

A staff survey was conducted to explore how staff are informed about the initial notification of patient deaths. The use of the qualitative data helps to inform change ideas that will impact compassionate contact, feedback suggestions included a new protocol to guide team managers and consultants on how to inform staff on the initial notification of patients death in a sensitive and compassionate manner. The long-term impact of this may help with alleviating distress, supporting staff mental health and wellbeing.

The below image showcases the poster abstract presented by Dr Kishan Pankhania at the RCPscyh International Congress Edinburgh, June 2024. Sharing the remarkable work of the Quality Improvement (QI) project on improving Initial Notification of Patient Deaths.



Click the following link to view the full poster: [Informing staff of patient deaths Poster draft.pdf]

Reduction of non NHS and out of area beds and to make our service users experience better

Improving the admission process - from A&E attendance to ward admission from Psychiatric Liaison Teams. The aim of the Quality Improvement (QI) project is to reduce length of time a patient waits in A&E admission to a hospital bed.

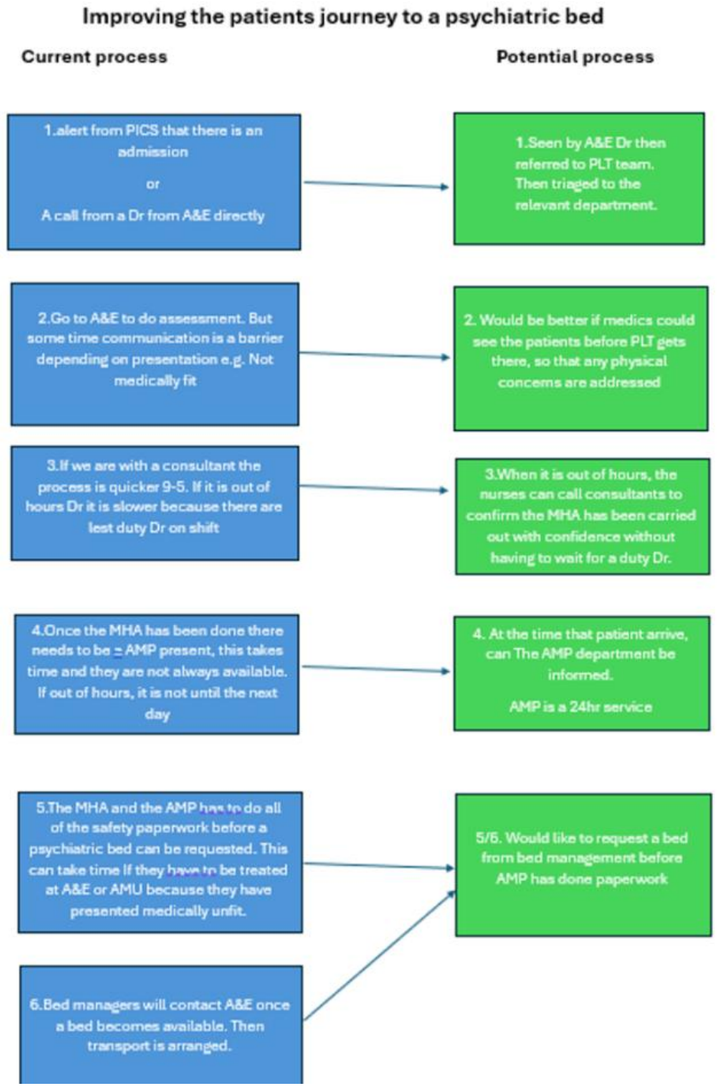
Dr Adelayi (Specialist Training Registrar) is leading the QI project as the Project Lead and Dr Sara Ormerod (Consultant-CMHT) is the Project Sponsor.

Over the last 12 months there have been huge changes to how a psychiatric bed is requested and managed. This is part of a significant effort to reduce the use of (very expensive) out of area beds, which means that we have had to fundamentally change the way our own beds are managed- hence gatekeeping and the locality model have been introduced.

As part of these overarching bed management discussions, Dr Ormerod has suggested a project to look at the process once the decision to admit has been made within Psychiatric Liaison. For those patients, where it is clear from very early on that a bed will be needed, the process can take hours if not days. There are a number of steps which are all followed in order.

BSMHFT has a 5 million overspend on using out of area beds which needs to be addressed to save the Trust.

We had a QI session where we had clinical managers and directors to see where and at what angle these issues can be addressed an improved. We also invited an expert by experience who shared her experience of being in an out of area bed. Listened to be changed to improving the experience of our service users who use out of area beds.



Spotlight on Directorate QI Projects

Integrated Community Care and Recovery

S2R QI Partnership: A Collaborative Journey of Improvement

The Steps to Recovery (S2R) Quality Improvement (QI) Partnership represents a powerful example of collaborative learning and shared ambition across our Integrated Community Care and Recovery (ICCR) directorate. This cross-site initiative brought together QI project teams from seven inpatient rehabilitation services—David Bromley House, Dan Mooney House, Endeavour Court, Hertford House, Forward House, Grove Avenue and Rookery Gardens—to collectively reflect, learn, and drive improvement.

The partnership focused on two core themes: reducing restrictive practices and improving patient experience. Project teams tackled a range of challenges including reducing violence and aggression, enhancing mealtime experiences, improving safety, personal care, activity levels, and the management of personal property. Despite each ward serving distinct needs within complex psychosis care, the shared commitment to quality and compassionate practice created a unifying thread across the programme.
Early barriers such as staff engagement, workforce pressures, and limited resources were met with persistence and creativity. Regular touchpoints, inclusive forums, and meaningful involvement of service users and Experts by Experience helped build ownership, cohesion, and a genuine sense of purpose.

What followed was inspiring: Teams embraced QI not just as a method, but as a mindset. Projects sparked innovation, fostered new ideas, and began to embed continuous improvement into everyday practice. Change ideas were shared and adapted across sites, amplifying their impact and sustainability.

The partnership culminated in a celebratory learning event in May 2024, with Executive Director Patrick Nyarumbu MBE as guest of honour. It marked not just the completion of a phase, but the start of a culture where QI is deeply rooted in how care is delivered, and how teams grow together.

Weight Management QI Partnership Launch

Thursday, February 13th, marked the beginning of an exciting new journey in patient care as stakeholders from across disciplines—clinicians, nursing staff, dietitians, health instructors, occupational therapists, and local ward colleagues - came together at Ardenleigh for the launch of the Healthy Weight Management QI Partnership. This innovative initiative embraces a Quality Improvement (QI) collaborative model, ensuring that the voices of service users, experts by experience, and frontline staff shape its direction.

Project Lead Alison Jowett (Head of Allied Health Professionals) led the session with an insightful introduction into the Weight Management QI Partnership initiative. She briefed about the Physical Health Committee's work and shared key themes from the annual audits. The data from these audits form the foundation for starting the QI partnership.

Members of the project group - Nicola Wilkes (Matron), Tom Teall (SHO), Pete Povey (OTA), Nok Hang Tse (OT), Amy Croke (Dietician), Lizzie Whitehead (Lead Dietician) and Sian Jones (Clinical Lead Health Instructor) shared their insight into current processes to review the impact of weight management that may affect Service Users. Keith Macdonald (QI Expert by Experience) shared his personal experiences around food and weight gain during hospital stay. He gave powerful insights into choices and challenges service users face regarding healthy weight management; he also shared potential ideas that the partnership could test and implement.
QI Lead Kuldeep Singh (Corporate, Integrated Community Care and Recovery) inspired the project team with an overview of QI and the Model For Improvement (MFI) with a recognition to the successful previous QI initiative Reducing Restrictive Practice QI Collaborative. He talked about knowing the gap between what we know and what we do, and how we can close this gap by creating a partnership in which interested teams work together with subject matter experts in topic areas where they want to make improvements. He was supported by QI Lead Lisa Farmer (Secure Care and Offender Health| Corporate) and Priya Roadh (QI Communications Officer).

In the first phase, the Healthy Weight Management QI Partnership (HWMP) starts at Ardenleigh and will extend an open invite to inpatient teams/wards across all directorates to join this work (Interested? Email: kuldeep.singh4@nhs.net)

As a starting up support, 'Change Packages' have been created by subject matter experts, these will help local teams to choose their area of focus to achieve the overarching partnership aim of 'Increasing the number of service users who maintain a healthy weight during an inpatient admission'.

Current change packages include:

Increasing access to physical activity – led by Gregg Newman
Training and staff support – led by Kathryn Roberston
Food and nutrition – led by Emily Stuart.

HealthyWeight
QI PARTNERSHIP

Visit Quality Improvement on Connect

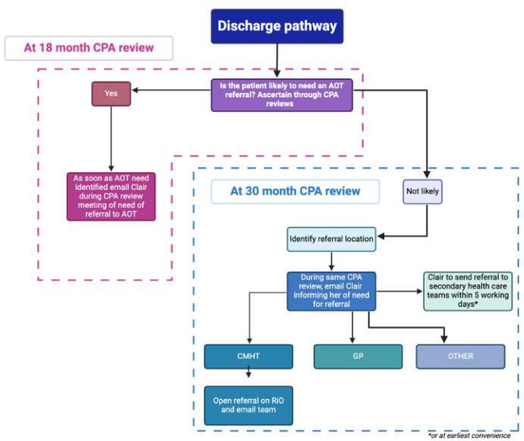
Quality Improvement Project to Reduce the Number of Delayed Referrals from Solihull Early Intervention Psychosis Services (EIS)

This project sought to identify the causes of delays in discharging patients from Early Intervention Services (EIS) within the Birmingham and Solihull Mental Health Trust. Significant delays were observed in transferring patients out of EIS after their care was completed, which in turn hindered the service's capacity to accept new referrals. By pinpointing the factors contributing to these delays, the project aimed to implement targeted changes to streamline the discharge process and improve overall efficiency.

Early Intervention Services (EIS) were designed to optimise treatment outcomes for patients in the early stages of psychotic illness through timely recognition, assessment, and intervention.

According to guidelines published by both NICE (1) and the Royal College of Psychiatrists (2), EIS should provide care within the first three years of psychotic illness. This time frame was suggested following the OPUS trial, a large, randomised control trial assessing the long-term benefits of a two-year intensive early intervention programme (3). Previous research (4) had demonstrated that the early phase of psychosis is an important opportunity for secondary prevention, but results from the OPUS trial demonstrated that two years of intensive early intervention, alone, did not significantly improve patients' clinical outcomes. As a result, UK national guidelines instigated that EIS should be delivered for a longer period - three years. Additionally, NICE stipulates that if individuals have not 'made a stable recovery' within that time frame, care can be extended beyond three years.

Throughout the project, the team faced several limitations, but their identification offers valuable insights for future initiatives rather than hindering current progress.



Notably, the current patient population consists only of those overdue for discharge, meaning the improvements made were due to addressing an existing backlog. While this was expected given the patient cohort, the true impact of the interventions on preventing delays remains to be seen. Despite this, The team are confident that the adoption from PDSA testing to implementing the new discharge process will have long term positive impacts on referral times.

Furthermore, this project is limited due to the complex involvement of the MDT in mental health services. Whilst the team aimed to improve EIS alone, this would always be limited to the capacities of downstream services in which referrals were being sent. Without addressing potential improvements within these services, improvements within EIS itself are restricted. One of the original change ideas proposed setting up MDT meetings between different services to discuss complex patients and optimise their movement through mental health services. Achieving this change idea would involve the optimisation and coordination of several mental health service teams, which extends beyond the current scope of this project. This could be a useful project to consider in the future.

Visit Quality Improvement on Connect

Addressing Culture-Based Health Inequalities in Clinical Practice

The project led by Dr Viba Pavan Kumar aims to ensure staff are equipped to meet the diverse mental health needs of our communities with cultural sensitivity, humility, and clinical competence.

This QI project team is comprised of an MDT from ICCR (Dr.Viba Pavan Kumar, Dr. Gurmeash Kaur, Dr. Iman Hassan, Dr.Kiran Badesha, Hafsa Shabaz, Alyson Coup, Dr.Heba Salem) and has a QI EBE representative Dr. Rekha Lodhia on the panel. Roisin Fallon-Williams, Chief Executive Officer is supporting the team as the Executive Project Sponsor and Dr. Rose Carter is the ICCR Project Sponsor. QI Lead Kuldeep Singh is also supporting the project team with guidance in Quality Improvement. It has been coproduced by working closely with the Recovery For All Forum.

A Two-Level Cultural Competency Training Programme

At the heart of the project is a training package designed to build cultural competence across the workforce. The training, developed with Experts by Experience (EBEs) and clinical teams, is structured in two levels:

- Level 1: For all front-facing staff, covering foundational cultural humility and awareness.
- Level 2: For all clinical staff, offering deeper skills in assessment, intervention, and culturally responsive supervision.

Following a successful pilot at Zinnia using the PDSA cycle, the full rollout across all ICCR Community Mental Health Teams (CMHTs) will be completed by June 2025. This work directly supports the Trust's PCREF and Health Inequalities Strategy.

Scan QR Code for the Cultural Competency Resources page on Connect.

Embedding Lived Experience and Resources

A QI-trained Expert by Experience is a core member of the project team, bringing authenticity and lived insights. The Recovery for All Forum has also actively shaped the development, including PDSA cycles and co-delivery of training sessions.

Resource hub

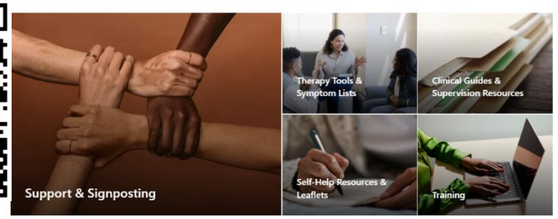
In parallel, a resource hub has been created on the Trust's intranet (Connect), offering streamlined access to interpreters, third sector partners, and social care links. The resource page has already had over 900 site visits and continues to grow with staff contributions.

Co-produced Communication Passport

A pioneering 'single-page communication passport' has also been developed and piloted, designed to improve cultural and clinical understanding between service users and staff. This tool, co-created with EBEs and clinical colleagues, has secured approval from Trust Clinical Governance Committee, IT, and is in development for integration into RiO electronic records. Early testing, including inter-rater reliability reviews, has shown promising results.

Looking Ahead

This project exemplifies how co-production, QI methodology, and strategic alignment can drive meaningful change in reducing cultural health inequalities. With its full implementation on track, it sets a strong precedent for embedding equity, compassion, and clinical excellence in practice.



Spotlight on Directorate QI Projects

Corporate

Room bookings project

Effective use of shared resources, such as meeting rooms, is critical for fostering collaboration, efficiency, and fairness within our Trust. The current issue of unused booked rooms led to several problems that impact both individual team members and the organisation as a whole. The aim of the project is to reduce the number of rooms which are booked and not utilised, which will improve the overall experience and access to that space for staff.

“Working with this project team was a pleasure. They attended every meeting and made sure they achieved their tasks ready for the next meeting. I missed our weekly catch up.”

Values Based Appraisals QI Project

The QI Project Team comprised of a group of core members from L&D and QI and an amazing team of staff who used their subject matter expertise in the Working Together Group (WTG) to coproduce improvements. The core team was led by Sunny Basra Learning and Development Manager, supported by Vinnett Lynch, Fundamental Skills Facilitator, Estelle Patil, Induction & Fundamental Training Lead, Jody Pritchard, QI Data Lead and QI Leads Tabassum Mirza and Lisa Farmer, Secure care and Offender Health and Corporate. The project sponsor was Diane Phipps, Training Manager and John Travers, Staff Experience and Engagement Lead provided insights into staff survey results to support discussions.

Visit Quality Improvement on Connect

Upcoming Corporate QI Work

Scoping out Sustainability the QI way with SSL!

On Thursday 21st November, Quality Improvement (QI) team members QI Lead Stacey Watkins and QI Facilitator Hannah Stanyard (Dementia, Frailty and Specialties) took a visit to the SSL (Summerhill Services Limited) hub.

Following a tour of the building, the team got together to discuss a prospective furniture sustainability project and how the Model For Improvement (MFI) can potentially support this work. To generate some ideas and discussion, a fishbone diagram was created; with the outputs to take shape in the new year. The fishbone diagram is a cause analysis tool that helps to visually explore and categorise causes of a problem/effect.

“It was fantastic to see how smart SSL work and how much they do to ensure the Trust works in a sustainable way. I am looking forward to working with the team in the future, this will be an interesting piece of work that aligns perfectly with our Trust strategic priorities”

- Stacey Watkins, QI Lead (Dementia, Frailty and Specialties and Corporate).

The Emergency Preparedness, Resilience & Response (EPRR) Officer, to ensure Trust staff/wards have clear Business Continuity Plans with Clinical systems

A Corporate prospective business continuity project is currently taking place lead by the Trust Emergency Preparedness, Resilience & Response (EPRR) Officer, Louise Flanagan. The project is looking at ways to ensure Trust Staff/Wards have clear Business Continuity Plans with Clinical systems, such as Rio and EPMA; so that in the event of any unexpected downtime of systems an accessible, informative, and consistent approach can be taken; with a shared goal for minimal disruption to patient care. A project team has been formed and are currently Process Mapping for Rio.

Values Based Appraisals QI Project (continued)

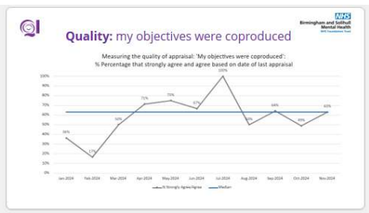
The primary focus of the project was to improve the quality of the experience of the values-based appraisal (VBA) for staff. The quantity of appraisals was also measured to identify teams that needed support and to increase the overall number of VBA's taking place across the Trust.
Coproduction was of paramount importance to ensure all change ideas and project outcomes were coproduced by staff for staff. Therefore, the project was supported by a working together group with 46 members of staff from across the Trust. Membership included staff from across all divisions including Reaside, ICCR, CMHT's Corporate, Barberry, SCOH, Acute, Bank Staff, Specialties. Staff representation was from varying roles including admin, catering, clinical, managerial, full time, part time, Bank and various other disciplines.

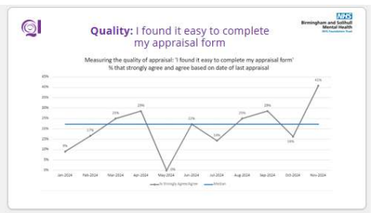
Members of the WTG met in person, online and supported with feedback on all aspects of the project including coproducing a survey to measure the quality of experience of a VBA for staff, coproducing the script and participating in filming to create resources for staff to better understand the importance of VBA's, testing out resources coproduced by the group such as a word template, protected time to do VBA's, coproducing an infographic of the VBA timeline and other change ideas, through the plan-do-study-act (PDSA) cycle.
The Driver Diagram summarises the project team's theory of change, the key drivers that the project team felt would improve the experience of a VBA for staff and the number of VBA's taking place across the Trust.

The data from the survey commenced in November 2024, the earlier data was through a Trust wide survey to collate a base line. It is encouraging to see the data above the median from November onwards, a meeting has been arranged with the L&D Team to review the progress in three- and six-months' time.

- The run chart above evidence improvement in the number of VBA's taking place across the Trust with the first statistically significant signal in June-July 2024.
- This improved level of performance is maintained, and second statistically significant signal can be seen in September-October 2024.
- Overall, there improved level of performance has been maintained and the Trust is still holding the gains
- At the time of publication, the dates for the PDSA's and L&D Team interventions had not been finalised so could not be included in this article. It would have been of value to see if any correlation existed between the change ideas and interventions and the signals in the data.

The project has been a triumph in coproduction with the valuable input of staff as subject matter experts as part of the working together group and the L&D and QI Team, and evidenced statistically significant improvement in the data. The resources that have been coproduced will be launched post QI-project and the QI Leads will meet with the team in three- and six-months' time to see what impact the launch of the resources will have had on the data.





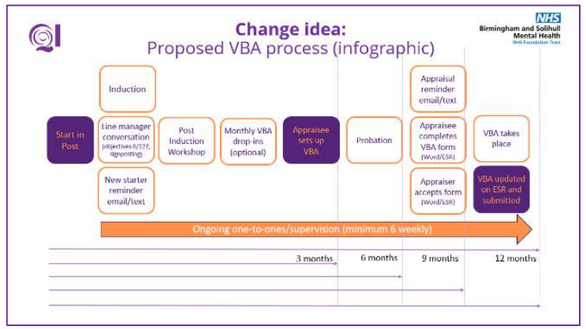
The change ideas are listed below

- **Protected time**: testing whether allowing staff to have protected time at work would have a positive impact.
- **MS Word version of the form**: testing if using a word version of the form reduced the time and improved the experience for staff and managers.
- **Monthly drop-in support sessions**: Estelle Patil will lead on this PDSA, offering online monthly drop-in session to provide technical support using ESR and the VBA forms. Due to staff capacity it was not possible to test this during the project, it is a recommendation for the team post QI-project.
- **Infographic**: The working together group felt that an infographic mapping out timelines, support and key steps would help with understanding the process better. They therefore helped to coproduce the infographic of VBA the time above/to the left. The VBA timeline will shared at Induction, Workshops and on the VBA Connect page.
- **VBA Workshops**: The workshops are to be delivered monthly to provide colleagues with a better understanding of the importance of VBAs and how the get the best out of their appraisal experience. The content of the workshops has been coproduced by project member; Vinnett Lynch
- **VBA offline Excel tool**: Co-produced and tested by Working Together Group member: Samsuma Bibi. The project team approved this as an additional resource to be made available on the VBA Connect page. Further testing of this resource is required to measure it's impact, to test if this would be beneficial to clinical staff.
- **Text message reminders**: The Working Together Group identified this change idea, to improve equity of access to colleagues with limited computer access. Project Lead Sunny Basra led on this change idea. Multiple barriers were encountered attempting to launch and test this change idea. This was taken to STMB for assistance in overcoming the barriers with support offered by Phil Powell. Detailed proposals have been submitted to the Project Sponsor; Di Phipps, for further consideration and approval. The impact of the change idea upon compliance will need to be measured post project.
- **Connect Page**: The Working Together Group reviewed the existing Connect page and made recommendations for improvement in relation to access, visual presentation and content. The recommendations will be implemented by the Learning & Development Team, once the Trust has completed it's moved to a new tenant, which will be post QI project

Measuring Quality: Through a series of workshops, the WTG identified what a quality appraisal experience means to them. The WTG identified three elements of greatest importance to them;

- to know that the appraisal helped to shape development,
- that their objectives were coproduced
- and the ease with which the appraisal form was completed.

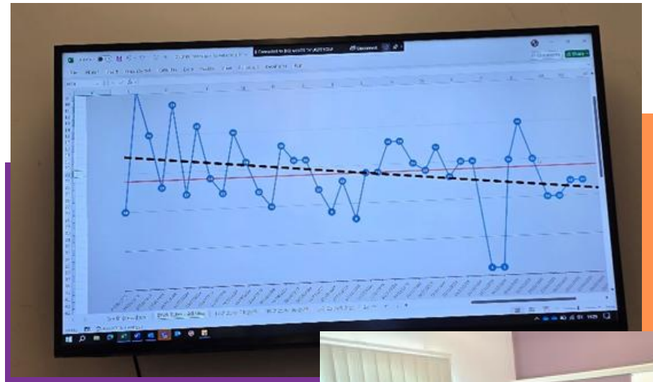
This then helped to coproduce a new, bespoke survey that was launched in November 2024, all members of staff who complete an appraisal receive the new survey to evaluate the quality of their experience.

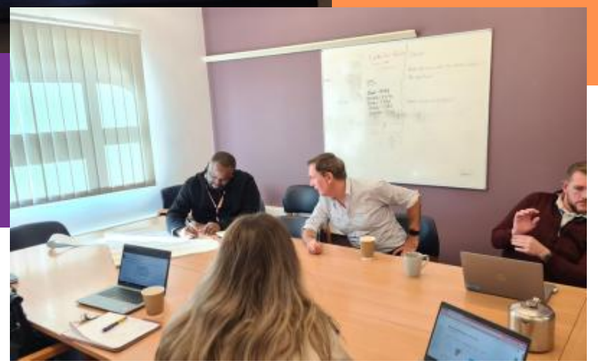


Spotlight on Directorate QI Projects

Dementia, Frailty and Specialties

Across Dementia, Frailty and Specialties, the number of **open projects is 7**. There are **18 prospective projects** and **1 project** has been **completed**.





Across Dementia, Frailty and Specialties, there are a number of projects underway including; A DNA (Did Not Attend) project in South Hub Mental Health Services for Older People (MHSOP) Community Mental Health Team (CMHT). Data has been extremely encouraging for the project team; in February 2025 there were only **7 total DNAs** which is a **33% reduction** from data taken in September 2024. The team have also started another PDSA (Plan Do Study Act) cycle by removing the withheld number off Juniper reception, which was a huge barrier to Service Users picking up the telephone.

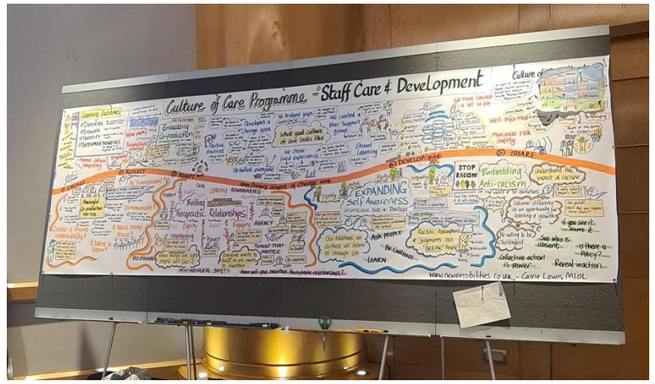
The Project team were not only nominated for a 2025 Values Award in the Trust but also nominated nationally for a HSJ (Health Service Journal) Award, in the Quality Improvement category.

In our Specialties services, a co-designed project to increase awareness of/access to Op COURAGE by female veterans is taking place; to help tackle the issue that Female veterans are at increased risk of mental health conditions but the numbers presenting to Op COURAGE for help are low. The project aims to increase the percentage of the female veterans who know that Op COURAGE exists, what services it provides and how to access it. The project team have produced their Driver Diagram and are starting their first PDSA cycle.

There are **two** perinatal projects taking place; in the East team that is reducing DNA rates and in the South; a Health Inequalities project, focused on access to services for young pregnant women/mums. Additionally, a prospective project is also taking shape in West Perinatal around DNA rates.

Three Specialties wards have began their journey on the Culture of Care Programme in Spring 2025 with Cilantro, Chamomile, and Jasmine Suites taking part. On Friday 28th March the teams completed a workshop covering topics such as co-production, building therapeutic relationships and embedding anti-racism practices. The programme is designed to support inpatient ward staff to create psychologically safe, caring, and relationally strong ward environments. Through site visits, reflective practice training, supervision, coaching, and skills-based development, the initiative aims to foster a sustainable culture of positive informal interactions and high-quality care.

The Reducing wait times for accessing the HI CBT Pathway in BHM (Birmingham Healthy Minds) project successfully closed in autumn 2024, as the project achieved its highly ambitious aim of “To reduce to zero the percentage of patients waiting over **40 weeks** for High Intensity Cognitive Behavioural Therapy (HI CBT) by the end of March 2024 (from joining the waiting list to being allocated a clinician)”. Due to the project’s success, the project was also submitted as a success case study to NHS Impact.



Open Projects

- ARAF appointments
- DNA project – OA South CMHT
- Empowering women: Women with first episode psychosis to have appropriate and timely preconception counselling.
- Improve quality of care and safety for patients on Chamomile ward
- DNA rates perinatal team
- South Perinatal Team Health Inequalities Project – access for young pregnant women
- Veterans EDI/Co-Production project

Future prospective / Projects soon to be registered

- Increase access to Eating Disorder services for people from a BAME background
- Improving discharge planning - Jasmine Ward
- Business continuity plans - clinical systems (Rio)
- Joy in Work – Bergamot
- Birmingham Healthy Minds – inappropriate referrals/SPOA form
- Health and Welfare LPAs in Huntington's patients
- Improving staff morale on Rosemary ward / Joy in Work
- Improving clinical supervision - Rosemary
- Admiral nursing - appropriate referrals
- Dementia bloods screening
- Ashcroft West Perinatal waiting times
- PCREF & improving cultural experiences
- Conception advice South Community Hub
- Utilising furniture across the Trust
- Health Inequalities -Psychological Therapies
- Reducing falls
- Improving the time it takes to complete clinic letters

Completed Project(s)

- Reduce waiting times for accessing High Intensity (HI) Cognitive Behavioural Therapy (CBT) Birmingham Healthy Minds

Spreading the QI word at Guard Education Sessions

On Thursday 16th of January, QI Lead Stacey Watkins and QI Facilitator Hannah Stanyard recently presented at one of Jasmine wards Guard education sessions to talk about Quality Improvement and how to get involved. Guard sessions are ways for Jasmine staff to gather information/ideas that would benefit Service Users and/or clinical knowledge.

Guard attendees are a mix of ward and community clinicians and usually include psychiatrists, nurses, psychologists, OT, support/recovery workers, ward manager and matron. Attendees are a mix of hearing and deaf staff therefore BSL interpreters are booked for the meetings.

"It was an honour to be invited to a guard education session and speak about QI. This is a great quality initiative by the team to provide a platform of education/learning for our staff to benefit our Service Users."

QI Lead Stacey Watkins (Dementia, Frailty and Specialties)

Reduce waiting times for accessing High Intensity (HI) Cognitive Behavioural Therapy (CBT) - Birmingham Healthy Minds Project

Staff from Birmingham Healthy Minds came together towards the end of 2023 with ambition to 'reduce to zero the percentage of patients waiting over 40 weeks for High Intensity Cognitive Behavioural Therapy (HI CBT) by the end of March 2024 (from joining the waiting list to being allocated a clinician). The service had already started to implement some changes prior to reaching out to the QI team. However, these changes hadn't necessarily improved the waiting list in the way they'd hoped, so Joanne Everill (Clinical Lead for BHM) began to wonder if a structured QI methodology might help the team bring about fundamental and sustained improvement.

Shelley Wreford, Quality Improvement Lead got straight to work, supporting the team with gathering information about the changes that had already been made; process mapping to understand how the system is currently working; and looking at the data to understand the baseline wait times for the pathway. Once all this information had been gathered, the project team could then build their driver diagram, including revisiting the change ideas that had already been implemented to see if there was scope for further improvement, and developing new ideas based on their learning so far.

Many of the initial change ideas the team implemented were focused on stemming the flow of referrals and tackling the backlog – such as the use of a digital partner (Xyla) and a robust screening gateway for new referrals. Whilst these change ideas helped reduce the number of people coming onto the waitlist, the data showed that there remained a persistent group of over 40-week waiters, which wasn't being impacted on by these changes. The project team had a suspicion that there was some 'cherry picking' by clinicians occurring, so decided to go back to the drawing board and do a deep dive to better understand who the longest waiters were, and at which point people were being taken off the waiting list. Once this work had been done, the team developed several potential change ideas aimed at maximising CBT clinician capacity; flagging people who required interpreters; taking into account geographical area; and developing a consistent process for taking patients off of the waiting list. The change idea the team decided to focus on first was an automated booking system (ABS), but quickly discovered through piloting the tool that the system was only as good as the appointments being put onto it. The continued to test an ABS using a PDSA methodology until they were happy that the system was being used effectively by clinicians and was adding value in terms of reducing the number of service users waiting over 40 weeks to be allocate a clinician for HI CBT.

Spotlight on Directorate QI Projects

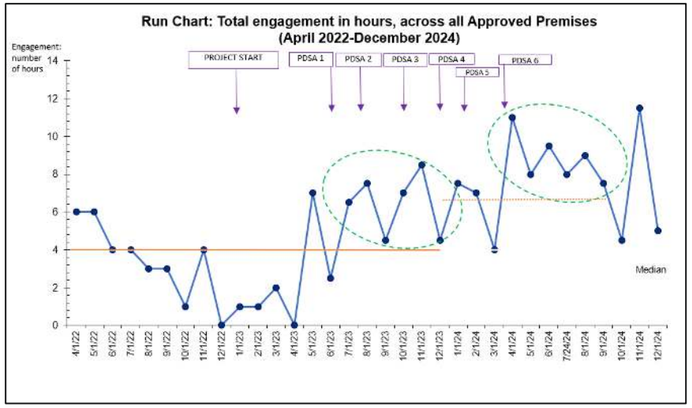
Secure Care and Offender Health

Project highlights

Offender Personality Disorder pathway

AFFIRM is part of the Offender Personality Disorder (OPD) Pathway services in the West Midlands. It is a partnership service delivered jointly by the NHS and HMPPS. The aims of the service are to promote psychologically informed practices to develop the skills and confidence of staff, increase psychological health and well-being, encourage engagement of service users, and ultimately protect the public by reducing re-offending. The AFFIRM team are expected to deliver a service to AP's within our service specifications to support these aims. At the start of the project engagement had been sporadic and required improvement. This project focused on improving engagement in services offered by AFFIRM staff working in to eight Approved Premises (AP), beginning with a pilot in one AP, but with a view to replicating the work across all AP's.

The team collected monthly data relating to the number of hours input offered by the OPD team to AP's and the number of hours of activity used/attended by AP staff.



The run chart above demonstrates that the aim was achieved by January 2024 with a new, recalculated median of 6.75 following a shift signalled in the data (shown by the first, green dashed line around six data points).

Furthermore, the gains achieved continued to be held with a further shift (shown in the second set of data points with a green dashed line) and a new median of 8.5 should the data be monitored beyond the QI project. The second shift in data has included engagement in a combination of the following activities: reflective practice sessions, case discussion and formulation / case busting, staff wellbeing sessions. training in personality difficulties and related issues, and support.

Thus, concluding that the QI project was a success, and the gains achieved have also been sustained.

Visit Quality Improvement on Connect

Secure Care Offender Health (SCOH) embarked on a Continuous Quality Improvement journey in 2023 through a longer-term QI project and have held the gains achieved, through to 2024-25 based on the strength of the change ideas that were tested and implemented. The run chart to the right shows a succession of three shifts (signals in the data, evidencing improvement), and each time the division has sustained the new level of performance.

SCOH started the financial year in 2024 with **6 projects** that were open and **10 prospective projects** where teams were consulting with SCOH QI Leads to ensure they were ready to start their QI projects. Over the course of the last 12 months SCOH has seen between 13 and 21 project ideas come through to Programme Clinical Governance each month from staff at all levels and are ending the year with an impressing 10 QI projects and 14 prospective QI projects. In addition, the Culture of Care: Live. Love. Life. project has 14 teams each with mini-QI projects that will form part of a Change Collaborative.

SCOH is the only division to have regular monthly local QI meetings, 'QI hubs', across all its sites for the last 12 months, achieved through the Continuous Quality Improvement project. The Qi hubs provide the perfect opportunity for staff to explore QI ideas, also as audits are completed and presented, the work emanating from the recommendations often leads to prospective QI project conversations and there are many occasions where QI leads provide in the moment QI coaching and share knowledge and guidance during the Qi Hub meetings. SCOH QI Leads continue to use the Q Hubs as an opportunity to deliver bespoke training too.

Thus, evidencing a change in culture with a sustained a higher level of QI activity, where QI is the way we make improvements in Secure Care Offender Health.

Local QI Hubs have also enriched the appetite for QI training and 6 bespoke Bronze training sessions have been delivered across SCOH throughout the year. This has significantly increased the number of staff within the division, who understand our approach to improvement work; using the Model for Improvement , and their ability to embark on improvement projects.

Feedback from our training:

"Both Tabs and Lisa were really knowledgeable and adapted the material to suit the needs of our service. We were grateful for them giving their time up to deliver training to us specifically - and it's really helped us to start thinking about new project ideas for our service."

As well as the increase in hours offered and used demonstrated in the graph above, the project has had a positive impact on all staff involved. Staff in AP's have reported feeling more confident in dealing with difficult and often complex individuals, learning new skills to understand trauma and the impact on personality and behaviours. Feedback suggests that the benefits of reflective practice have been realised by staff, including the importance of sharing personal feelings and emotions when working with complex individuals with personality difficulties to support their psychological health and wellbeing.
Staff have started to embrace the importance of relational and trauma informed practice and have reported putting these skills into place when working with complex service users. One staff member described the new skills they had learnt helping them when inducting and setting boundaries with new residents entering the AP.
Through the QI project, data collection methods have improved, allowing better evaluation of performance by analysing both the hours offered to the AP's and utilisation of this time. We have also been able to look more closely at the types of input being requested and considered valuable by the AP staff.
Additionally, various efficiencies have been achieved within the AFFIRM team. For example, having fewer sessions cancelled or re-arranged we are utilising our time more productively. This provides better value for money.

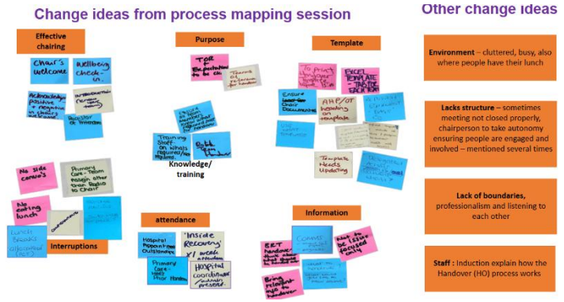
HMP Birmingham

The first ever, QI project with HMP Birmingham launched early 2025 looking to improve the integrated clinical handover and is a collaborative QI project with multiple stakeholders committed to making improvements including Primary Care, Birmingham Recovery Team (BRT), Mental Health, Pharmacy, Administration and Allied Health Professionals.

A process mapping session including all stakeholders and all levels of staff generated many change ideas that were then themed to create a driver diagram.

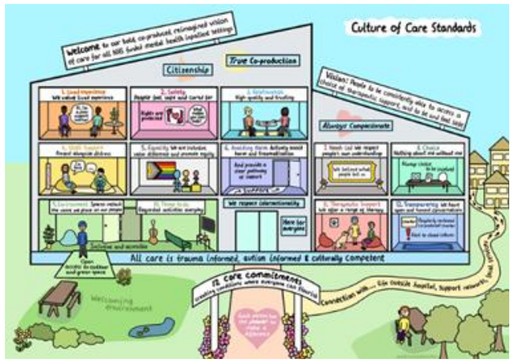
- The project team started with the change idea to coproduce a term of reference for the handover that sets out expectations for conduct, attendance and participation. This is currently being finalised and agreed by all stakeholders and will be tested through the PDSA cycle.
- Protected meeting times is another change idea to ensure that staff are not having lunch or social breaks during handover, and this has been tested through one PDSA cycle and is now being tweaked and re-tested.
- Radio's that are essential to roles but often go off during handover create disruption in the handover, therefore the next PDSA will be to test out earpieces to see if this reduces the noise and disruption.

The project is progressing well with quantitative and qualitative data is being continually collected to measure attendance, duration and experience.



Culture of Care: Live Love Life

The Culture of Care (CofC) is a national transformation programme that aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work.
The programme takes a trauma-informed and autism informed approach with a strong commitment to anti-racism. These principles are integrated into every aspect of the initiative, ensuring that the care provided is sensitive to the diverse needs of all individuals. Central to the programmes ethos is the emphasis on lived experience, leadership, co-production and collaboration.



The above diagram represents the 12 standards of the CofC programme.
A bespoke version of the CofC programme, tailored to the needs of Reaside started in late January 2025 bringing together staff, inpatients and Experts by Experience (EbE) who are service users trained in quality improvement methodology. Dr Helen Smith, Consultant Forensic Psychiatrist, Jonathan Warren, Former Chief Executive and Chief Nurse and Tabassum Mirza, QI Lead with additional support from all members of the QI Team have walked alongside Reaside staff and service users to support them through this work.

Through an appreciative inquiry lens, several face-to-face conversations have been held with staff and EbE representing service users. Furthermore, anonymous staff surveys, both in paper and digital were shared across Reaside, supported by QI Team visibility days at Reaside twice a month and many floor walks through wards. Reaside teams have also gathered further ideas for change through their local team meetings, with Ward Managers holding their own process mapping sessions following QI training they received. Together this culminated in a wealth of feedback highlighting what has been accomplished by staff and service users across Reaside to date and change ideas to further improve on what has been achieved.
The ideas that have been generated over the past few months will be organised into themes at the upcoming workshop in May 2025. The QI project has started from a blank slate, coproducing everything, this includes developing the driver diagram, generating change ideas, developing measures, organising training and much more to come. The local teams will help with the development of the formal theory of change (Driver Diagram), linked to the 12 standards of the culture of care.

There have been many achievements in the short few months the project has been running including positive feedback from Quality review, staff survey results, morning meetings established for service users, positive Residents' Council, carers' Group re-established with identified Carer Leads for each ward. In addition to this:
An EbE workshop focused on renaming the QI project and through insightful discussions the EBE group agreed on changing the project name from Culture of Care Reaside to:

Tabassum Mirza, QI Lead, Secure Care & Offender Health, delivered a training session for Ward Managers on how to use process mapping and its relevance to The Model for Improvement.

The session generated much discussion highlighting some points of escalation and action. Ward Managers have since organised their own process mapping with their teams that will generate further change ideas, identify any quick wins that can be achieved immediately and any actions to take forward.
A bespoke QI training session was co-delivered to service users by Kuldeep Singh, QI Lead ICCR and Donna Thomas, QI Facilitator Acute & Urgent Care. Dr Helen Smith and Jonathan Warren commented:

"This is the first time that we are seeing inpatient service users, in a medium secure unit, trained in QI to coproduce improvements in the culture of care making it a great place to receive care and a great place to work."

Through the appreciative inquiry conversations, both staff and service users were keen to make Reaside great again and wanted to start with decluttering, clearing, cleaning, painting and decorating the site. The idea for a 'Reaside Clean up Week' was born! It took place week commencing 7th April and was a resounding success with the support of all staff and service users, departments, leads and managers.

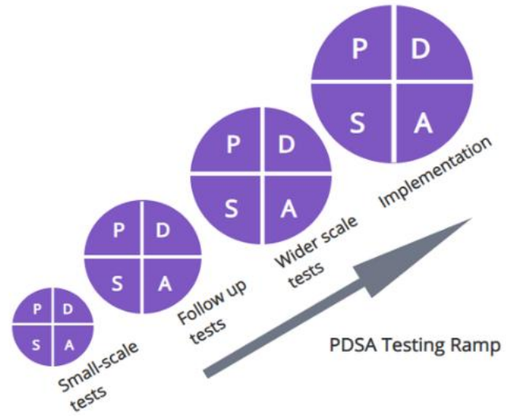
Staff have commented that there is a real sense that the culture is starting to change/improve; For example, staff and service users were energised by and during Clean Up week and want to make it an annual event. Staff and service users are feeling valued seeing the physical changes at Reaside.

The next steps for the Culture of Care: Live Love Life is to collect, organise and prioritise change ideas that will be part of the Change Collaborative. To develop the theory of change for the project visually represented by a driver diagram. Progress against the chosen change ideas will then be shared by some of the 14 teams at monthly share and learn QI events. There will also be masterclasses delivered focussing on equality diversity and inclusion and Quality Improvement.

FIRST Physical Health Clinics

The project team aim to improve the physical health monitoring of FIRST Service Users that are taking antipsychotic medications. Evidence-based research shows the life expectancy of people with a serious mental health illness and prescribed antipsychotic medications is dramatically reduced by 10-15 years compared to those that don't have a mental illness. The project team came up with multiple change ideas to test:

The project team developed a Decision Tree Chart for staff to reference, to aid identification of physical health checks required for Service Users. The ease of use and effectiveness of the Decision Tree Chart was tested through multiple PDSA cycles, and measured by the responses to the following questions:



The Decision Tree Chart is now displayed and widely used within FIRST. The project team are continuing to test following change ideas; satellite clinics and appointment reminders via text messaging.

Wellbeing Clinic at Ardenleigh CAMHS

There are currently **7 young people** at Ardenleigh **across 2 wards: LSU & MSU**. Staff identified young people were having adverse health effects attributed to their medications, and wanted to tackle this issue with the aim of:

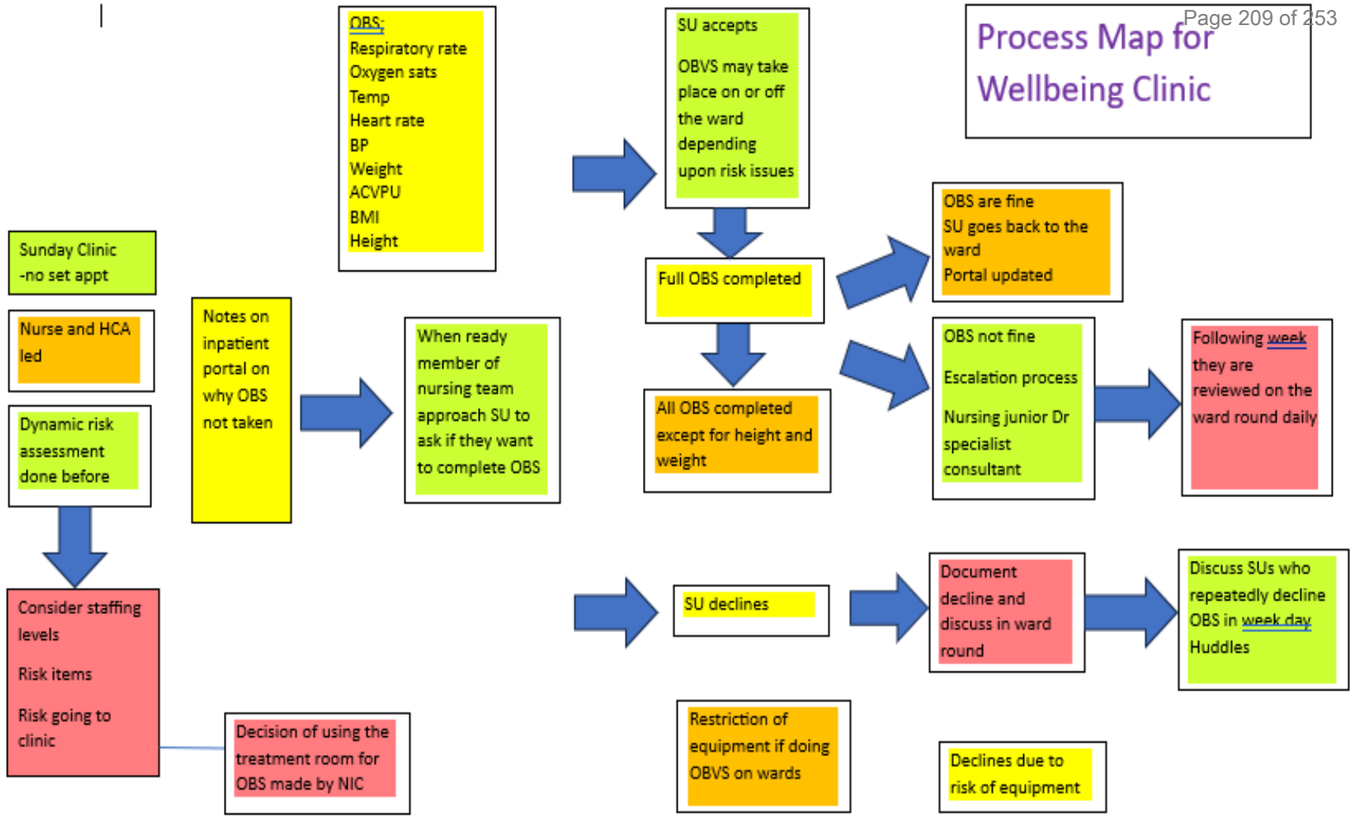
100% of Young People in Secure CAMHS to have a healthy BMI within normal range by **October 2025.**

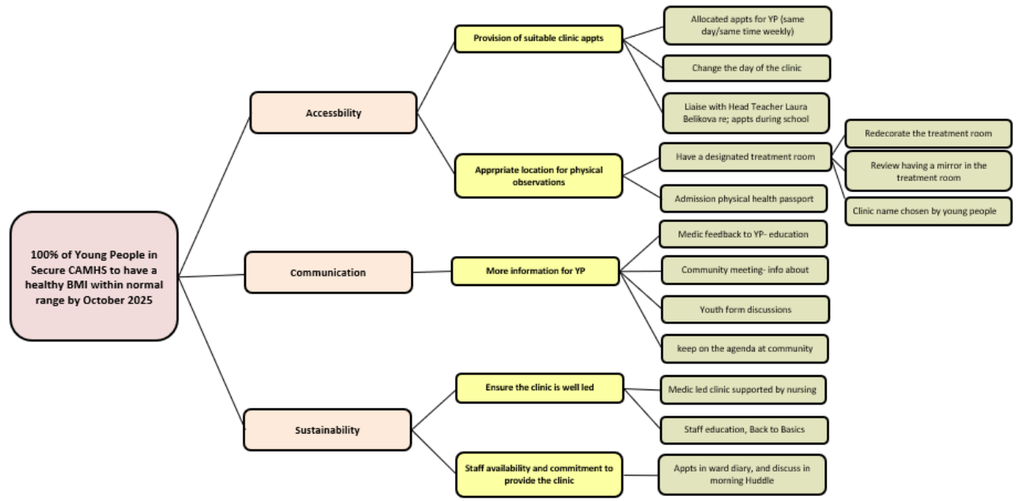
With the support of the QI Team and using QI tools, the project team undertook a process mapping session, to aid identification of hot spots, and places to disrupt the current system, by testing out change ideas. The process mapping session helped the team to produce the driver diagram, the project plan on a page.
A treatment room has been set up to ensure physical observations, are not completed on the wards. A lot of thought went into the design of the new treatment room, and it was co-produced by the young people, they chose:

- the colour it was painted
- the name of the room: The Treatment Room
- to keep a self-selected mirror

The clinic day was moved from a Sunday, to a weekday, and this was agreed with the education team. Each young person has a self-selected recurring clinic slot each 3-month this will help imbed routine to support those with LD&A. Education is provided to young people regarding their health at each appointment. Clinic attendance has been incentivised, each young person chose a reward (£15 budget pp) they would like to receive for attending 70% of their appointments over a 3-month period, reviewed at CTMs. Some examples of their choices:

Next steps: collaborate with the Healthy Weight QI Partnership enabling teams to learn from each other and from Subject Matter Experts to make a sustained improvement.





Wellbeing Clinic at Ardenleigh CAMHS Driver Diagram

Health Justice & Vulnerability Service Youth Outreach Engagement

The project group wanted to increase the number of young people who had been assessed in Police custody, attend and engage with an STR Worker in the community. It was noted that a large number of young people did not attend their first community appointment, however staff had learned that those who did attend their first appointment were much more likely to continue to engage with the service, so the aim was to get them to their initial appointment following referral.

Process Mapping session with the project team

Following lots of hard work and commitment from the team, the project has progressed through the phases of process mapping, defining the project aim, defining measures, and creating the driver diagram, to now testing their change ideas using the Plan-Do-Study-Act (PDSA) process.

The initial Youth Focus Group, was such a success, that the project team have established an ongoing Youth Forum, to fully co-produce service delivery with young people.

Project Lead; Laura O'Brien, has forged links with a local community enterprise, who will support the Youth Forum to produce a website, and videos explaining what the service offers, to be shared with young people in custody. The whole project group have been incredible motivated and enthusiastic, to drive forward changes than lead to improvements, to create the best possible service for young people. The passion for their work is undeniable!

Current PDSAs	Impact
Change of shift pattern: 8am-8pm	The project team reported working beyond 5pm has been a 'game changer'! As they ability to engage with young people and their families/carers has significantly improved, due to being outside of school and work hours. They have been able to take young people to evening activities.
Dedicated Practitioner & STR Worker in custody	Whilst the Practitioner focuses on assessing mental health, the STR Worker has been able to promote the benefits of HJVS and build rapport with the young persons which increases HJVS and their continued engagement in the community.
Youth Focus Group	A key component of this project is co-production with young people, to ensure the service meets their needs. Currently they are co-producing: • a new name for the service • leaflet to be given in custody • bespoke and interactive digital assessment tool • videos to promote the service • service website
Appointment text reminders	The data shows a dramatic increase in attendance at planned appointments.
Bespoke assessment tool aimed at young people	The assessment tool is being adapted through the PDSA cycle. Feedback is being gathered from young people post assessment, and adaptations being made. Co-production is also taking place via the Focus Group.

Process mapping session with Health Justice & Vulnerability Service Youth Outreach Engagement Project Team

Positive Behaviour Support at Ardenleigh Women's Service

Positive Behaviour Support (PBS) aims to help reduce violence, aggression and self-harm specifically on Citrine and Coral wards by intervening in the early stages. Following identification of a problem behaviour via CTM, using ABC Charts, a functional analysis will take place, thus enabling a PBS plan to be co-produced between staff and the Service User.

The project team came up with the following strap live for their project: Thriving not Surviving

The project aim;

By **Summer 2025**, **100%** of Service Users on Coral and Citrine will have a PBS plan which is reviewed monthly by their clinical team and highlights the progress they have made in reducing risk behaviours.

A training programme was written for staff by members of the project team, and this has now been rolled out to staff on both wards. This will support staff to complete comprehensive PBS plans with Service Users, additionally PBS Champions have been identified to offer additional support to staff.

A key take away from a co-production session with Service Users, was their dislike of the terminology 'positive behaviour support', they felt this was child like. They have been tasked with co-producing a title for the plans, which they feel is appropriate and resonated with them.

This project has been moving at pace all year, and is now moving into it's final phase towards project closure; the PBS plans have started to be completed for Service Users on the wards. The project team are completing PDSAs for each use of the PBS plan, for continuous learning, to arrive at the best version. A request will then be made for this to be added to Rio.

For her commitment and dedication to this improvement project, Project Lead; Sarah Mottram was nominated for a Trust Values Award.

POSITIVE BEHAVIOUR SUPPORT
ARDENLEIGH QI PROJECT

Our First Change Idea:

To create a good quality PBS plan, we first need to understand the function of a behaviour, what leads up to it and what happens afterwards that reinforces it.

To ensure we always capture this information clearly, we would like to try a new template for completing eclipse forms on Coral and Citrine when there has been an incident of violence, aggression or self-harm behaviour.

"Thriving not Surviving"

POSITIVE BEHAVIOUR SUPPORT
ARDENLEIGH QI PROJECT

The template follows an ABC structure

As you complete the eclipse, make sure you have covered the questions beneath each heading.

Antecedent

What were the events leading up to the behaviour? Think about: where the service user was, what they were doing, what were the early warning signs or had there been any triggers or incidents on the ward prior to this behaviour and if so, what were they? Was there anything else that has happened for this person over the last few days that could have contributed?

Behaviour

What was the behaviour? Be specific with what was said and the actions they engaged in.

Consequences

What happened after the behaviour (positives and negatives)? Was a restrictive intervention used and what was it? What helped the behaviour de-escalate? How were they able to regulate? Was support provided by staff and in what form?

If the behaviour was a ligature, you must also use the ligature assessment tool!

We will be asking for regular feedback about your experience of using this template

"Thriving not Surviving"

SCOH Summary

The last 12 months has been exceptionally busy with continuous improvement work across the division. This includes our regular QI Hubs, QI training, and QI projects, both open and prospective. We will be opening 5 new QI project across SCOH in the next month, outside of the Culture of Care: Live. Love. Life. Project which has 14 teams each with mini-QI projects that will form part of a Change Collaborative. The Culture of Care initiative will also formally commence at Ardenleigh, followed by Tamarind, although work is already underway amongst staff.
The are currently a further 10 prospective projects registered, with more being presented on a regular basis, so it's looks the year ahead is going to be as busy, if not busier than the last 12 months.

QI Training Academy

The training strategy continues to build a strong foundation of QI capability to put improvement at the heart of what we do. The strategy aims to provide a breadth of training which enables staff to develop awareness of QI, and those participating in QI projects will have sufficient skills, knowledge and expertise to participate or lead QI projects. The QI academy offers a range of short courses which outline the model for improvement, it's value and when it can be applied. For those who plan to participate in QI or develop additional skills there is more in-depth training through the bronze or silver offer. Attendees who have completed the QI courses receive a follow up thank you email with QI resources slides to look back on the information provided in the course. They also receive a certificate for completion of the course.

Throughout this journey, the team collects evaluations of the training in the interests of making the training effective and enjoyable for those attending. The feedback we have received from the training we provide has been overwhelmingly positive, with delegates sharing that the training built their knowledge and understanding.

New Training Lead, Stacey Watkins

In late August 2024, QI Lead Stacey Watkins (Dementia, Frailty and Specialties) joined the team and is also the new Training Lead of the QI Academy. Stacey has extensive experience in Training and developing courses in both NHS and non-NHS settings, training over 1000 NHS staff on clinical systems in her career.

One of Stacey's most "memorable" training experiences was training First Aid Skills at a Ministry of Defence site when a light fitting caught fire in the room, and everyone had to be evacuated; luckily the newly acquired skills of the delegates didn't need to be used that day!

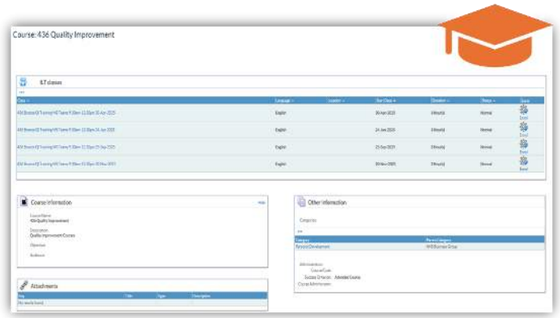
Exciting Training Academy redevelopments

The training academy took a pause over January-February 2025 so that redevelopments of training content could take place, all the QI courses are now refreshed with new slides and continuous developments scheduled to take place.

The QI Training Academy is also excited to report that all courses are now bookable via the ESR system; making for a efficient way to book on to training for both attendees and our administrators! Benefits include:

- Instant booking confirmation (no need to wait for an answer)
- Quick and easy to book/cancel
- Instantly see course availability for dates in advance
- Automatic waitlist option
- Course completion sits on ESR record

Click the link to view the QI Training Academy page on Connect.



ESR page Quality Improvement courses

Intro to QI	Quality Improvement projects are a way for teams to address some of our more complex areas for improvement work. Although many people will have heard about QI, this course is a short introduction aimed at all staff who are curious to find out what it is. Over the course of 1-hour participants will learn why we use QI, when it can be used and what a QI project is.
Bronze	This is a half day workshop which outlines the model for improvement within QI. Participants will learn how to understand and apply the model to a quality improvement project and how to use the PDSA cycle. This is aimed at people participating in a project. You will come away with enough knowledge to actively participate in project meetings as you will recognise the language being used, and what needs to happen for each part of the model.
Silver	Silver training aims to support participants to translate the QI methodology into practice. Participants should come with a QI project, which they then develop during the training and implement in-between the training days. The course covers QI methodology, introduces tools and guides participants to translate this into the real world. Exercises are fun and engaging with support on hand. This is ideal for project leads and project members looking to develop their skills. As project work is undertaken during the course it works particularly well when project members can all attend together.
First Line Managers	The training course looks at the basics of what a QI project is; when, how and why to use QI; Leadership role in change and QI; and getting started with your QI project. This is just a brief introduction to QI principles and how they can be incorporated into your leadership role. It is not intended to be a full introduction to how to run a QI project, and at the end we'll tell you about how to access the rest of our training which will take you through this is you are interested. Training takes place over Microsoft Teams.
EBE QI Training	We're committed to coproduction, so it's vital that our Experts by Experience (EBEs) understand the Model for Improvement. Our tailored training equips EBEs with the knowledge and confidence to actively contribute to QI projects, understand key terminology, and engage meaningfully at every stage.
Bespoke QI Training	Quality Improvement offers bespoke QI training sessions for teams. If you are interested in this training, please contact the Quality Improvement inbox: bsmhft.qualityimprovementteam@nhs.net

Visit Quality Improvement on Connect

QI PowerPoint slides; You Said We Did

Part of the Training academy redevelopments were updating the Training Academy slides, we had received some feedback that slides were outdated and didn't fully reflect the excitement of QI. Below is feedback we received from a feedback form, from a delegate who attended a QI Introduction in 2024 prior to our redevelopment:

"The facilitators were engaging initially but the power-point slides were not as appealing"

2-day Silver Training Trial

In December of 2024, the QI team trialled a 2-day silver training to streamline activity and ease of booking for clinical staff.

New QI Silver course for 2025 under development

The team are redeveloping the Silver QI course and are currently pausing QI Silver training dates. To register your interest when the new course launches and have your name on a waiting list please email bsmhft.qualityimprovementteam@nhs.net

ATAPP
Applying Theory and Practice Pathway
Shaping the Future Nurse

Now training as part of ATAPP

The QI Academy is excited to be providing training slots as part of Applying Theory and Practice Pathway.

The design of ATAPP allows guided learning using scenarios, role play and sharing experiences, to increase the confidence of student's clinical skills and knowledge.

The QI course will provide ATAPP delegates an introduction to Quality Improvement, the Model For Improvement, their first PDSA (Plan, Do, Study, Act) cycle, and information on how they can get involved and embed QI into their practice!

QI at Induction

Quality Improvement has a regular session at the Trust's 'Welcome Induction.' New starters are introduced to the Model for Improvement and are encouraged to participate in an interactive PDSA (Plan Do Study Act) cycle exercise. The QI methodology was used to gain insights and shape this session.

-Induction redevelopment

Refreshed Quality Improvement Induction slides were launched for the March 2025 Trust Induction cohort. Hannah Stanyard, QI Facilitator (Dementia, Frailty and Specialties) showcased the newly updated QI slides.

The QI Induction slides introduce new starters to Quality Improvement, how they can get involved and even provides a taster of their first PDSA (Plan, Do, Study, Act) cycle.

Training Feedback across 2024

Throughout the QI Training journey, we welcome all feedback to enable us to better develop our courses. We have also received an overwhelming amount of positive feedback that we have shared below:

"Information provided during the training session was, overall, very useful as it offered a good overview of QI and its appropriate application within projects"

"Very enjoyable and engaging presentation. Clearly explained concepts and I walked away with a good understanding of QI projects. Interesting and engaging exercises (e.g., handwriting exercise to demonstrate variation) to explain complex concepts. Thank you!"

"Just a thank you to Kuldeep for the really engaging delivery"

"It was good to have knowledge of the different QI skills and chance to work through our own examples"

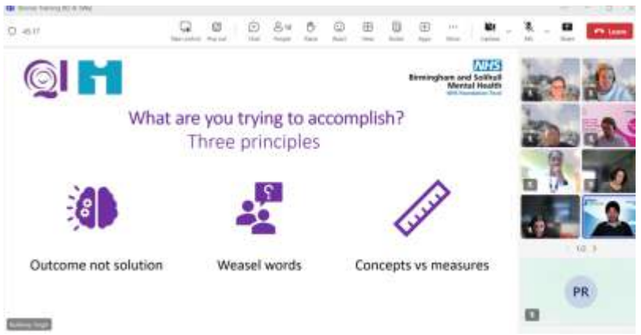
"It was very comprehensive and helps"

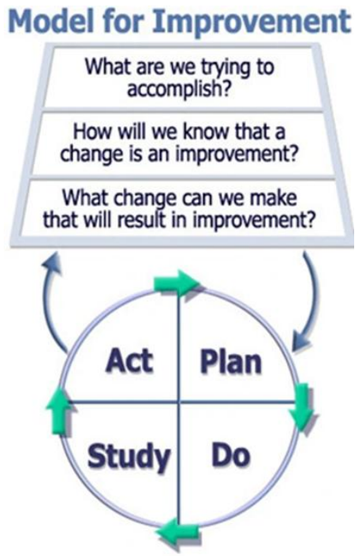
"Both Tabs and Lisa were really knowledgeable and adapted the material to suit the needs of our service. We were grateful for them giving their time

"I would like to highlight that the training was informative"

"Very well presented, open and friendly space, clear presentation and it felt easy to ask questions"

"Really well facilitated, engaging and motivating to engage in QI!!"





QI Training Academy statistics

Following ESR launch Increase of training bookings; in just **April 2025** alone, at the time of writing the QI Academy have an astonishing number of 43 delegates booked on Bronze QI training! The chart below shows the trajectory based on current bookings taken from ESR.

There has been over a **300% increase** over the usual median bookings for our Bronze training offering, which in the month of **April 2025** is the most bookings we have received on record for bronze QI training in years.

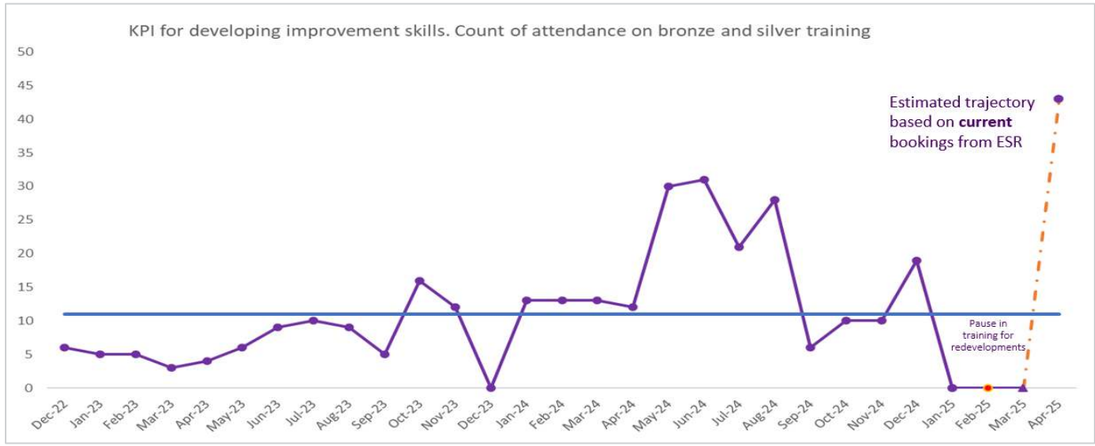
<u>For those staff who are leading / participating in QI projects, to have the skills and knowledge to apply the Model for Improvement</u>

<u>Encourage and inspire staff to participate in QI through the Intro to QI
course and other ad hoc training opportunities</u>

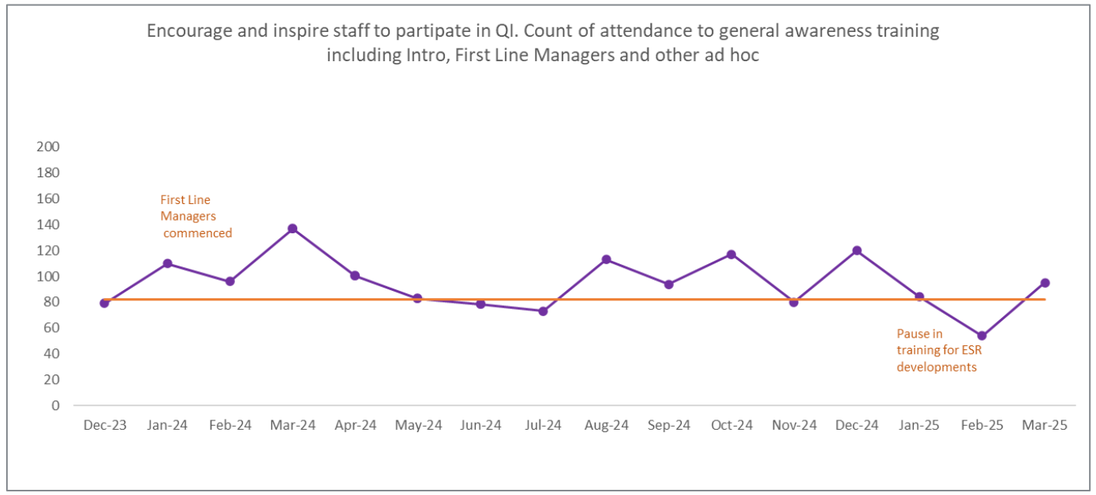
In **2024** the total number of people accessing some form of QI training was **1407**. With the training offer now being bookable via ESR and our addition of including QI as part of ATAPP this year; it is predicted that **2025** will see an increase!

Looking forward

Despite the huge developments that have taken place in the QI Academy there is still so much more to go! Silver QI training is under development and the plan is to have some regular dates set for staff to book on.
We have also had queries for a face-to-face QI Bronze Training option; some of our QI Leads have been testing this when conducting Ad-Hoc training for clinical staff. The plan is to have some options for a face-to-face option to give delegates the choice if this is preferable over MS Teams.



Zoom out showing data from Dec 2022:



(Despite pause in bookable training offers, induction awareness and some ad-hoc training still took place)

QI Communications

QI Newsletter

The Quality Improvement Newsletter is published every 6-8 weeks. It's an opportunity to showcase the latest QI news happening in the world of QI at Birmingham and Solihull Mental Health NHS Foundation Trust. The QI Newsletter has attracted up to **600 subscribers** across the Trust.

QI Connect

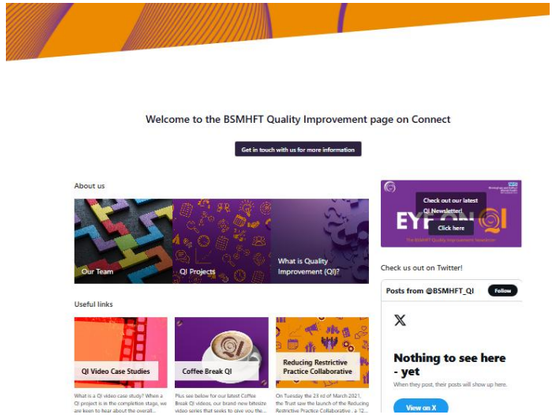
The Quality Improvement Connect page is updated regularly with the latest QI project updates through weekly articles via the Trust Colleague Briefing and a newsletter that is published every 6-8weeks. The QI Training Academy page is updated with a new set of training dates and promoted via both Colleague Briefing and the QI Newsletter.

Colleague Briefing Articles

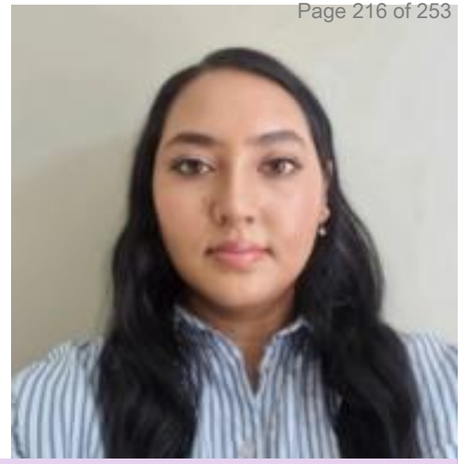
Quality Improvement projects from each directorate are regularly shared on the Trust Connect page via the Colleague Briefing, which is published each week. This enables staff within the Trust a view of the latest Quality Improvement project updates and news. The articles spread awareness about the QI projects, starts conversations on QI and in turn encouraging staff to get involved in QI.

QI Case Studies-YouTube

When a QI project is in the completion stage, we are keen to hear about the overall experience of a QI project from the project lead and members involved. Filming QI video case studies and interviewing members from the project team gives insight into the background of the project and how implementing QI tools such as the Model for Improvement has helped to create a positive impact on the service for service users, staff and stakeholders. Have a look through past QI projects below to learn about each Quality Improvement journey.



Join the continuous improvement movement



QI Communications Officer, Priya Roadh

"Over the past year, I have had the privilege of being involved in a diverse array of Quality Improvement (QI) projects and initiatives across the Trust. In my role as a QI Communications Officer, I am responsible for capturing and sharing QI stories, providing a platform for many voices to be heard and to participate in the improvement process.

Being part of the QI Team is incredibly rewarding. It allows me to actively engage with the remarkable Quality Improvement work and to witness firsthand the significant positive impacts these initiatives have on service users, staff, and stakeholders. Additionally, my role enables me to explore platforms and innovative ways to produce and publish content. I am passionate about my role because it not only enables me to contribute to meaningful changes but also to learn continuously from the experiences and insights of others involved in the QI process.

QI Communications have been involved in the creation of content for the Culture of Care: Live Love Life Programme at Reaside to share regular updates of the incredible innovative and collaborative work that staff, service users and stakeholders are completing to help make a better and more therapeutic environment for all at Reaside. The Culture of Care: Live Love Life newsletter has received good engagement through both distribution via the Trust Connect page and physical distribution.
We have also supported with promote the launch of the Culture of Care National QI Collaborative Programme through Trust articles, Newsletters and Connect. "

QI Content

QI has been involved in creating posters for QI projects entering external awards. In the past year **5 QI projects** submitted their poster abstracts to showcase the remarkable QI project work and share the significant impact of the changes made.

Visit Quality Improvement on Connect

QI Roadshows

QI has been out and about over the past year, with the QI Team hosting each stall to engage and network around the Trust. These events have provided valuable opportunities to share insights, gather feedback, provide useful QI materials and collaborate on various Quality Improvement initiatives. The team has been dedicated to fostering a culture of continuous improvement and innovation, ensuring that every voice is heard, and every idea is considered.

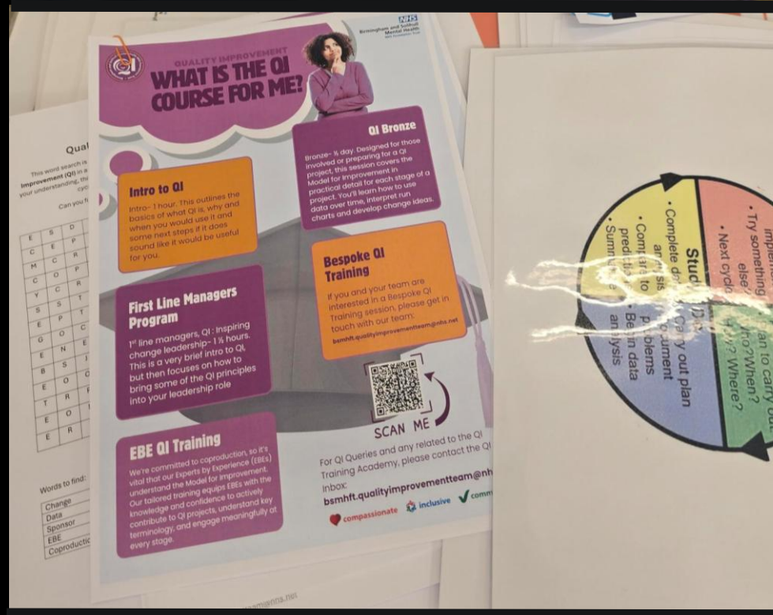
We look forward to continuing this journey together and making even greater strides in the coming year. If you have any suggestions or would like to get involved, please don't hesitate to reach out to us.

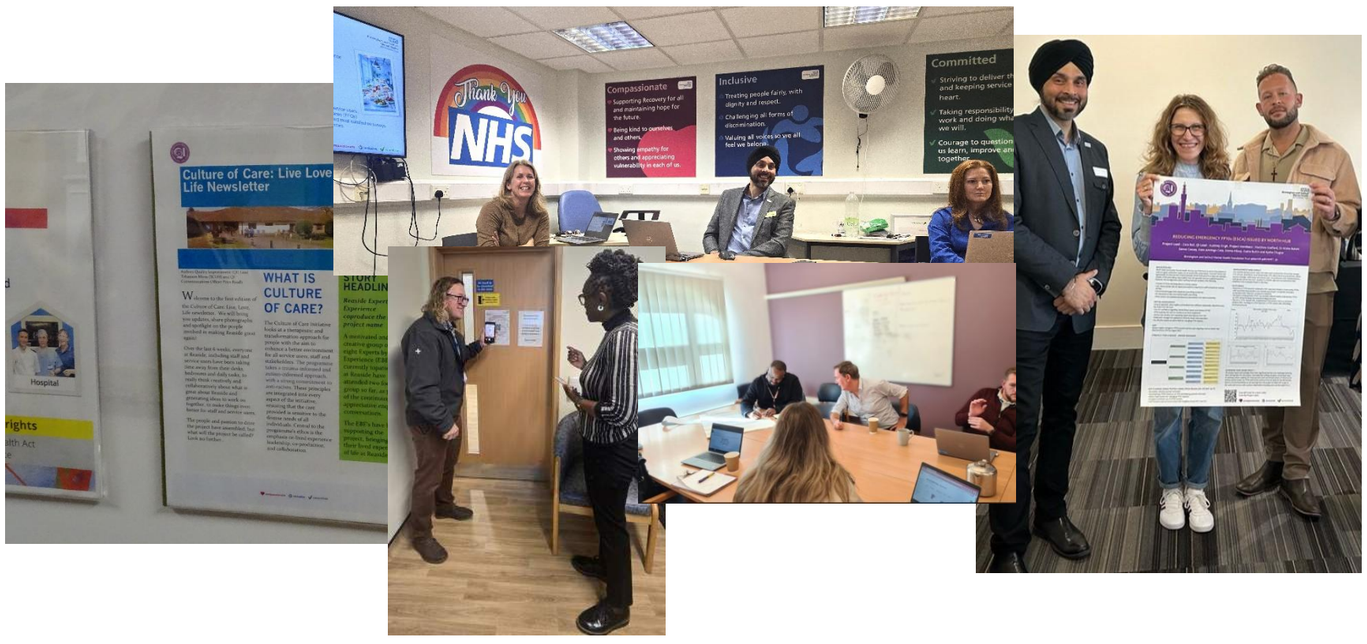
Culture of Care: Live Love Life

QI Communications is involved in producing and publishing content for the Culture of Care: Live Love Life Programme at Reaside. It's a great opportunity working with staff, service users and stakeholders at Reaside to shine a spotlight on the improvements made, which is inspiring.

Through this collaboration, we aim to highlight the positive changes and innovative practices that are transforming the care environment. Our team is committed to capturing and sharing these stories, showcasing the dedication and hard work of everyone involved. By doing so, we hope to inspire others within the Trust and beyond to embrace Quality Improvement and contribute to a culture of excellence.

We encourage you to stay connected with us and follow our updates. If you have any stories or achievements you'd like to share, please reach out to the QI Communications team. Together, we can continue to make a difference and celebrate the progress we've made.





Visit Quality Improvement on Connect

The Next 12 Months for Quality Improvement at BSMHFT

What does the next 12 months look like for Quality Improvement:

- NHS Impact
- Trust-wide scale up of Culture of Care QI
- Personalised approach to risk
- Safety, inclusion and sustainability
- Learning disability and autism pathways
- Access to services for Children and Young people
- EBE and Staff QI Training to include system wide reach
- Patient and staff experience
- Out of area beds
- PSIRF (Patient Safety Incident Response Framework)
- QI Roadshows/conference
- QI Week

If you're interested in participating in Quality Improvement, whether through QI Training with the QI Training Academy or by leading/collaborating on a QI project, please contact the QI Team at the email below. We look forward to hearing from you!

We hope you enjoyed this edition of "A Year in QI." If you have any feedback, we'd love to hear your thoughts. Please send your feedback to the QI inbox.

Quality Improvement links:

- Quality Improvement
- QI Training Academy
- Coffee Break QI
- QI Resources
- What is Quality Improvement (QI)?

Email: bsmhft.qualityimprovementteam@nhs.net

Visit Quality Improvement on Connect

12. People Committee Report

Committee Escalation and Assurance Report

Name of Committee	**People Committee Strategy Session**	
Report presented at	**Board of Directors**	
Date of meeting	**4 June 2025**	
Date(s) of Committee Meeting(s) reported	**22 April 2025**	
Quoracy	**Membership quorate: Y**	
Agenda	The Committee held a strategy session on the Staff Survey Results.	
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • There was dedicated work to undertake to address feedback that members of staff continued to experience bullying from managers and colleagues.	
Assure:	• The Committee celebrated that the Trust was the second highest improved engagement score for the region and had an increase in team engagement responses. • The Committee was assured by the improved engagement with the organisation's workforce, noting the increased response rate of 56% (2,650 in 2024, compared to 2,393 in 2023).	
Advise:	The Committee received positive feedback in recognition of its EDI work for the Race Equality Code Assessment and looked forward to building on the foundations in place. The Committee discussed the inconsistency across the Trust in the implementation of policies and procedures in relation to discrimination and bullying. A review into how policy practices were equitably implemented in alignment with the Trust's discrimination frameworks and dedication to prevent racial abuse would be conducted.	
Board Assurance Framework	The Committee had identified the following revised risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. Scrutiny of the risks would continue to ensure the risk scores correlated to rationale and the mitigations and plans in place.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**20 May 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • People Dashboard • Shaping our Future Workforce Group Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • Workforce Planning Overview and Themes • Medical Directorate Quarterly Report • Multi-Professional Workforce Education and Training Group • Safer Staffing Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The Committee noted that there was an anticipated increase in turnover due to the way fixed-term contracts were defined in systemwide data collections. • The Committee discussed work-related stress data, noting that triangulation of areas with staff shortages, staff survey results and high sickness levels may target areas of the Trust that required additional support.
Assure:	• The Committee was assured by the improved sickness trajectory, noting the plans around this to ensure effective sickness absence management. • There was a lot of positive progress and successes reported through the People Dashboard and associated reports, which supported the triangulation of data, risk and feedback from staff. The Committee was keen to celebrate the overall improved position of the Trust. • Appraisal rates for doctors were currently at 98.7%, and job planning at 66%.
Advise:	A new subgroup had been established to review multi-disciplinary mandated and fundamental training, learning and education. The Committee would begin to receive formal assurance reports from July. The Committee was advised that an additional six roster controls had been implemented to support with bank staff use. This would be included in bank reduction plan submissions to NHSE. The Committee received an overview of the themes arising from the workforce planning round, noting that all plans reflected national, system and local priorities.
Board Assurance Framework	The Committee scrutinised the following risks:

	• Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. The Committee recommended a reduction in risk scores as follows: • SR1 *Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care* to be reduced from Impact 5 x Likelihood 4 = 20 to Impact 3 x Likelihood 4 = 12 to reflect some of the progress that has been made with mitigating this risk. • SR2 *Inability to attract, retain or transform a resilient workforce in response to the needs of our communities* to be reduced from Impact 5 x Likelihood 4 = 20 to Impact 4 x Likelihood 3 = 12 to reflect some of the progress that has been made mitigating this risk. Scrutiny of the risks would continue to ensure the risk scores correlated to rationale and the mitigations and plans in place.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

13. 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	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**24 April 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • Financial Plan Delivery 2025/26 Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Committee received the financial delivery plan for 2025/26. The scale of the challenge was noted, but some assurance was received in relation to capital programme prioritisation and continued focus on out of area bed planning and reduction in bank and agency use. • The Trust Group position at Month 12 was a reported surplus of £10.8m. This was in line with the forecast of £10.7m and was £8.7m better than the original plan. • There continued to be significant challenges in relation to non-Trust beds, with the full 2024/25 financial year expenditure reported at £23m, an overspend of £9m. • There had been a significant increase in non-Trust bed use during February and March, with the number of bed days in March at the highest level for the year. • The year-end position for temporary staffing was a reported £39m, which was £2.7m less than plan. An increase in nursing and medical bank usage had been reported during the final quarter of the year, and action was required to meet the significant challenge in 2024/25.
Assure:	• The Trust had achieved its £10.8m surplus at year-end. • The Committee was assured that the entirety of the financial challenge for 2025/26 was fully understood. • The Committee was assured by the delivery of £14m savings, and that mobilisation plans were in place for medium-risk savings plans.
Advise:	The 2024/25 savings achieved was £17.8m, in line with plan. The total savings target for 2025/26 was £36m, with £22m of plans deemed medium to high risk.

	The Committee discussed the vision for AI and Digital use throughout the organisation and how it could link to strategy and performance, and enhance financial performance. The Committee endorsed the final 2025/26 plan submission for 30 April.	
Board Assurance Framework	The Committee was assured by the revised Board Assurance Framework and discussed the draft detail of the three new risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and environmental standards • Failure to deliver optimal outcomes with available resources The Committee requested further review of the risks to ensure strategic terminology and succinct language was utilised to strengthen framework.	
	New risks identified: No new 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	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**22 May 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • SSL Estates and Environment Report • Out of Area Reduction Programme Report • Business Development and Partnerships Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Trust Group position at Month 1 was a reported deficit of £0.3m. This was a significant shortfall of £1.4m in the first month of the financial year and mainly driven by slippage on savings delivery. • There continued to be significant challenges in relation to non-Trust beds and discharge management. Bed usage reduced in April however the month 1 spend of £2m was an overspend of £0.5m. • The savings plans target for 2025/26 was £36m. The month 1 savings achieved was £1.3m, which was £1.7m adverse to plan. The Committee highlighted that £11.8m of savings plans were deemed high-risk.
Assure:	The Committee was assured by the good progress made in understanding and actioning the challenges that the Trust faced. A comprehensive Out of Area productivity plan was received, and the Committee was assured by the robust approach to bed management and discharge processes.
Advise:	The Committee was advised that discussions continued throughout the organisation to review the implications of the financial position and review savings schemes. The Quality Improvement process was highlighted through the Integrated Performance Report, and the Committee advised on the need for an increased strategic approach.

Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and environmental standards • Failure to deliver optimal outcomes with available resources The Committee recommended a change to risk title as follows: *Failure to maintain acceptable governance and national standards.*	
	New risks identified: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

14. Finance Report

Report to Board of Directors						
Agenda item:	**14**					
Date	4 June 2025					
Title	Month 1 2025/26 Finance Report					
Author/Presenter	Emma Ellis, Head of Finance & Contracts / Richard Sollars, Deputy Director of Finance					
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					
Alert	✓	**Advise**		**Assure**	

Purpose
To provide an overview of the Group month 1 financial position.

Introduction
The 2025/26 consolidated Group month 1 position is a deficit of £1.1m which is a significant shortfall of £1.4m at the outset of the financial year. This is mainly attributable to £1.7m slippage on savings delivery.

Key Issues and Risks
Alert: The Committee is asked to note and discuss the following key financial alerts:

- **Month 1 deficit** – The month 1 position is a deficit of £1.1m compared to a planned £0.3m surplus. Each month of deficit not only adversely affects the revenue position but will directly reduce available cash resources which in turn will impact capital plans. Managing and reducing the monthly deficit is critical for ensuring sustainability and a viable cash position. Delivery of savings will be crucial for 2025/26.

- **Savings** – The 2025/26 savings target is £36m. The month 1 savings achieved is £1.3m, this is £1.7m adverse to plan (57% of savings plan unachieved to date). The month 1 delivery equates to delivery of £15m annually, with £21m still to be delivered. Savings delivery of £3.4m per month for the remainder of the year will be required to meet plan. £11.8m of plans are deemed high risk and £9.6m medium risk.

- **Non-Trust Beds overspend** – The 2025/26 non-Trust beds expenditure plan is £17.8m. Bed usage has reduced in April, compared to the peak usage in March, however, the month 1 spend of £2m is an overspend of £0.5m resulting in a shortfall against the bed expenditure reduction

savings target

- **Temporary staffing** - The 2025/26 temporary staffing plan of £31m has been set in line with the NHSE ceiling (reduction of 30% agency and 15% bank spend compared to month 8 2024/25 forecast). Additionally, local savings targets of £0.5m for agency and £1.7m for bank expenditure have been set. The month 1 spend of £2.9m is at the lowest point of the preceding 12 months, however it is £0.3m above the NHSE ceiling plan and £0.5m adverse to local savings targets.

Advise: Discussions are taking place at Sustainability Board and Operational Management Team meetings to review the implications of the financial position and review at service area level, including status update on individual savings schemes.

Capital position:

The month 1 2025/26 Group capital expenditure is £0.1m, this is £1.3m adverse to plan. The £16m capital plan has been phased equally across the year.

Cash position:

The Group cash position at the end of month 1 was £76m, including £16m Trust cash balance.

Recommendation

The Board is asked to review the month 1 financial position and discuss the key alerts noted.

Enclosures

Month 1 2025/26 finance report

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2025 to 30th April 2025

Month 1 Group financial position £1m deficit

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	706,066	58,839	56,798	(2,041)
Other Income	24,082	2,007	2,110	103
Total Income	**730,148**	**60,846**	**58,908**	**(1,938)**
Expenditure				
Pay	(319,512)	(26,626)	(26,468)	158
Other Non Pay Expenditure	(369,430)	(30,786)	(30,334)	452
Drugs	(6,058)	(505)	(667)	(162)
Clinical Supplies	(685)	(57)	(53)	4
PFI	(13,896)	(1,158)	(1,175)	(17)
EBITDA	**20,567**	**1,714**	**210**	**(1,504)**
Capital Financing				
Depreciation	(10,034)	(836)	(834)	2
PDC Dividend	(500)	(42)	(42)	-
Finance Lease	(6,939)	(3,009)	(3,011)	(2)
Loan Interest Payable	(882)	(73)	(78)	(4)
Loan Interest Receivable	3,376	281	373	92
Surplus / (Deficit) before taxation	**5,588**	**(1,965)**	**(3,381)**	**(1,416)**
Taxation	(380)	(32)	(33)	(1)
Surplus / (Deficit)	**5,208**	**(1,997)**	**(3,413)**	**(1,416)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	0	0	-
Adjust PFI revenue costs to UK GAAP basis	(1,013)	2,343	2,343	-
Adjusted financial performance Surplus / (Deficit)	**4,200**	**346**	**(1,070)**	**(1,416)**

Month 1 2025/26 Group Financial Position

The 2025/26 consolidated Group month 1 position is a deficit of £1.1m (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 of £2.3m).

The 2025/26 final annual plan submission was submitted to NHSE on 30.4.25. The plan remains consistent with the £4.2m surplus plan submitted on 27.3.25. In line with system agreement, the BSMHFT financial plan does not include Children and Young People's (CYP) services. All 2025/26 planning for CYP has been included within the Birmingham Women's and Children's Foundation Trust plan.

The month 1 position is £1.4m adverse to plan. This is mainly driven by £1.7m slippage on savings. 57% of the month 1 savings plan is unachieved. See page 9 for further detail.
Temporary staffing expenditure has reduced in month 1 compared to 2024/25 average, however expenditure is £0.3m above the NHSE ceiling (see pages 5 to 7). Non-Trust bed expenditure has reduced in month 1 compared to the month 12 2024/25 peak, however, spend is £0.5m above plan resulting in a shortfall against the bed expenditure reduction savings target (see page 8).

The Group 2024/25 outturn position is driven by a deficit of £1.1m in the Trust, break even position for Summerhill Services Limited (SSL) and the Mental Health Provider Collaborative (MHPC) and a surplus of £21k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

The draft month 1 position for Birmingham and Solihull Integrated Care System (BSOL ICS) is a deficit of £15m, which is £10m adverse to plan. All providers and the ICB are at a deficit position for month 1, with UHB at £11m deficit.

Month 1 Group position
Segmental summary

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Trust	SSL	Reach Out	BSOL PC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	32,077	-	13,349	39,256	(27,885)	56,798
Other Income	2,103	2,376	-	-	(2,368)	2,110
Total Income	**34,180**	**2,376**	**13,349**	**39,256**	**(30,254)**	**58,908**
Expenditure						
Pay	(24,808)	(1,086)	(300)	(297)	23	(26,468)
Other Non Pay Expenditure	(7,502)	(617)	(13,131)	(39,076)	29,992	(30,334)
Drugs	(701)	(174)	-	-	208	(667)
Clinical Supplies	(53)	-	-	-	-	(53)
PFI	(1,175)	-	-	-	-	(1,175)
EBITDA	**(60)**	**500**	**(81)**	**(117)**	**(31)**	**210**
Capital Financing						
Depreciation	(545)	(272)	-	-	(17)	(834)
PDC Dividend	(42)	-	-	-	-	(42)
Finance Lease	(3,010)	(30)	-	-	29	(3,011)
Loan Interest Payable	(78)	(169)	-	-	169	(78)
Loan Interest Receivable	319	4	102	117	(169)	373
Surplus / (Deficit) before Taxation	**(3,416)**	**33**	**21**	**0**	**(19)**	**(3,381)**
Taxation	-	(33)	-	-	-	(33)
Surplus / (Deficit)	**(3,416)**	**1**	**21**	**0**	**(19)**	**(3,413)**
Adjusted Financial Performance:						
Adjust PFI revenue costs to UK GAAP basis	2,343					2,343
Adjusted financial performance Surplus / (Deficit)	**(1,072)**	**1**	**21**	**0**	**(19)**	**(1,070)**

Commissioning overview

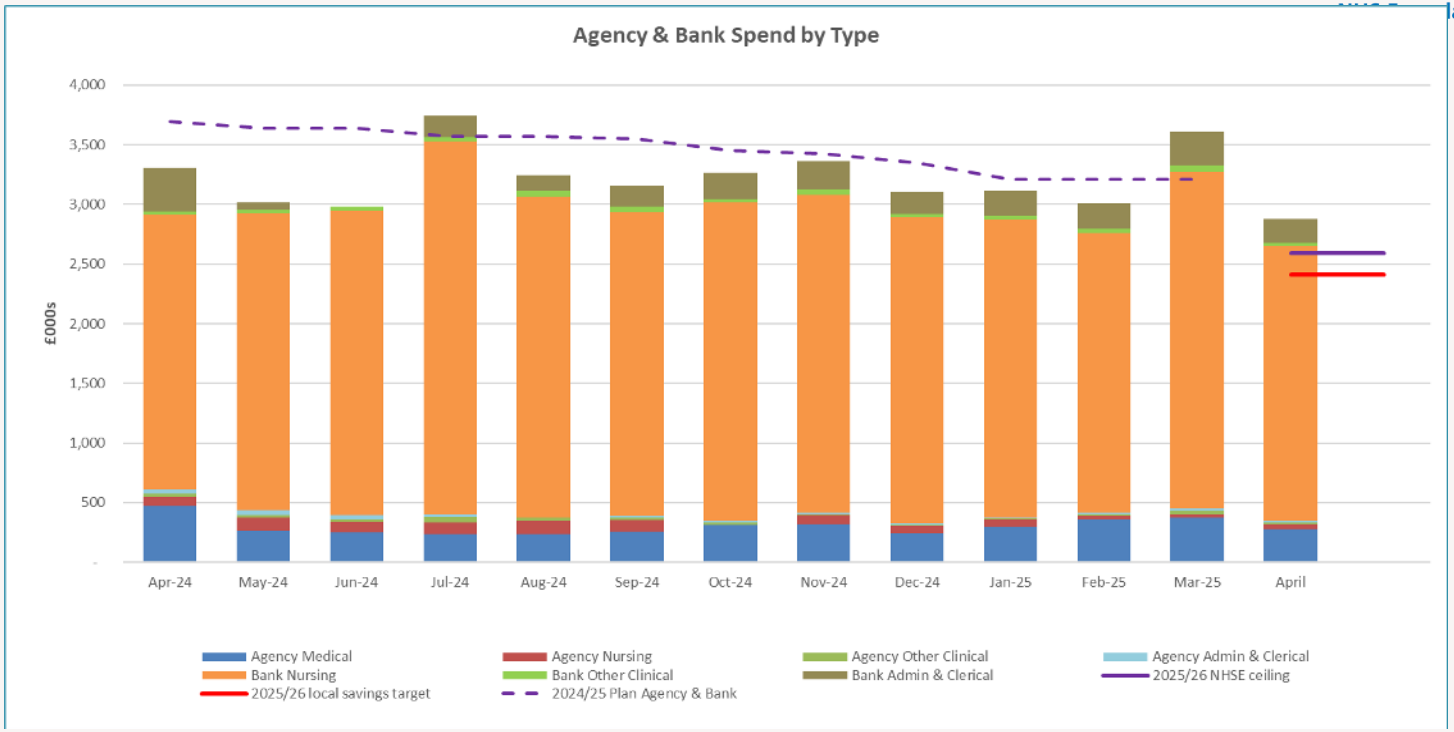
Mental Health Provider Collaborative (MHPC)

- 2025/26 income plan is £479m.
- Month 1 position break even
- Month 1 cash balance £27m.
- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

Reach Out Provider Collaborative

- 2025/26 income plan is £173m.
- Month 1 position £21k surplus – in line with agreed contribution to Trust overheads.
- Month 1 cash balance £29m.
- Key risks:
- Clinical concerns around expected growth in out of area numbers and EPC costs.

Temporary staffing expenditure



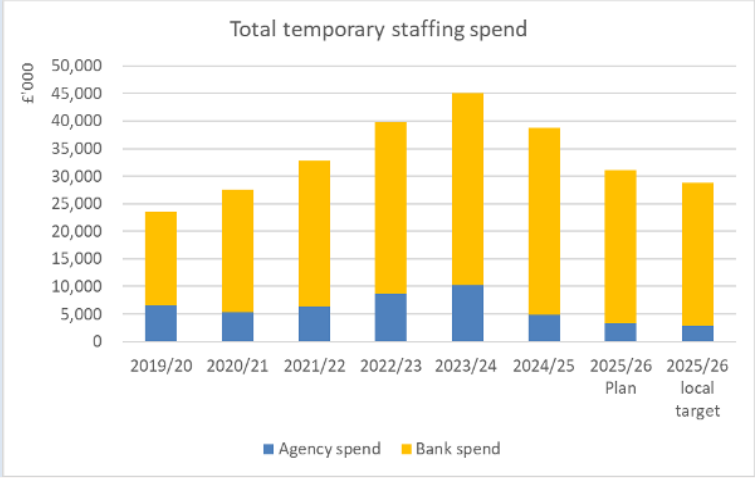
The 2025/26 temporary staffing plan of £31m has been set in line with the NHSE ceiling (reduction of 30% agency and 15% bank spend compared to M8 2024/25 forecast). Additionally, local savings targets of £0.5m for agency and £1.7m for bank expenditure have been set.

The month 1 spend of £2.9m is at the lowest point of the preceding 12 months, however it is £287k above the NHSE ceiling plan and £470k adverse to local savings targets.

Bank expenditure £2.5m (86%) – the majority of bank expenditure relates to nursing bank shifts - £2.3m

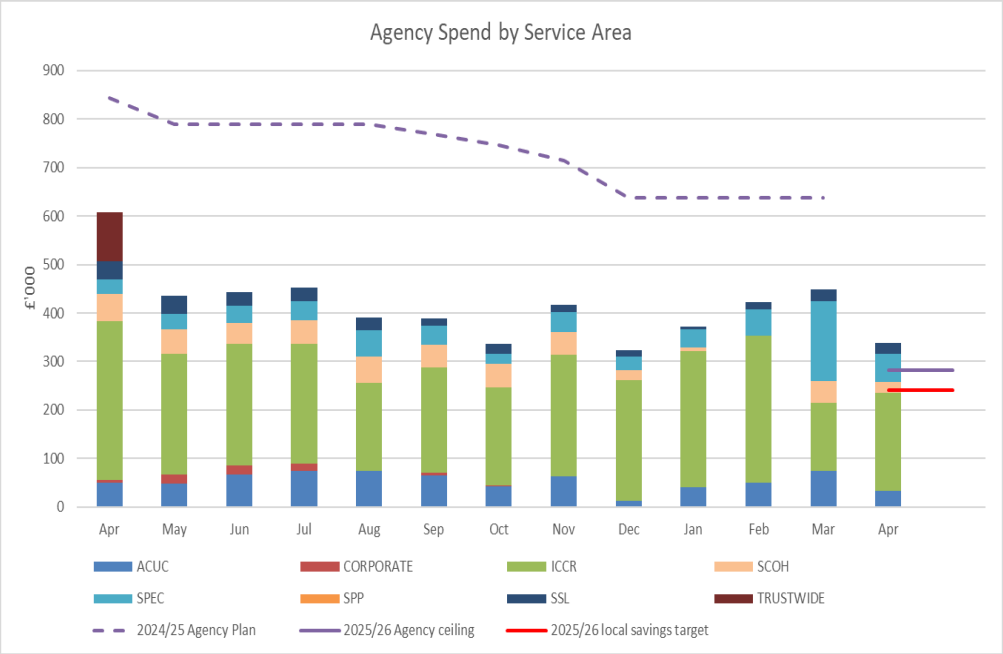
Agency expenditure £0.35m (14%) – the majority of agency expenditure relates to medical agency - £0.28m.

For further analysis on bank and agency expenditure, see pages 6 to 7.

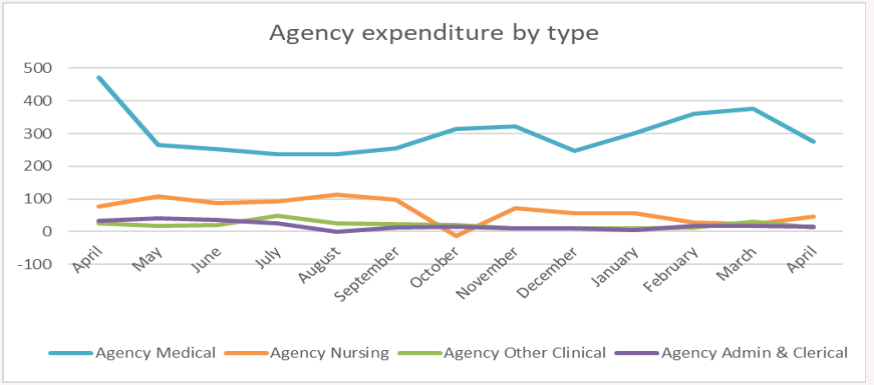


Agency expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust



KPIs	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Agency spend as % of pay bill (YTD)	3.2%	1.7%	1.7%	1.7%	1.6%	1.6%	1.6%	1.3%
Above price cap bookings - medical	0	9	9	9	12	12	9	10
Above price cap bookings -nursing	0	5	4	4	4	0	0	0
Admin & Estates bookings - Trust	0	0	0	0	0	0	0	0
Admin & Estates bookings - SSL	0	4	5	5	5	5	4	4

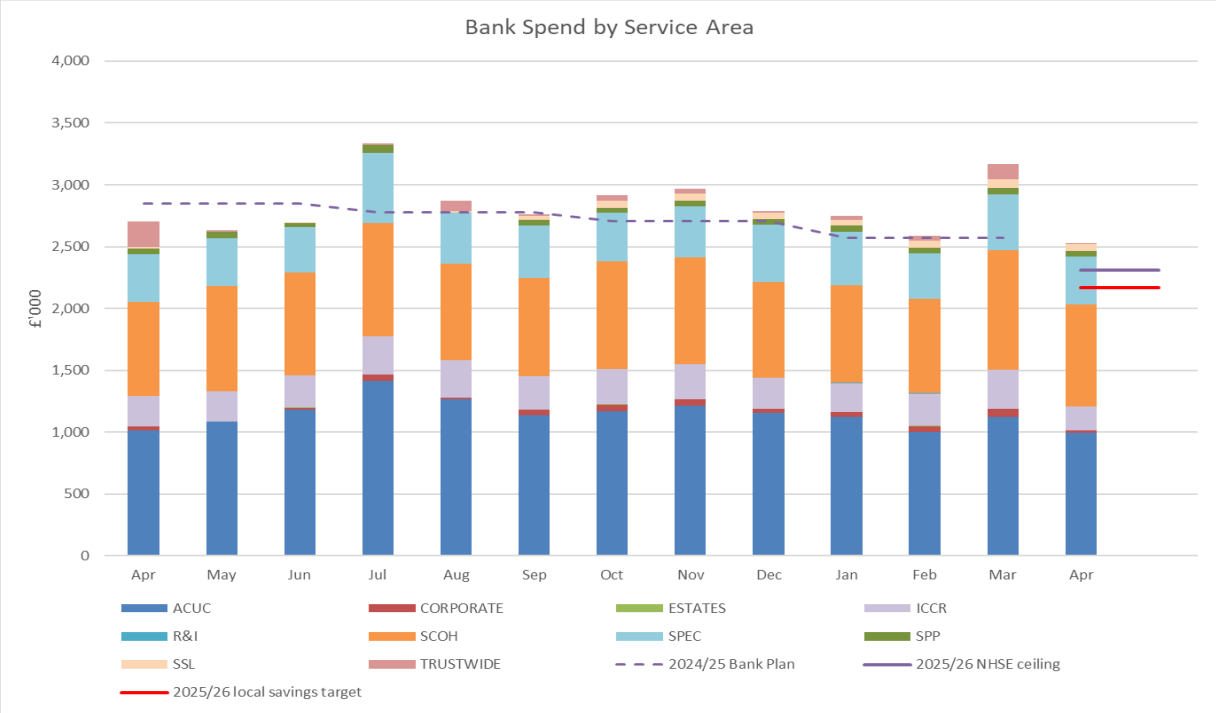


	2025/25 YTD	
	£'000	% of pay
Agency Expenditure	348	1.3%
NHSE Ceiling	282	
Variance to NHSE ceiling	(66)	
Expenditure by type	£'000	% of pay
Agency Medical	276	6.7%
Agency Nursing (Registered)	43	0.6%
Agency Nursing HCA	2	0.1%
Agency Other Clinical	13	0.3%
Agency Admin & Clerical	14	0.2%
Agency Expenditure	348	

Agency expenditure

- The month 1 2025/26 agency expenditure is £348k which is £66k adverse to the NHSE ceiling (set as 30% reduction from month 8 2024/25 forecast).
- The month 1 spend is a £64k (16%) reduction compared to the 2024/25 quarter 4 average. Although spend has reduced in month 1, in order for total spend to be within the NHSE ceiling, monthly spend will need to reduce by a further £72k per month from month 2 onwards.
- ICCR has set an additional stretch target of £503k as part of local savings plans which equates to a further £46k monthly reduction required for the remaining 11 months of the year.

Bank expenditure

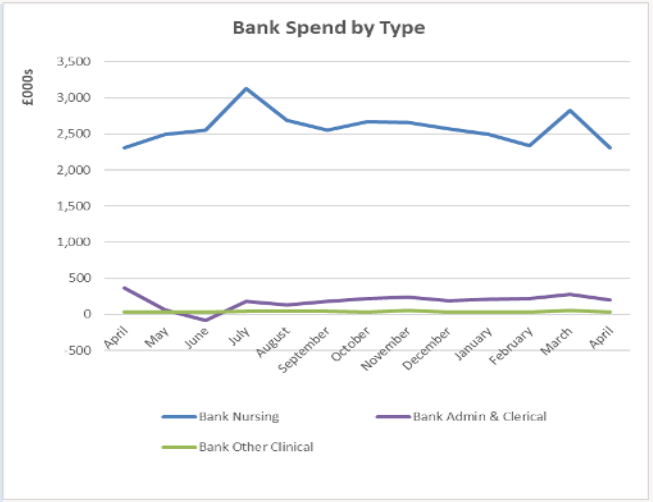


	2025/26 YTD	% of total sub category pay
	£'000	
Bank Nursing (Registered)	847	11.1%
Bank Nursing HCA	1,457	37.7%
Bank Other Clinical	28	0.6%
Bank Admin & Clerical	198	3.3%
Bank Expenditure	2,530	

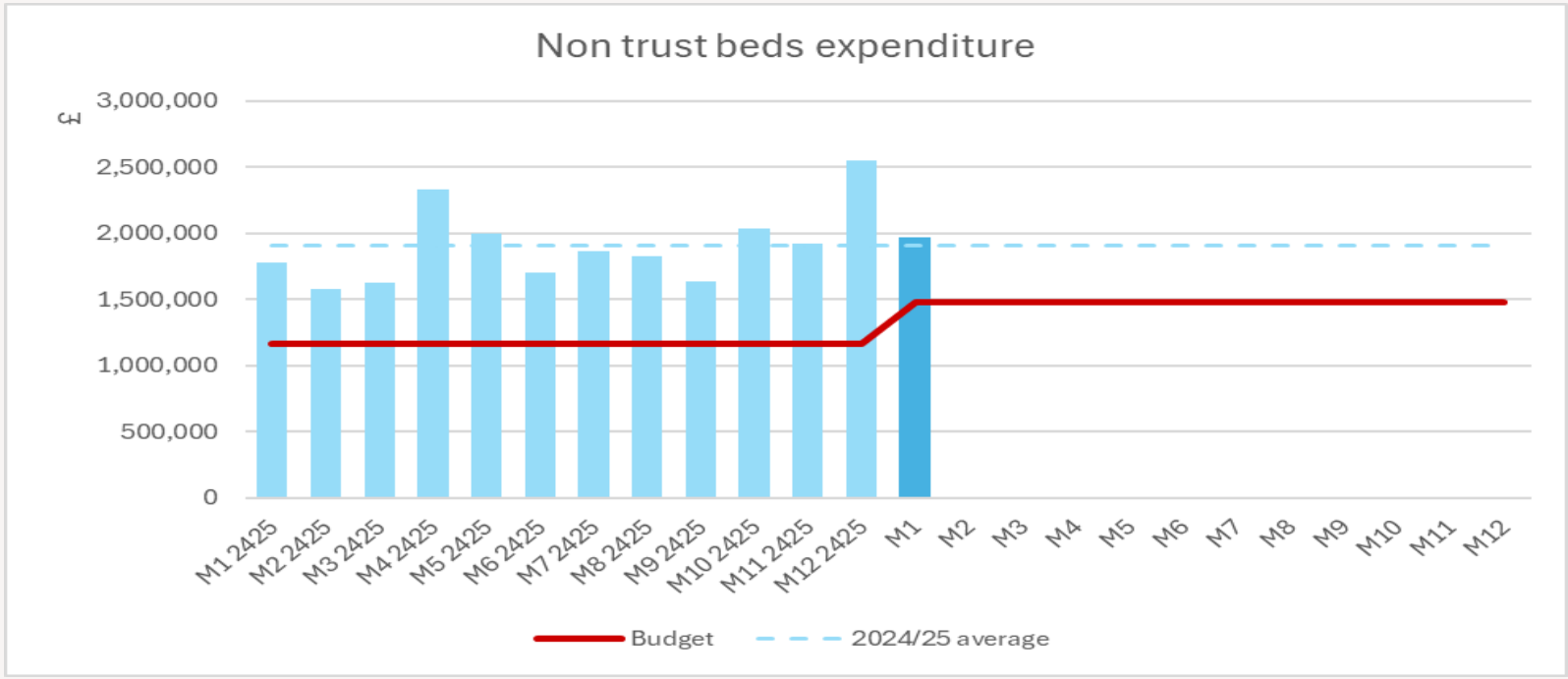
Operational service areas	YTD Bank spend £'000	Bank as % of service area pay
Acute & Urgent Care	994	21%
Secure & Offender Health	822	15%
Specialties	392	9%
ICCR	193	4%

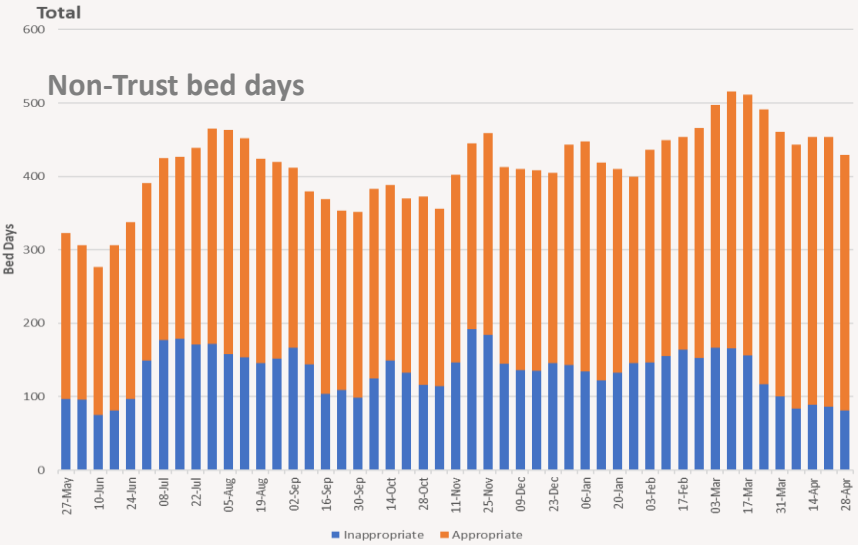
Bank expenditure

- The month 1 2025/26 bank expenditure is £2.5m which is £220k adverse to the NHSE ceiling (set as 15% reduction from month 8 2024/25 forecast).
- The month 1 spend is a £302k (36%) reduction compared to the 2024/25 quarter 4 average. Although spend has reduced in month 1 and is at the lowest point of the preceding 12 months, in order for total spend to be within the NHSE threshold, monthly spend will need to reduce by a further £240k per month from month 2 onwards.
- Operational areas have set an additional stretch target of £1.7m as part of local savings plans which equates to a further £154k monthly reduction required for the remaining 11 months of the year.
- The bank reduction project team continues to identify a number of actions including review of professional services bank utilisation, roster rules and review of enhanced observations.



Non-Trust Beds overspend



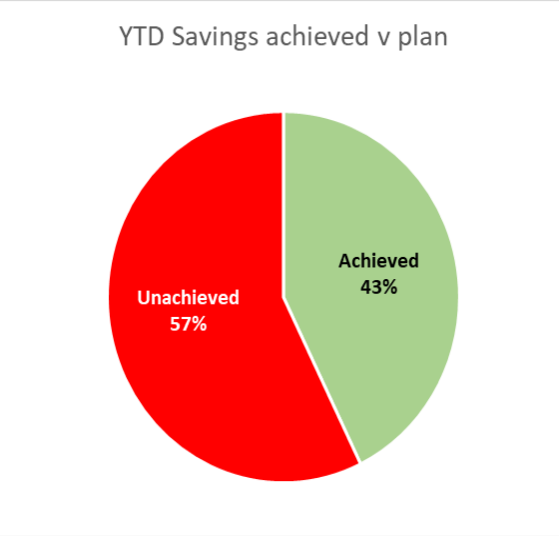


- The 2025/26 non-Trust bed budget is £17.8m which equates to £1.5m per month.
- The average monthly expenditure for 2024/25 was £1.9m and reached an average of £2.2m in quarter 4. Bed usage has reduced in April, compared to the peak usage in March, however, the month 1 spend was £2m which is an overspend of £0.5m. In order for total annual spend to be within budget, monthly expenditure would have to reduce by £0.5m per month for the remainder of the year.

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent	2,490	1,075	(1,415)	30,879	30,879	-
Non Recurrent	461	188	(273)	5,529	5,529	-
Total Efficiencies	**2,951**	**1,263**	**(1,688)**	**36,408**	**36,408**	**-**

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
High Risk	900	-	(900)	11,800	11,800	-
Medium risk	823	9	(814)	9,879	9,556	(323)
Low Risk	1,228	1,254	26	14,729	15,052	323
Total Efficiencies	**2,951**	**1,263**	**(1,688)**	**36,408**	**36,408**	**-**



- The 2025/26 efficiency target is £36.4m. This comprises £30.9m recurrent and £5.5m non recurrent targets.

- The month 1 savings achieved is £1.3m, this is £1.7m adverse to plan (£0.9m high risk schemes and £0.8m medium risk schemes). Savings delivery of £3.4m per month for the remainder of the year is required to meet plan. The month 1 delivery equates to delivery of £15m annually, with £21m still to be delivered.

- The month 1 slippage mainly relates to:
- Acute & Urgent Care £754k – slippage on non-Trust beds reduction and operational savings plans.
- Trustwide £475k - slippage on decommissioning savings and provider collaborative non recurrent income.
- Other Operational and Corporate savings plans £479k

- In month 1, £323k of savings plans have been re-categorised from medium risk to low risk.

	YTD Variance £'000
ACUC	(754)
Trustwide	(476)
ICCR	(164)
SPEC	(106)
Corporate	(88)
SCOH	(84)
SPP	(16)
Grand Total	**(1,688)**

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'draft'* 31-Mar-25 £m's	NHSI Plan YTD 30-Apr-25 £m's	Actual YTD 30-Apr-25 £m's	NHSI Plan Forecast 31-Mar-26 £m's
Non-Current Assets				
Property, plant and equipment	221.1	222.2	220.4	227.5
Prepayments PFI	1.2	1.2	1.4	1.2
Finance Lease Receivable	0.0	-	-	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	222.4	223.4	221.8	228.8
Current assets				
Inventories	0.6	0.6	0.7	0.6
Trade and Other Receivables	31.0	31.0	34.7	31.0
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	86.4	85.5	76.4	83.0
Total Curent Assets	117.9	117.1	111.7	114.6
Current liabilities				
Trade and other payables	(86.2)	(86.3)	(77.0)	(86.2)
Tax payable	(6.7)	(6.7)	(6.5)	(6.7)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.3)	(1.3)	(1.3)	(1.3)
Provisions	(1.3)	(1.3)	(1.2)	(1.3)
Deferred income	(35.6)	(35.6)	(40.3)	(35.6)
Total Current Liabilities	(133.7)	(133.8)	(128.7)	(133.7)
Non-current liabilities				
Deferred Tax Liability	0.2	0.2	0.2	0.2
Loan and Borrowings	(20.8)	(20.1)	(20.1)	(18.6)
PFI lease	(79.4)	(81.5)	(81.8)	(78.9)
Finance Lease, non current	(4.8)	(4.7)	(4.7)	(4.1)
Provisions	(2.4)	(2.4)	(2.4)	(2.4)
Total non-current liabilities	(107.1)	(108.4)	(108.6)	(103.8)
Total assets employed	99.6	98.4	96.1	105.9
Financed by (taxpayers' equity)				
Public Dividend Capital	117.9	118.1	117.9	119.1
Revaluation reserve	49.1	49.1	49.1	49.1
Income and expenditure reserve	(67.5)	(68.8)	(70.9)	(62.3)
Total taxpayers' equity	99.6	98.4	96.1	105.9

SOFP Highlights

The Group cash position at the end of April 2025 is £76.4m.

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

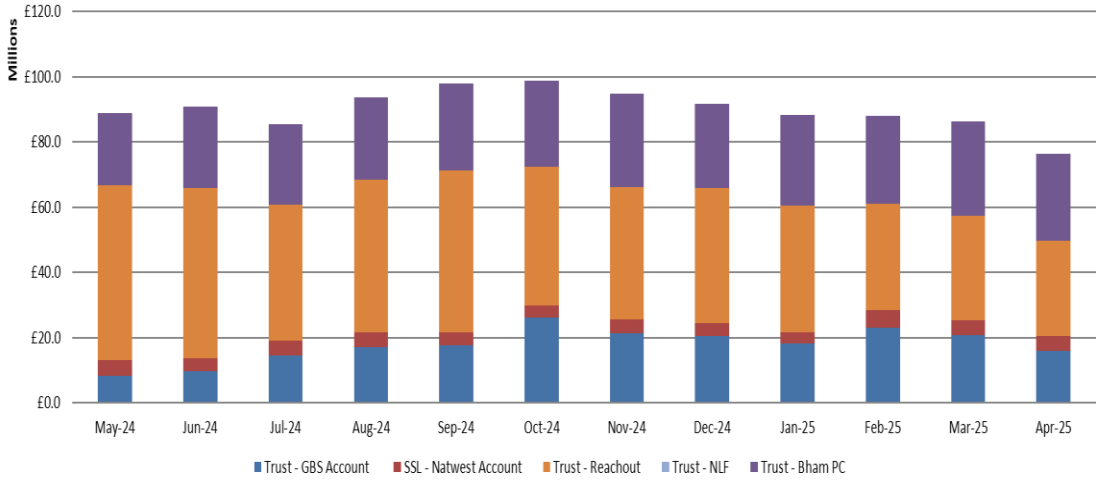
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

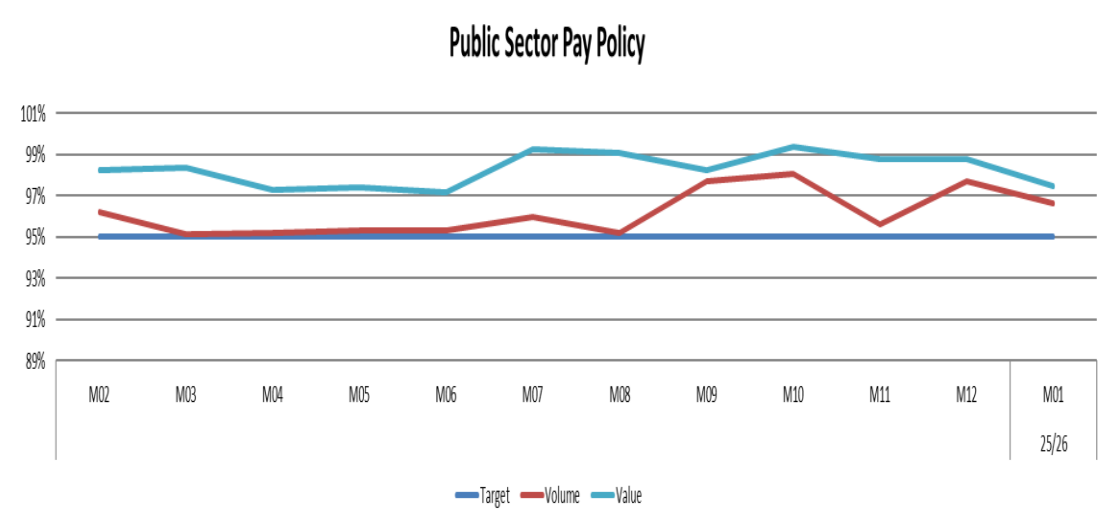
Current Ratio :	**£m's**
Current Assets	111.7
Current Liabilities	-128.7
Ratio	0.9

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

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust





Cash

The Group cash position at the end of April 2025 is £76.4m. This comprises of Trust £16m, SSL £4.4m, Reach Out Provider Collaborative £29.4m and Mental Health Provider Collaborative £26.6m.

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

Better Payments

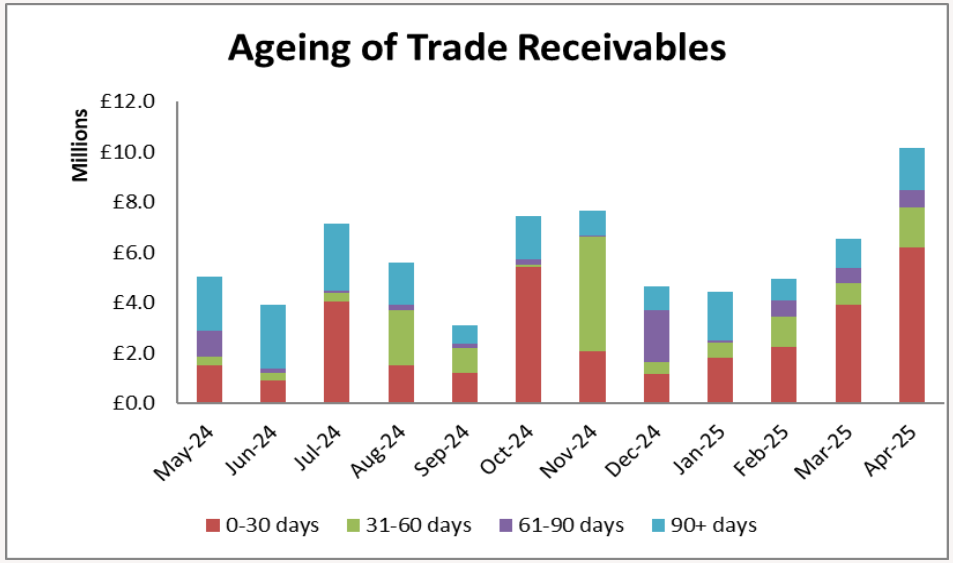
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

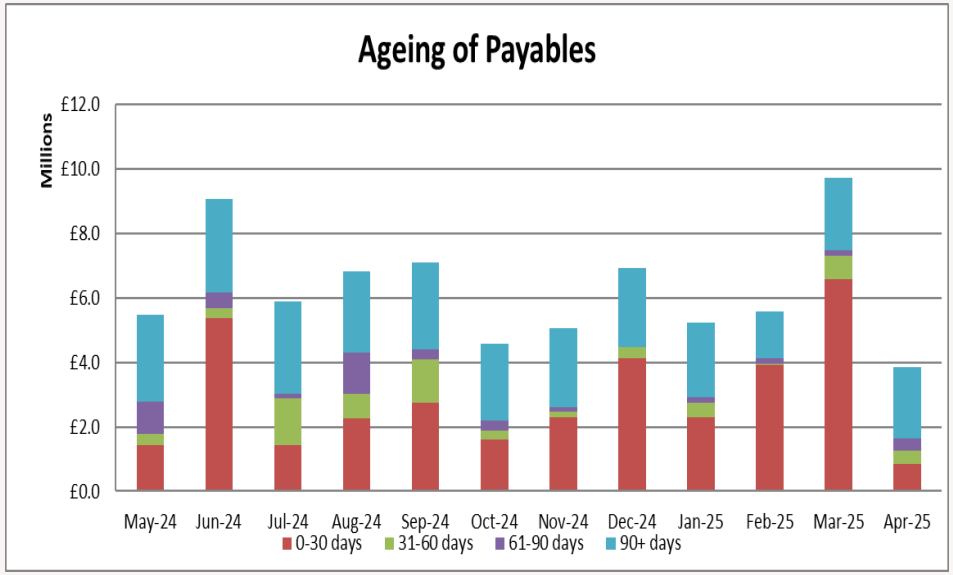
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	96%	✓	98%	✓
Non - NHS Creditors within 30 Days	97%	✓	97%	✓

Trust Receivables and Payables





With a focus in the NHS currently around intra-NHS debts BSMHFT have been working with NHS colleagues to ensure as far as possible any issues are rectified.

Where required escalations to DDoF or EDoF have been pursued between organisations.

Trade Receivables :

- **0-30 days-** Overall Balance £6.2m–significant increase in balance due to catch up from 24/25 invoices for UHB-£1.93m & ReachOut-£2.2m. Several debts have been paid, approved awaiting payment, awaiting approval. Balance consists of monthly/daily ad hoc invoices waiting to be advised if approved or in query.

- **31-60 days-** Overall Balance £1.7m - significant increase due to balance from UHB. *Paid May 25*: £1.5k, *Awaiting authorisation:* £177k. *In query:* balances that are currently being resolved. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £665k- slight increase in balance. *In query*: various balances including BWC, UHB, Access to Work, SDSmyhealthcare . Remaining balance mainly staff overpayments (on payment plans).

- **Over 90+ days-** Overall Balance £1.7m–significant increase in balance. *Awaiting authorisation/paid:* £6.5k. *In query:* BWC- £825k, UHB - £154k, Reach Out - £223k, UoB - £90k, Ethypharm £87k, Parexel £67k, Access To Work - £8k. Remaining balance mainly staff overpayments (on payment plans).

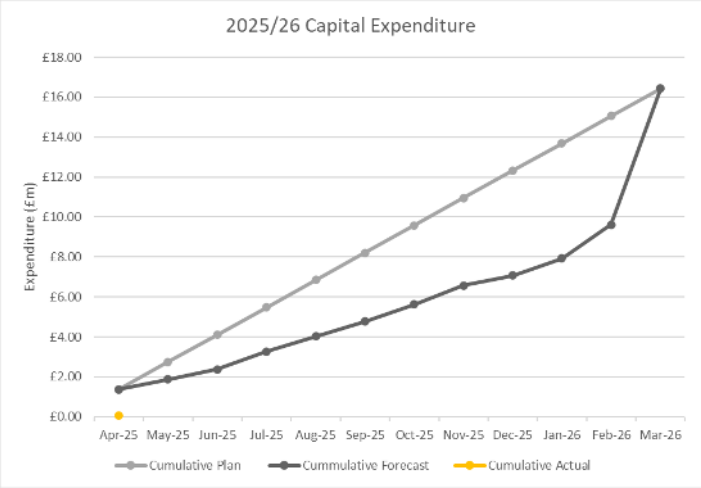
Trade Payables-Over 90 days:

NHS Suppliers £1.0m: NHS Property £123k-historic invoices with Estates and Facilities, UHB £742k in query (working directly with UHB to resolve accordingly).

Non-NHS Suppliers (50+) £1.2m: mainly bed/out of area fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in May 2025.

Month 1 Capital expenditure

Capital schemes	Annual Plan	Annual Forecast	Adjustments	New annual forecast	YTD Forecast	YTD Actual	Variance to Forecast
	£'m						£'m
Approved Schemes:							
Highcroft New Build	6.1	6.1		6.1	0.5	0.0	0.5
AUC/Others - Anti-Barricade Alarmed D	0.4	0.4		0.4	0.0	0.0	0.0
Refurbishment for FIRST Team and Reco	1.0	1.0		1.0	0.1	0.0	0.1
ACUC Bathrooms	0.2	0.2		0.2	0.0	0.0	0.0
SSBM Works	2.1	2.1		2.1	0.2	0.0	0.2
Medical Devices	0.1	0.1		0.1	0.0	0.0	0.0
Lease Vehicles	0.3	0.3	0.5	0.8	0.1	0.0	0.1
Recognition of IFRS 16 Leases	0.3	0.3		0.3	0.0	0.0	0.0
ICT	0.1	0.1	0.3	0.4	0.0	0.0	0.0
Minor Works	4.8	4.8	(0.8)	4.0	0.4	0.0	0.3
CIR Estates Risk	1.1	1.1		1.1	0.1	0.0	0.1
Total	16.4	16.4	0.0	16.4	1.4	0.1	1.3



Group Capital Expenditure

As per the table above, there has been minimal spend against capital in month 1 - in particular against Minor Works.

Regular updates are provided to Capital Review Group including updates on any changes that need to be made to phasing expectations. The finance team meet regularly with the estates and capital team to ensure a joint understanding of the position.

Current Capital for 25/26

The total planned capital for 25/26 is £16.4m, this includes

BAU Capital	6.53
Highcroft New Build	6.13
CIR Estates Risk	1.12
Additional from System	2.65

Other capital bids submitted totalling £15.8m

CIR Secure Services (NHSE)	12.00
MH bid (24/7)	3.18

15. Audit Committee Report

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 June 2025**
Date(s) of Committee Meeting(s) reported	**30 April 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • Commissioning Board Assurance Framework • SSL Risk Summary • Internal Audit Progress Report • Internal Audit Action Tracking Report • Draft Head of Internal Audit Opinion • Internal Audit Plan 2025/26 • Internal Audit Reviews: Finance Culture Repeat Survey; Sickness Absence Management Follow-Up; Disciplinary Process Follow-Up; Board Assurance Framework and Risk Management • Local Counter Fraud Specialist Annual Report 2024/25 • Local Counter Fraud Specialist Work Plan 2025/26 • Single Tender Waivers Report • Draft Annual Report 2024/25 • Draft Annual Governance Statement 2024/25 • Annual Accounts 2024/25 Briefing • Audit Strategy Memorandum 2024/25 • Race Equality Code Assessment
Alert:	The Committee wished to alert the Board of Directors to a key issue flagged within the Local Counter Fraud Specialist Annual Report 2024/25, related to performance management and accountability within the organisation. The Report had highlighted these issues in relation to overpayments and people systems issues.
Assure:	The Committee was assured on the following areas: • The Committee was assured by the positive draft Head of Internal Audit Opinion, which highlighted a significant amount of improvement across the organisation during the year. • The Committee was assured by the positive assurance rating given to the **Board Assurance Framework and Risk Management** internal audit review.

	• The Committee noted the Reasonable Progress that had been demonstrated from the **Disciplinary Process Follow-Up Report**, in implementing agreed management actions. • The Committee noted the Good Progress that had been demonstrated from the **Sickness Absence Management Follow-Up Report**, in implementing agreed management actions. • Positive assurance was received on the action tracking report. Good progress had been made to respond and close recommendations in line with deadlines. • The Committee was fully assured by the Quality Mark that the Trust had received for its work on the Race Equality Code Assessment.	
Advise:	The Committee was assured by the draft Annual Report 2024/25, noting that it was on track to be completed by the required deadline. The Committee also noted the Annual Accounts 2024/25 briefing. Additional considerations were provided by the Committee in relation to the Annual Governance Statement, which would be updated following recent risk discussions and the receipt of the Head of Internal Audit Opinion. The Committee wished to highlight the continued importance of financial awareness across the organisation, which was noted in the low response rate to the **Finance Culture Repeat Survey**.	
Board Assurance Framework	The Committee reviewed the revised Board Assurance Framework and was satisfied with the progress made so far, noting that the BAF provided greater clarity and strategic oversight and would continue to mature. The Corporate Risk Register was received, and the Committee was encouraged by the progress made and by the process for reviewing and escalating risks through the Risk Management Group. Positive assurance was received on the SSL Risk Summary, and the Committee noted that a draft revised Board Assurance Framework was in place for the Mental Health Provider Collaborative and would be taken in its first iteration to Commissioning Committee in May.	
	New risks identified: the Committee identified a thematic risk related to performance management and accountability. This would be discussed at People Committee and a recommendation made as to whether it should be reflected on the BAF or the risk register.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

16. Caring Minds Committee Report

17. Trust Seal Report

Report to Board of Directors

Agenda item:	**17**					
Date	4 June 2025					
Title	Trust Seal Report					
Author/Presenter	Safia Khan, Head of Legal					
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**	✓

The Trust leases 32 Grove Avenue, Moseley, Birmingham from ActivePine Ltd and the lease for the property required renewal.

Trust Seal Number 3/2425

The Trust Seal was used on 24 March 2025 and affixed to a Lease Agreement between the Trust and ActivePine Limited.

Recommendation

The Board is asked to acknowledge and endorse the use of the Trust Seal.

Enclosures

N/A

18. Living the Trust Values

19. Board Assurance Framework reflections

20. Any other business

21. Questions from Governors and members of the public