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 6 August 2025

Uffculme Centre

AGENDA

Ref	Item	Purpose	Report type	Time
	Expert by Experience Talk 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 4 June 2025**	Approval	Enc	09.35
5	**Matters arising from meeting held on 4 June 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	09.45
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	10.00
9	**Integrated Performance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	10.10
	Quality and Clinical Services			
10	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.20
11	**Quality and Safety Report** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	10.30
12	**Quality Account 2024/25** *Lisa Stalley-Green, Chief Nurse*	Approval	Enc	10.40
13	**Research and Development Annual Report, inc Research Trial Dashboard** *Emma Patterson, Head of Research and Development and Alex Copello, Associate Director Research and Development*	Assurance	Enc	10.45
	People			
14	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.55
15	**Guardian of Safe Working Hours Quarterly Report and Annual Report 2024/25** *Hari Shanmugaratnam, Guardian of Safe Working Hours*	Assurance	Enc	11.05
16	**Freedom to Speak Up Guardian Quarterly Report** *Emma Randle, Freedom to Speak Up Guardian*	Assurance	Enc	11.15
	Sustainability			
17	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.25
18	**Finance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	11.35
19	**SSL Business Review Report** *Shane Bray, SSL Managing Director*	Assurance	Enc	11.40
20	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.50
	Governance			
21	**Constitution, inc Standing Orders and Scheme of Delegation** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	12.00
22	**Emergency Preparedness, Resilience and Response Annual Report** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	12.05
23	**EPRR and Business Continuity Policy** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	12.10
	Reflections			
24	**Living the Trust Values** *Nick Moor, Associate Non-Executive Director*		Verbal	12.15

25	**Board Assurance Framework reflections**	Verbal	12.20
26	**Any other business**	Verbal	12.25
27	**Questions from Governors and members of the public**		
Close by 12.30 **Date and Time of Next Meeting: Wednesday 1 October 2025, 09.00-12.30**			

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 4 June 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
	Nick Moor	NM	Associate Non-Executive Director
	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)
	Julie Romano	JR	Head of Quality Improvement and Clinical Effectiveness (item 12 only)
	Afeisha Sanchez	AS	Internationally Educated Nurse (item 1 only)
	Sandra Shaju	SS	Internationally Educated Nurse (item 1 only)
	Kuldeep Singh	KS	Quality Improvement Lead (item 12 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	**Staff Story** The Board welcomed AS and SS to the meeting to share their experiences joining the Trust as internationally educated nurses. AS shared her journey following her successful recruitment from Trinidad and Tobago noting the recruitment and onboarding process was supportive and communication throughout was encouraging. She noted her thanks to the team for its inclusive approach. Since joining the Trust AS confirmed she had worked at Ardenleigh where, from the outset, she felt isolated. She stated she had been failed by her immediate line manager with a lack of understanding of cultural differences with a generic approach to the transition. Following an opportunity arising for promotion, AS was successfully appointed to a band 7 position and then the offer retracted due to lack of support from the immediate team. RFW apologised to AS for her experiences with the Trust and thanked her for her forgiveness and patience. She confirmed the Trust will take the learnings to ensure bias was addressed and pastoral care and training for managers improved. RFW asked AS what the Trust could do to support her aspirations. AS noted that she wanted to be able to enhance services with her expertise and competencies in physical health and focus on bridging the gap between physical and mental health. RFW thanked AS for recognising the need and agreed her expertise was a benefit to the Trust and duality of skills should be utilised.

	PN thanked AS for her authenticity and bravery in sharing her experiences. He queried what the barriers were for internationally educated nurses in securing promotions and what the Trust can do differently to better support staff. AS felt that staff needed to understand differences in cultures and managers should be aware of individual backgrounds, including competencies and leadership skills and experience. She also asked that references from countries of birth should be requested. LC queried whether AS would recommend the Trust as a place to work. AS confirmed that if she was asked the question in November she would have said no, however under new management and with regular clinical supervision there had been significant improvements and so she would recommend the Trust as a workplace. FA noted that without international staff the NHS would cease to exist and as an international graduate herself she highlighted the importance of celebrating all cultures. She thanked AS for sharing her journey. MS thanked AS for sharing her experiences and confirmed as a Board of Directors the concerns had been acknowledged. RFW stated the Trust cannot accept these experiences for staff and noted that the launch of the culture of care programme would support the ongoing improvements. LSG confirmed she had taken personal leadership of the concerns raised and maintained oversight of the international nurse recruitment programme. She thanked AS for sharing her personal journey. SS thanked the Board for the opportunity to share her experiences and was proud to be able to represent international nurses. She noted in her home country of India, mental health still represented a stigma which prevented people coming forward; this was a key driver for her move to work at the Trust. SS noted that the interview and onboarding process was supportive and comforting, with someone waiting for her at the airport when she arrived in the UK. She highlighted the positive experience at the Oski bootcamp where there was the opportunity to meet staff, learn from each other and address any challenges. SS thanked the Board of Directors for the supportive approach to internationally recruited staff as the process was welcoming with accommodation, banking and travel arrangements in place from arrival. SS confirmed she was currently working at Eden Acute and staff have been welcoming. She noted her line manager had struggled at times to offer support and cultural differences at times have been challenging. She shared her experience of her first incident on the ward, noting this was traumatic but the pastoral support offered was exceptional. SS stated she is proud and thankful to work at the Trust. PG thanked both AS and SS for sharing their experiences and for taking the chance on joining the Trust where their skills and expertise would greatly improve the lives of others. RFW thanked both AS and SS for their inspirational journeys and amazing bravery in their honest responses. PG assured both AS and SS both staff and service user stories shared at Public Board meetings were reviewed and reflections from learnings implemented. An annual report showcased the commitment from the Board to support improvements.
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 2 April 2025** The minutes were approved as a true and accurate record.
6	**Matters arising from meeting held on 2 April 2025** All actions were updated.
7	**Chair's Report** The Board received the report and PG noted the following key points: • PG had visited Ardenleigh and noted that there had been improvement since his previous visit. There was no bank or agency use, and substantive staff were taking on shifts. Service users had fed back positively about the staff. • Eden Ward had also been visited and positive improvements had also been noted there. • The Trust's Staff Values Awards had taken place on 23 May, and PG had enjoyed the evening celebrating and recognising the work that staff across all areas of the organisation did each day. WW noted that the report made reference to meetings with the NHSE Director of System Coordination and Oversight, and queried whether there were any particular areas of focus for the Trust from these meetings. RFW commented that the continuous and primary ask was to deliver the plans that the Trust had developed, and how the current financial position would impact on this.
8	**CEO and Director of Operations Report** The Board received the report for information. RFW and VD highlighted the following key points: • A sustained improvement on the Trust's People position was noted. • Confirmation had been received that pay awards would be made. • Industrial action was expected for junior doctors and nurses, with the organisation beginning to operationalise its plans. • SSL had sponsored the Staff Awards, which was greatly appreciated. • The Mental Health Provider Collaborative strategy blueprint had been shared with partners, with positive feedback received. The Trust's strategy was being developed alongside this. • There was clear understanding of the anxieties and concerns of staff around planning and what was needed to address financial challenges. • The Trust had been a lead pilot site for 24/7 neighbourhood centre. The work that had been done on leading the way with this has been acknowledged and recognised, as the Trust had opened the doors to service users alongside learning and developing the offer. • There had been a lot of good improvement seen across service user and colleague experience through increased focus on productivity and performance. • Additional training had taken place for integrated neighbourhood teams. • There had been focus on specialist training and waiting times for Solar services. • Continued scrutiny on out of area placements remained. Spot purchase beds within the system had supported improvement but was not a sustainable solution and continued patient flow improvement was needed. • A data cleansing exercise was taking place into the memory assessment service to understand the Trust's position. There had been no patients waiting over 52 weeks since the pandemic. • A quality improvement approach was being utilised for long waits in neuropsychiatry services. • The Trust congratulated the Deputy Director of Operations who had obtained a position in another Trust. An interim internal opportunity was being advertised, with an external advert to go out in due course. LC asked about the work that was ongoing in relation to social care and housing, which was a key part of the out of area pathway. VD commented that a lot of work was taking place in relation to Children and Young People and

	older adults services to address what was in the Trust's control. PG asked how the Trust was fostering closer ties with Local Authority colleagues. VD noted that continued work with social workers, embedded staff within Trust teams, and close working with patient flow managers were contributing to positive working relationships. RFW noted that the actions that had been agreed were showing some improvement in older adults services, but other areas needed escalation. WW queried partner working that was taking place between system CEOs and SROs and the difference this was making to the way the NHS worked. RFW commented on the increased holistic approach to the population andh ow this was evaluated to ensure positive improvements to service users across the system.
9	**Board Assurance Framework** The Board received the BAF for information and assurance. DTi highlighted key changes in relation to SR1, SR2, SR8 and SR9 reduction in scores as a reflection of work that had been carried out to provide greater assurance. The Board debated perspectives of impact and the rationale for reducing impact. The Board was assured by continued Committee oversight, scrutiny and review of all risks and accepted the recommendations made. It was noted that the next Board Strategy Session would focus on the Board Assurance Framework to continue discussions on risk score and determine risk appetite.
10	**Integrated Performance Report** The Board received the report for information. WW commented on the need to ensure plans for the length of stay trajectory and what would be put in place should it not be achieved.
11	**Quality, Patient Experience and Safety Committee Report** The Board received reports from April and May meetings. LC noted the following key points: • The Committee had received some assurance from the Safer Staffing Report on overall recruitment and retention, however an inherent risk remained in relation to competencies of staff moving into more senior roles. • The Committee alerted the Board to issues highlighted on Adriatic Ward in relation to incidents and quality of care. • The Committee had visited HMP Birmingham and, although the challenging environment remained, a lot of significant improvements had been noted. • Assurance had been received in relation to the culture of care programme at Reaside. • Learning from the Nottingham review had been discussed, including how the Trust was managing serious mental illness within the community. Additional investment had been identified to manage this pathway. • S29 notices had been removed from the Community Mental Health Teams following a reinspection by the CQC. • The Committee had approved the Quality Account in May. Next year's report would be more service user friendly, with a shorter report planned and video to highlight the good work that had taken place during the year.
12	**Quality Improvement: A Year in QI Report** JR and KS attended to present the Annual Report to the Board. JR advised that there had been focused work on the Green Plan and sustainability agenda during the year, and the team had continually ensured that projects were mapped to the Trust's strategy. There had been a clear focus on service user experience. Quality Improvement facilitators had continued to train staff over the last 12 months, reporting that take-up had increased by 300%. The team was undertaking value-mapping and working with corporate teams to understand the impact of QI projects and understand the benefits and financial impact.

	The team continued to work closely with patient safety teams and consistently considered improvement work in relation to new frameworks. JR noted that the team was able to be flexible and adaptive. BC noted that Quality Improvement had been discussed at Finance, Performance and Productivity Committee in May and there was a perception that QI was generally a bottom-up approach and not aligned to the strategy, so he was pleased to note that this would be reflected in future work. BC also noted that it was positive to hear that there was a culture of continuous improvement. BC thanked the team for all of the work, and liked the format of the report. NM reflected on how QI could integrate with the BAF to demonstrate links to the strategy. RFW commented that there were some excellent pieces of work that had happened last year. A step change was now needed to ensure that the investment that had been made to move to a more strategic level would happen over the next year. RFW was confident that the team understood this challenge and knew what had been requested.
13	**People Committee Report** The Board received reports from April and May meetings. SB noted the following key points: • A strategy session had been held in April on the Staff Survey results. The Committee had been encouraged by the increased engagement and response rate. • The Committee meeting in May had been positive, with assurances demonstrated in relation to the sickness absence trajectory and positive progress on the People dashboard data which triangulated with site visits and reports received. • The Committee alerted the Board to some discrepancy in data due to systemwide changes to how fixed-term contract data was defined and collected. • A new sub-group had been established to review workforce learning and training. • The Trust had been awarded a Quality Mark for its work on the Race Equality Code assessment. PG acknowledged the real and significant improvements that had been seen in a number of people data trajectories. SB also acknowledged the work that LSG was doing in relation to bank and agency reduction and nursing staffing.
14	**Finance, Performance and Productivity Committee Report** The Board received reports from April and May meetings. BC noted the following key points: • A positive year-end position had been reported, with a £10.8m surplus. • Agency use had significantly reduced. • The Trust had delivered its savings target for 2024/25. • A significant cost reduction challenge for 2025/26 was highlighted, with a total target of £36m. • The Committee had been advised of £12-14m worth of high-risk savings delivery. Assurance had been provided that the team was actively working to identify ways to deliver and that the team was working closely with the system to identify opportunities. It was noted that the biggest opportunities and risks relate to non-Trust beds and bank and agency spend. RFW commented that a recovery action plan had been requested on non-contracted beds.
15	**Finance Report** The Board received the report for information. WW asked about deliverability and the Trust's ability to manage the plan and deliver it when there was potential disruption and anxiety around cost reductions. RFW noted that the Trust was cognisant of morale and energy within the organisation; plans had focused on patient experience and not on removing people from substantive posts.

	SB asked about the financial gap in relation to Children and Young People's services. DT advised that the Trust aimed to close the gap over a period of time, with a plan developed to deliver for this financial year and clear accountability in place.
16	**Audit Committee Report** The Board received the report from April's meeting. WW noted the following key points: • The Committee had been pleased to note that the Trust had received a Quality Mark for its Race Equality Code Assessment. • Assurance had been provided that the Annual Report and Accounts was on track. • The Head of Internal Audit Opinion had been positive, which demonstrated the amount of significant improvement that had been achieved over the year.
17	**Caring Minds Committee Report** MS verbally reported from the meeting which had been held on 2 June: • Birmingham Community Healthcare Trust was supporting the strategic development of Caring Minds; a Service Level Agreement had been received, however the Committee had requested specific measures to ensure robust monitoring. • The Committee had agreed that the charity would match Staff Network funding provided by the Trust.
18	**Trust Seal Report** The Board **endorsed** the use of the Trust Seal.
19	**Living the Trust Values** DT verbally reflected on the following: • External visitors always commented on how warm and friendly staff members were. This was demonstrated through the amount of support provided to new staff members, including colleagues from Children and Young People's services. • DT had often observed colleagues treated others equally, never assuming anything and ensuring that Staff Side were included in discussions. • There were numerous examples of staff who consistently went above and beyond, with examples occurring all the time that are not necessarily noticed and celebrated but were important to acknowledge. This was particularly highlighted at the Staff Awards and should make the Board proud.
20	**Board Assurance Framework reflections** There were no further reflections.
21	**Any other business** PG formally thanked John Travers as his term as Lead Governor and Non-Clinical Staff Governor was due to end on 15 June.
22	**Questions from Governors and members of the public** • A question was asked about the root of the improvements at Ardenleigh, as the Trust needed to be fostering these improvements. RFW commented that it was linked to the strategy in relation to ensuring good patient experience; services were responsive to service user needs and making the best use of finances. Staff were also increasingly utilising quality improvement approaches to address issues. PG noted that leadership at Ardenleigh had also significantly strengthened the services. • A question was asked about the culture of care programme and whether this was supporting the level of substantive staff. LSG noted that the programme was a good vehicle for conversations with staff in relation to recruitment and retention, and that there had been a number of years of intense work on values and culture to support this. The Trust was able to engage people in local ownership of their teams and service

	developments and also ensuring that service user and experts by experience were heard. SB commented on the Trust as a system leader for coaching. FA advised that the Trust was also seeing a number of returning staff, which demonstrated positive working environments across the organisation. • It was observed that 44% of staff had not responded to the Staff Survey, and a question was asked about whether there were other ways to approach staff who did not engage. PN advised that the teams who did not respond had been identified and there was focused work ongoing to engage them. RFW commented that the Trust was also connecting with other organisations to learn from partners. PN advised that BSMHFT was the second most improved Trust in the region, but it was recognised that there was more work to do.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Board Assurance Framework	The Board formally accepted the recommendations to reduce risk scores, and noted the opportunity to discuss further at the Board Strategy Session on 6 August.		
Trust Seal Report	The Board endorsed the use of the Trust Seal.		

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors						
Agenda item:	**6**					
Date	6 August 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

The Board is asked to note the contents of the report for information and accountability, and an overview of key events and areas of focus.

Enclosures

N/A

BOARD OF DIRECTORS CHAIR'S REPORT

1. Introduction

I am pleased to present this summary of my activities as Chair since our last Board meeting and to reflect on key national developments that will shape the future of our work. Since my previous report, the Government has launched its long-anticipated NHS Ten-Year Plan a pivotal moment for the NHS and the wider health and care system. This strategic framework outlines a bold vision for transforming healthcare delivery through three core shifts: moving care from hospitals into communities, focusing on prevention over treatment, and transitioning from analogue to digital systems. These reforms are aimed at reducing pressure on acute services, improving access and outcomes, and ensuring the sustainability of high-quality care.

At the heart of the plan is the ambition to build a 'Neighbourhood Health Service', underpinned by multi-professional teams working locally to deliver more integrated, personalised care. The plan also proposes a comprehensive reform of the NHS operating model, including capital investment approaches and a transition to outcomes-based funding mechanisms. Importantly, it recognises the critical need to support workforce development and foster stronger collaboration with local strategic partners to drive health and economic growth. Digital innovation features prominently, with expanded use of tools such as the NHS App as the central access point for services, and a clear ambition for the NHS to become the most AI-enabled healthcare system globally within the next decade. There is also a renewed emphasis on tackling the broader determinants of health social, economic, and commercial as part of a whole-system approach to prevention. Crucially, the plan presents significant opportunities for mental health. These include the development of dedicated mental health emergency departments, the rollout of neighbourhood-based mental health models, the expansion of mental health support in educational settings, and increased investment in digital tools to support the management of anxiety and depression. Additionally, greater funding for mental health research offers promising prospects for evidence-based innovation in care. As Chair, I remain committed to ensuring that our organisation is well positioned to respond to and help shape this ambitious agenda, particularly as it relates to mental health transformation and the role of local systems in delivering person-centred care

2. Governance Matters

I am pleased to confirm that I have completed the annual appraisal process for all Non-Executive Directors (NEDs) and the Chief Executive. These appraisals are a key component of our commitment to strong governance, ensuring effective leadership and continued accountability at Board level.

In addition, following the conclusion of our Lead Governor's term of office, Governor elections were held last month. This provided a valuable opportunity to further strengthen the Council of Governors by appointing both a new Lead and Deputy Lead Governor. I am delighted to announce the appointments of David Slatter as Lead Governor and Chris Barber as Deputy Lead Governor. Both individuals bring a wealth of experience, having served on the Council of Governors for several years, and we are confident that their leadership will continue to add significant value to the work of the Council and to BSMHFT. Governors play an essential role

within our governance framework holding Non-Executive Directors to account for the performance of the Board, representing the voices of our members and wider communities, and contributing meaningfully to important decisions, including Board appointments and amendments to our constitution. Their ongoing engagement and oversight remain fundamental to the integrity and transparency of our organisation's governance.

SERVICE VISITS

2.1

Engagement with our frontline services remains a central priority, and I am pleased to report that visits to our Trust sites continue, with active participation from both Non-Executive Directors (NEDs). These visits are far more than a routine exercise they represent a critical aspect of our responsibility as Board members to maintain close connection with the realities of care delivery across the Trust.

Through these visits, we are able to engage directly with staff, patients, and service users, creating invaluable opportunities to hear first-hand about their experiences. These conversations bring to life both the areas of excellence within our services and where further improvement is needed. This rich, qualitative insight not only deepens our understanding of how our services are functioning on the ground, but also meaningfully informs our oversight, scrutiny, and strategic decision-making. For Non-Executive Directors and for me personally, these interactions are among the most impactful aspects of our governance work. They ensure that the voices of those delivering and receiving care remain central to our deliberations and help to reinforce our culture of openness, responsiveness, and learning. Moreover, visible leadership at all levels is critical. These visits send a strong message of support to our staff and reinforce the importance we place on their perspectives. They also serve a practical purpose, enabling us to triangulate the data we receive at Board level with what we observe and hear directly from teams and patients. This joined-up approach helps build a more accurate, compassionate, and evidence-informed understanding of service performance, safety, and quality.

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

Hertford House – I spent a great morning in Solihull, 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.

2.4

I was delighted to visit SOLAR at Bishop Wilson, our specialist service delivering emotional wellbeing and mental health support to children, young people, and families across Solihull.

The visit was truly inspiring and left me feeling incredibly encouraged by the energy, commitment, and innovation within the team. I had the opportunity to meet a range of staff and speak directly with them. I was particularly impressed by the team's proactive and determined efforts to reduce waiting times and improve access to their service. They shared several promising initiatives currently being implemented and others in development aimed at further cutting delays and enhancing the experience for children and families in need of support. The joint working arrangements they have with other providers is working very well. Equally notable, was the fact that the service is fully staffed, with no current vacancies a reflection of the positive

culture, strong leadership, and sense of purpose within the team. Everyone I spoke with expressed genuine pride in their work and a deep commitment to the children and families they support. Overall, this was a highly positive and uplifting visit, showcasing an exceptional service that exemplifies the values and impact we strive for across the Trust.

2.5

I recently visited Little Bromwich, one of our key mental health sites within the Trust, to engage with staff and gain deeper insight into the vital services provided there. During the visit, I met with clinical teams such as the memory assessment clinic Birmingham Healthy Minds and other teams, toured the facilities, and listened to staff experiences and ideas for service improvement. I was thoroughly impressed by all of the services at this site and during my recent visit to the Community Rehabilitation Team, I had the pleasure of seeing first-hand the work they are doing in partnership with Birmingham Mind. The strength of their joint working arrangements is clear, seamlessly blending clinical expertise with community-based support to deliver holistic, recovery-focused care for service users. Their collaborative approach is a shining example of integrated mental health provision at its best.

What made the visit particularly exciting was the opportunity to experience their cutting-edge use of virtual reality technology. I was invited to try on the Meta Quest 3S virtual headsets, an experience I found both fascinating and inspiring. These advanced, mixed-reality tools are being introduced as part of therapeutic interventions for certain service users, and the potential they offer is remarkable. The team explained how virtual environments are being tailored for use in exposure therapy, relaxation training, and cognitive behavioural therapy, making treatment more immersive, engaging, and personalised. The innovation on display here is not only forward-thinking, but truly reflective of a service that is passionate about improving outcomes and embracing new ways to support recovery. It was great to hear how service users will benefit from this exciting development. This visit was an energising reminder of the creativity, dedication, and progressive thinking that exists within our services and left me both impressed and optimistic about the future of mental health care within our Trust.

3. Partner and System Development / Stakeholders

3.1

As Chair, I remain deeply committed to championing the work of our Trust and acting as a visible ambassador at every opportunity. Over recent months, I have actively participated in a wide range of high-level strategic meetings and regional forums to strengthen partnerships, build influence, and ensure our Trust's voice is heard in key decision-making spaces. A particular highlight was attending the national webinar for NHS Chairs and Chief Executives on the very day of the launch of the NHS Ten-Year Plan. This dynamic session featured a live Q&A with **Dr** Penny Dash, Chair of NHS England, and senior executive colleagues from NHSE. I was proud to represent the Trust and to pose questions during the session which were directly responded to reinforcing our commitment to staying informed, engaged, and contributing meaningfully to the national conversation on the future of the NHS. In addition, I've taken part in a number of influential meetings, including the Midlands NHS Leadership Meeting, the BSOL Integrated Care Partnership Board, the NHS Confederation Mental Health Chairs Group, the Midlands Chairs Meeting, and a focused CEO and Chairs session on the development of the NHS Ten-Year Plan. These forums have been vital for collaborative learning, sharing best practice, and aligning regional efforts to national priorities. I also continue to attend the monthly BSOL Chairs Meeting, which covers a broad and ambitious agenda, providing invaluable opportunities for joint working, strategic alignment, and collective leadership across our system. Through all of these engagements, I am proud to advocate on behalf of our Trust promoting our values, championing mental health, and ensuring that the voices of our service users, staff, and communities are well represented at the highest levels.

4. Stakeholder Engagement

4.1

Last month, our Vice Chair, Bal Claire, expertly chaired the Council of Governors meeting, where we created space for robust assurance on key areas of strategic focus for the Trust. These meetings continue to serve as a vital platform for meaningful dialogue, accountability, and collective learning, strengthening the connection between the Board and our Governors and supporting their ongoing development and effectiveness. Alongside this, I continue to prioritise strong external engagement. I continue to meet with Shane Bray of SSL, remain consistently insightful and instrumental in shaping our strategic direction. These regular touchpoints ensure we stay closely aligned with regional developments and system-wide priorities. In addition, I meet bi-monthly with Rebecca Farmer, Director of System Coordination and Oversight at NHS England, to explore key priority areas for the Trust. These discussions are invaluable in ensuring that our work remains aligned with national expectations, while also allowing us to share our progress, ambitions, and innovative practice as part of a wider system of transformation.

5. PEOPLE / QUALITY

5.1

I continue to chair our Board Strategy Sessions, which serve as a dynamic and forward-thinking forum for collaborative dialogue, strategic alignment, and the pursuit of continuous improvement across the Trust. These sessions are instrumental in shaping our organisational direction, enabling us to proactively respond to challenges and opportunities while maintaining a sharp focus on delivering high-quality, person-centred mental health care. In addition, I hold regular one-to-one meetings with our Chief Executive, Roisin Fallon-Williams, as well as with Executive Directors and Non-Executive Directors, to ensure leadership cohesion, clarity of purpose, and a unified approach to governance and performance. These touchpoints are critical in sustaining momentum and reinforcing our shared vision. At the heart of my role is a deep and ongoing commitment to championing innovation, improving processes, and driving excellence in everything we do. I remain passionate about ensuring that compassion, quality, and continuous improvement are embedded in the fabric of Birmingham and Solihull Mental Health Foundation Trust, for the benefit of our service users, staff, and communities.

PHIL GAYLE
CHAIR

Report to Board of Directors							
Agenda item:	**7**						
Date	6 August 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

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

Operational Team

Both our overall Fundamental Training and Appraisal compliance remained above Trust target for Quarter 1. Specifically, our Appraisal compliance has surpassed our Q.1 goal and currently sits at 81.3%.

In support of reducing our overall time spent for staff within formal cases and our Management Essentials agenda, we are piloting informal case and DMG (Decision-Making Guidance) tracking with divisions, enabling us to capture a more complete picture of ongoing management activity. This approach aligns with RLJC (Restorative, Just, Learning Culture) principles and supports early, informal resolution of issues. The pilot includes structured support for line managers and promotes proactive engagement with HR at earlier stages of case management. In addition, we launched our two management essential modules in June which have been well received and are designed to support our goal to reduce the disproportionality of radicalised groups in people processes.

We are introducing a new Wellbeing Platform via our Occupational Health provider Optima Health, which will enhance our health and wellbeing offer. This new wellbeing platform will be launched during August / September. In addition, we will be launching a new staff health and wellbeing space at the Uffculme centre during the next quarter. Work is also underway to achieve our system and local goal of reducing our sickness rate by March 26 through a multi-disciplinary action plan.

Workforce, Recruitment and Temporary Staffing Service

The Learning & Development team continue to review and offer support to teams that are below our expected 75% compliance in Fundamental Training and Appraisals.

There has been some expected fluctuation in compliance due to data migration following the transfer to the Trust of Birmingham Children and Young People Services.

The Trust vacancy rate for June was 8.8%, and we have observed a steady decrease in this rate over the past 12 months. Notably, there has been a significant reduction in the Nursing band 5 rate, with only a 3.7% vacancy rate in June.

Turnover continues to remain stable at 9.65% in June. We now have an agreed system-wide definition of turnover which will assist with our benchmarking efforts.

Resident Doctors Industrial Action

Industrial action by Resident Doctor members took place between Friday 25th July – Wednesday 30th July. All teams and colleagues worked together to ensure the continued safe delivery of services for our service users during this time.

Learning & Development

The People team have successfully launched the CONNECT Knowledge Base and Resource Hub, providing colleagues with a centralised, self-service platform for HR guidance, templates, and operational tools. This has already improved access to consistent, up-to-date information and supports our commitment to empowering staff with the resources they need to work effectively.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

The ICCR portfolio continues to progress key service improvements, with focused action underway in response to the national inquiry following the Nottingham incident, particularly for service users of Assertive and Intensive services. Core areas of work include caseload complexity reviews, implementation of Patient Initiated Follow-Up (PIFU), enhanced diagnostic pathways, recognition of carers' concerns, escalation processes, and improved next of kin data recording. Caseload reviews are underway across all Community Mental Health Teams.

Neighbourhood and Community Mental Health Teams (NMHTs and CMHTs)

Neighbourhood Teams: Work is advancing with the Integrated Neighbourhood Teams (INTs) roll-out, prioritising the East locality. Planning is also underway for a pilot enabling direct referrals from NMHTs and Birmingham Healthy Minds to Specialist Psychotherapy Services (SPS), aiming to improve access and integration.

Solihull: The Dialectic Behaviour Therapy Skills group has seen good engagement, and joint referral meetings are progressing positively. Engagement is ongoing with Coventry and Warwickshire Partnership Trust to collaborate further around the Talking Therapies offer.

CMHTs (North & East): A joint workshop with Home Treatment Teams (HTTs) supported cross-team understanding of shared pressures. This format will be extended to other CMHTs.

Solihull CMHTs: Focus remains on clinically validating complex caseloads as part of the Assertive and Intensive Action Plan, alongside managing waiting lists.

South and West CMHT- Currently working through validation of complex and more complex caseload. An action plan in place looking at wait times for first and second appointments, which has been progressing well over the past 6 weeks, whilst there remains a way to go there has been a visible reduction in waits overall.

Assertive Outreach Teams (AOTs)

Significant progress has been made over the last 3 months to promote the flow of individuals between CMHT and AOT to help address the AOT access waiting times. Through structured interface meetings with CMHTs, a six-week discharge transition target is now in place which has resulted in the service user waiting list reducing from 46 to 24. Joint working with acute care and bed management colleagues has enabled this improvement in patient flow.

Homeless Mental Health Services

- **Homeless Health Exchange (HEX):** The Primary Care Mental Health Team has been set up on the RiO system and will soon begin usage to enhance care coordination.
- **Rough Sleeper Mental Health Team:** Continues to work effectively with partner agencies. Discussions are ongoing regarding potential access to Home Treatment where appropriate.
- **Homeless CMHT:** Maintains strong performance with all referrals seen within 1–4 weeks. Staffing has returned to full strength with the addition of a new CPN.

Solihull Integrated Addiction Service (SIAS)

SIAS has restructured its safeguarding model, with the Trust Safeguarding Team now leading supervision and oversight. A revised triage process now captures more data upfront, streamlining clinician assessments.

The 12-week DayHab programme continues to develop as a community-based alternative to residential rehabilitation, alongside new recovery-focused activities such as walking football and film nights.

Early Intervention in Psychosis (Solihull)

The service consistently meets referral-to-treatment standards. A new physical health nurse is due to start in August and Social activities are now fully risk compliant. An away day is scheduled to revisit team values and processes in preparation for the digital transition of the National Clinical Audit of Psychosis (NCAP) audit.

Recovery Near You (Substance Misuse Services)

Commissioners have confirmed a 5+2-year direct award for the service which is positive news. The dual diagnosis model has been strengthened with three Band 6 nurses and a clinical lead based in Wolverhampton, supporting integrated care with Black Country Foundation Trust.

Steps to Recovery

Introduction of Patient Reported Experience Measures (PREMs) has provided valuable insights for service development. Approval of the Recovery Business Case will enable the formation of a team to support step-down from out-of-area placements and promote community discharge. Referrals remain steady, with low waiting lists. However, admission pressures persist for male High Dependency Unit (HDU) and female Complex Care Unit (CCU) beds. Timely social care input remains key to effective discharge planning.

Children and Young People's Division (CYP)

Successful Service Transfer

On 1 July 2025, Children and Young People's Mental Health Services safely transferred into BSMHFT from Birmingham Women's and Children's NHS Foundation Trust. This involved the mobilisation of over 500 staff and nearly 10,000 live cases. Transition planning was extensive and collaborative, and early feedback from families and teams has been positive. This marks a significant milestone in aligning the 0–25 mental health offer within the Trust. A formal post-transfer review and mobilisation of Phase II objectives is now underway.

Access and Performance

The division remains on track to meet the national CYP access target by August 2026, with current performance two months ahead of trajectory. Performance has improved through better data capture and consultation models, though some issues remain with coding and voluntary sector reporting. The NHS oversight framework now focuses on year-on-year contact growth, and we are seeking further clarity on this ahead of the next planning round.

Other access targets are largely positive, and we are proud to report a stable position, without deterioration having taken place during the transfer agenda.

Workforce Pressures

Workforce stability is improving in some areas, such as our early help and referral management clinical group, due to successful recruitment and agency conversions. However, gaps remain in services such as Youth Justice, ADHD and Neurodevelopmental care, and specialist eating disorder pathways. Targeted recruitment, reflective practice, and wellbeing support are ongoing priorities.

Our greatest focus remains our medical workforce, where temporary staffing usage is proving difficult to reduce. New support with this now we are within the trust is welcomed and already starting.

Early Help and Prevention

Our more acute early help pathway (STICK service) has reduced average waits from over six months to 21 days, and consultation models, allowing improved data and access reporting are now embedded in systems. Following Integrated Care Board (ICB) support, we are progressing plans with our existing Mental Health Support Teams (MHST) provider (COMPASS) to establish three new Mental Health Support Teams in South Birmingham, increasing our Birmingham coverage significantly over the next 12 months (from 53% to around 67%).

Secure Care and Offender Health (SCOH)

Reaside clinic & Hillis LodgeThe Culture of Care programme continues to be implemented across services with several projects underway already and some great work and development in train. Work has been completed on the alarm upgrade and phase one of the full bathroom refurbishment has started in recent weeks. A recent assurance visit from QPES committee members took place in July and positive feedback was received from the visit. Collaboration with our Experts by Experience (EBE's) across the services continues, we are proud to share that we have 20 EBE's working with teams, supporting with recruitment and projects across the site. Bed occupancy remains high, and the service has been at 100% capacity on several occasions over the last few months. Several carers' events have taken place with great success. We have fully recruited to all RMN posts in the service, and our final planned Health Care Assistant (HCA) recruitment is taking place in August which will confirm a further 26 HCA positions in our establishments.

Ardenleigh

The Youth First team have successfully recruited to the in-reach team, and they have commenced Makaton communication training to enhance the provision on offer. In low secure CAMHS, the young people have now commenced their summer timetable and engagement has been positive, as has the recruitment of an Activity worker are making a positive impact on ward activities.

HMP Birmingham remains very busy and challenging. Population pressures remain high with several late receptions happening over the last month, introducing risks to screening and an impact on other night nursing duties. The teams continue to work with partners to explore how we can reduce these and keep all safe. We continue to work with our Birmingham Community Healthcare Trust (BCHCT) partners and have introduced regular meetings to ensure we are collectively delivering in accordance with our clinical model and our contractual obligations. Staffing is improving across the site and recruitment is ongoing, along with some changes to the healthcare senior leadership team due to maternity leave and the Head of offender health being successfully recruited to the interim Associate Director of Secure and Offender Health role.

A huge thank you to everyone who supported the recent peer review cycle with the Quality Network. We were proud to host colleagues from HMP Northumberland, HMP Manchester, and the Quality

Network, and received outstanding feedback that reflects the dedication and quality of care delivered by our mental health team at HMP Birmingham. Commendations included our strong leadership, innovative MDT working, and exemplary team culture. Patient feedback was overwhelmingly positive, and our service was described by partners as one of the best they've worked with. Areas for development include expanding psycho-social interventions, refining care continuity during staff leave, and progressing our ADHD pathway. We look forward to receiving the draft report in the coming weeks and will share the final version once available. Well done, everyone!

The Health and Vulnerability Service

There has been an improvement in recruitment across the service following a recent recruitment fair event. The team have experienced challenges across the custody pathway in line with Right Care Right Person processes and are actively working with partners to mitigate the impacts of this. Our Primary Mental Health Treatment Requirement team continue to hold a waiting list, however with additional funding obtained to increase the workforce, we have seen a recent reduction of this by 11%.

Acute and Urgent Care

Reducing usage of non-contracted beds remains a key focus for the division. We have established Key Performance Indicators (KPIs) to underpin our action plan, which is monitored through our internal governance structures. This will support patient pathways, admission avoidance, reducing length of stay and discharge efficiency. We are implementing additional improvement actions for our Recovery Action Plan (Patient Flow) and have implemented a weekly Gold call, bringing together our children and young people and adult bed capacity with a focus on reducing our current use of spot purchase beds. Progress is monitored weekly in the Patient Flow Improvement Programme (PFIP) that will support and report via our current governance structures.

Productive discussions from the second interface meeting between Acute and Urgent Care and ICCR divisions have fed into the action plan and inpatient strategy, which have enabled us to develop trajectories to reduce Length of Stay (LOS) which have been submitted to NHSE. Positive feedback has been received from the Patient Council and Experts by Experience on this work.

Our work as described above will be supported by the imminent launch of our Culture of Care Programme, as we recognise that high quality care supports better patient flow.

A £40,000 bid has been approved by Caring Minds to establish the Highcroft Staff Rest Centre, housed in a modular building between George Ward and Eden Unit. It will be a resource for colleagues of George, Eden PICU, Eden Acute wards, and the wider Highcroft site, providing a designated break space which they currently do not have.

Within urgent care, we are collaborating with the CYP division to ensure clinical prioritisation of patients from 18+. We are also focusing on our winter plans, working internally with CMHT colleagues to support known service users who are attending A&E departments and working with system partners through the Urgent Care Pathways Group to define our urgent care offer. The Recovery House (formerly Crisis House) will go live in October, and this will provide additional care options to support admission avoidance and discharge planning.

A training pilot for inpatient staff in Low Intensity Psychological Skills is due to start and will be expanded after evaluation. Both clinical supervision and Regular Management Supervision figures

are steadily improving. An action plan with weekly updates is in place to monitor and support managers with this required improvement.

Following the CQC inspection of North and Zinnia wards, feedback highlighted quality concerns requiring immediate, medium and long-term action. To strengthen our clinical leadership and staff development we are in the process of recruiting three additional matrons along with an additional Head of Nursing.

Primary Care, Dementia Services & Specialties

Dementia and Frailty team

Following a competitive bidding process, the team have been successful in their application for the Fairer Futures Fund Citywide Partnership funding. This is a three-year funded project to address health inequalities faced by people not accessing a timely dementia diagnosis and provides opportunity to work differently across the system. As part of the ongoing collaboration work with voluntary, community, faith and social enterprise (VCSFE) partners, the Alzheimer's Society now have bi-monthly drop-in sessions across three of the Dementia and Frailty community hubs, this provides a place for service users, carers and staff, to get information, support and advice from a local Dementia Adviser.

The Community Dementia and Frailty teams have been working with the apprenticeship team to look at workforce opportunities as part of a wider piece of work developing pathways across the service. Funding has been secured for three new apprenticeship admin roles; this is an exciting opportunity which aligns with the division's workforce plan.

Community Perinatal Service

The service has recently expanded to include the mother and baby unit Outreach Team, which is funded by West Midlands Provider Collaborative funding. This will support the rapid and safe admission and discharge into the mother and Baby unit, whilst providing specialist perinatal expertise for women requiring acute or urgent care services. Previously overseen by Barberry services, this closer connection with community perinatal services will improve the pathway for women to and from community services. The service has had some success in building pathways with West Birmingham midwifery bereavement services as a result, we are now receiving referrals for women who have experienced perinatal loss and require the service.

Veterans service

The service is working closely with our Veterans Voices group which is our regional service user collaborative group and has been pivotal in co-designing/co-producing and supporting the service to further improve the pathway and service regionally. We have been reviewing our treatment pathway and the clinical offer to ensure our workforce plans are on track to deliver the skills required. Positive patient and carers feedback received about their experience often reporting that it has been life changing. Staff members have received excellent feedback for demonstrating trust values from one of our external partners especially in the way they were able to compassionately challenge and advocate for the patient they were working with.

Birmingham Healthy Minds

The service continues their monthly performance meetings and ICB progress updates are given on our service action plans regarding 2+ completed treatment contacts, Did Not Attend (DNA) rates and recovery rates. Birmingham Healthy Minds is now commissioned to provide a long term condition (LTC) service, and we have been successfully delivering group and 1:1 intervention. We have 6 x High Intensity Trainees from the University of Birmingham joining in September. We receive regular Friends and Family Test Feedback, one of many reads as "I started therapy due to social anxiety which was affecting my work, social life and relationships. I am now more confident and thriving in my development following my sessions with skills to support me in my future development".

Bipolar service

Waiting lists have reduced both for assessments and intervention now we have a full compliment of staff and have also increased the number of Mood on Track programmes per year. This month the team submitted an initial bid for £300,000 National Institute for Health and Care Research for Patient Benefit funding. This would support the team in further developing Compassion Focussed Therapy for Bipolar Disorder and with testing it within community mental health services. The team have been working closely with Professor Paul Gilbert the founder of Compassion Focussed therapy in doing this. The service has been supported by an excellent service user steering group and two of the co-applicants have lived experience of bipolar and psychological intervention and their input has hugely benefitted both the application and study design.

SUSTAINABILITY

BSoL Mental Health, Learning Disability & Autism Provider Collaborative

The BSoL Mental Health, Learning Disabilities & Autism Provider Collaborative have undertaken the following key activities over the past quarter:

- The MHPC has overseen the successful transfer of Forward-Thinking Birmingham CYP 0-25 Mental Health Services into Birmingham & Solihull Mental Health NHS Foundation Trust on 1 July 2025. The transfer was approved at the ICB Audit Committee on 3 June 2025. A Development Plan is now in place following the transfer to conclude any outstanding mobilisation actions.
- A new life course specification for mental health has been developed building on the feedback received from stakeholders and will be issued to BSMHFT alongside an implementation framework for CYP.
- The MHLDA Provider Collaborative has commissioned a new Mental Health text service, which will go live on 4 August 2025 across Birmingham and Solihull. People will be asked to text SPACE to 85258 for a free confidential conversation about their mental health. This service aims to give people easy access to mental health support by talking to a clinically trained mental health professional who can help avoid a crisis and signpost to other services.
- A market engagement event surrounding counselling services has taken place with plans to commence a procurement process during 2025/26.
- The MHPC has supported the investment of Reach Out funding into the development of a multi-disciplinary Assertive & Intensive Enhanced provision within locality hubs. Whilst the funding will cover a period of two years, the MHPC will monitor the impact of this investment on patient experience and outcomes following mobilisation.
- The collaborative has commissioned a new Intensive Support Team which has a primary aim to reduce inappropriate admissions for those with autism into mental health hospitals and support them to remain in the community.
- Procurement for emergency beds for those with Learning Disabilities or Autism is now underway to ensure appropriate and high-quality provision is available for our patients.

Winter Planning Requirements

The winter planning requirements were issued some weeks ago, and we have been working on our plan both as a Trust and as a Birmingham and Solihull System. The joint work required to ensure we manage patient needs through winter is significant and the plan will therefore be very detailed.

The initial submission date was Friday 1st August, and we will be taking the plan through our Governance, in particular to both Finance Performance and Productivity Committee and Quality Patient Experience and Safety Committee in August. Board Assurance will be required in September, so we plan to hold an extraordinary Board meeting in September (as part of our scheduled Strategic Session) to consider our plan and receive assurance reports on it from both Committees.

Funding and Finances

The financial position for all NHS organisations in the local system continues to be challenging. BSMHFT has ended the first quarter of the financial year off the plan we had in place and continues to face significant pressures, especially in relation to our efficiency programme and our performance on usage of non-contracted beds. Operational and corporate divisions are working together have to relook at our financial plans for the year to ensure delivery of savings plans, and where performance is not improving, financial recovery plans have been requested and are being monitored. On going reporting and oversight remains via our Finance, Performance and Productivity Committee.

QUALITY

CQC - Section 29As and Focused Inspections

The Sections issued in autumn 2024 at Zinnia Centre are the only ones remaining in place for the Trust, progress on our associated action plans has been regularly shared with CQC colleagues and been reported to Board via QPES Committee.

The final version of the CQC report for Reaside inpatients and the FIRST teams, following the most recent inspection of these services was published on June 11, 2025. The overall rating remains at Requires Improvement, however, there have been notable improvements in areas such as Caring, Responsive and Well-led compared to the previous inspection in 2024.

Acute Care Inpatient Wards were subject to a CQC focused inspection between June 17th and 18th 2025. Larimar was also planned for inspection but was postponed due to the circumstances on the ward at that time and was subsequently inspected on 8th July. The inpatient wards at the Zinnia were also re-inspected on June 19th to review the findings from the previous inspection in October 2024. We await the formal report from these inspections.

Door Alarm System

To ensure ongoing improvement in service user safety, we have commenced the second phase of the door monitoring alarm system installation programme. For the reporting period the bedroom doors were completed on all wards in Acute Care at the end of Q1 2025/26.

Reducing Restrictive Interventions

As well as each area having a local Reducing Restrictive Practice plan in place, there is a trust wide quality goal focused on reducing the use of restrictive practice through the promotion and

strengthening of de-escalation skills. As part of this initiative, a toolkit will be made available to support staff in managing challenging situations safely. As well a QI (quality improvement) piece of work led by the EDI (Equality/Diversity/Inclusion) team to support colleagues who face discrimination, this will form part of our culture of care programme.

Culture of Care

Culture of Care Quality Improvement (QI) Programme – Two-Phase Approach

1. National QI Programme
The Trust is actively participating in the national Culture of Care QI Programme, delivered in collaboration with the Royal College of Psychiatrists and specialist partners. This programme is designed to enhance the culture within inpatient mental health, learning disability, and autism wards—creating environments that are safe, therapeutic, equitable for patients, and rewarding for staff. Currently, four pilot wards are engaged in the programme: Forward House, Sage Ward, George Ward, and Severn Ward. Additional wards—Hertford House, Chamomile Suite, Jasmin Suite, and Cilantro Suite—are in various stages of scheduling ward visits and coaching sessions.

2. BSMHFT Inpatient QI Collaborative
This local collaborative initiative is aligned with NHS England's 12 Culture of Care Standards and is supported by the Trust's Culture of Care Assurance Framework. It encompasses all inpatient wards and units across the Secure Care, Acute Care, Specialties (Older Adults), and Steps to Recovery Directorates. The programme is being implemented in phases over an estimated two-year period. Initial launches have taken place successfully at Reaside, Ardenleigh, and Tamarind (secure care). The Acute Care Directorate is scheduled to begin implementation on 18 August 2025.

Local Trust, Birmingham and Solihull System and Midlands Regional News

Midlands Health and Care Inequalities Policy Commission Report

Organisations across the Midlands and leading national health charities are collectively launching a policy commission which has the potential to transform the health and care of people across the region by addressing health and care inequalities.

The Midlands Health and Care Inequalities Policy Commission, led by Midlands Innovation Health and following an intensive period of community and stakeholder involvement and engagement, proposes a range of transformative measures, from short- to longer-term initiatives, from simple to comprehensive, to drive forward innovative change. A key recommendation is to enable and embed people-powered health – supporting and empowering people to take charge of their health and care needs.

The commission's 10 Priorities for Change outline a path for the Midlands to make significant strides in reducing health disparities. These recommendations include:

- **Develop a Unified Regional Strategy:** Establish a single, coordinated approach to improve access and tackle systemic health inequalities, with strong leadership support across NHS, local authorities, and care organisations.
- **Ensure Long-Term Investment:** Prioritise sustained, reliable funding over short-term programmes to build trust and deliver lasting impact. Introduce regional funding models with ring-fenced budgets focused on health inequalities.
- **Leverage Regional Strengths in Data and Innovation:** Capitalise on the Midlands' digital infrastructure and diverse population to lead nationally in health tech, inclusive clinical trials, and AI-driven solutions. Establish a Midlands Centre for Evidence to integrate research, industry, and care systems—boosting patient outcomes and economic growth.

Special Educational Needs Partnership in Birmingham with Joint Ofsted and CQC Inspection

This inspection took place during June and July and involved all partners including ourselves as both a Lead Provider (Commissioner) and a Trust (Provider). Whilst there remains a considerable amount to do to reach our joint ambitions, significant partnership work to support those with these needs in Birmingham has been undertaken over recent years and we look forward to this being recognised in the report that is awaited following the inspection.

NHS Changes

As part of the announced changes to the NHS architecture, several Integrated Care Board (ICB) System geographies are altering, enabling a national move from 42 to 26 ICBs. This includes our local footprint.

It has been confirmed that Birmingham and Solihull and the Black Country will now cluster to become a single Birmingham Solihull and Black Country ICB. The process to establish the new leadership arrangements has commenced and we expect the initial appointments of Chair and CEO to be announced imminently to enable a 1st September commencement date.

We have begun to explore how we can develop opportunities for wider working across the cluster, both system wide and as a Mental Sector.

'Brew Up' Strategy

The Strategy Team has been actively engaging with colleagues across the Trust to co-develop our new Trust Strategy. Recent engagement activities included visits to, Zinnia, PROSPER and Rookery Gardens , teams at Little Bromwich, and all wards at Reaside and Tamarind. These sessions provided valuable opportunities for open dialogue, with comment cards and post-boxes left behind to capture further input. The team also attended the Patient Council for the first time, listening to service users from Steps to Recovery. Upcoming visits include HMP Birmingham, the Dementia and Frailty Community Forum, and the Health and Justice Vulnerability Service. We extend our sincere thanks to all staff and service users who have contributed so far—your insights are helping shape a strategy that reflects the needs and aspirations of our Trust community. For details of upcoming engagement sessions before September, please refer to BSMHFT Connect.

BSMHFT Annual General Meeting

Join us at the Uffculme Centre on Tuesday 23 September, 10am-3pm, for our Annual General Meeting (AGM).

As part of the day, we are creating a giant interactive timeline celebrating our journey from 2021 to 2025 - and we want everyone to be part of it. Whether it is a proud team moment, a personal milestone, or an improvement that had influence, come along and add it to the timeline.

It is a chance to reflect, connect with colleagues and partners, and celebrate all we have achieved together.

National News

Agency Spend

In a letter during June to All NHS Chief Executives, the Secretary of State and Sir James Mackey reiterated the expectation set out in the NHS Planning Guidance that all trusts must reduce agency staffing spend by at least 30% in the next financial year, with the collective ambition to eliminate agency use entirely by the end of this Government's term. To support this, NHS organisations are asked to prioritise staff bank usage, ensuring competitive but not excessive bank rates, and to evaluate local market conditions accordingly. Trusts should have robust migration plans in place, and those not already working with NHS Professionals are encouraged to consider their national bank offer. A joint DHSC and NHS England delivery group will monitor progress, and further legislative action may be considered if sufficient improvement is not evident by autumn. Achieving this goal could release up to £1bn over five years to reinvest in patient care.

As a Trust we have made significant progress on agency use reduction and have an on going plan for further doing so.

Dr Penny Dash – Patient safety Review

Dr Penny Dash's review of patient safety across the health and care landscape in England, which was commissioned by the Department of Health and Social Care was published in July and a number of announcements aligned to the NHS 10 Year plan would made a result, including the move to establish one single regulator (CQC) for the NHS. The publication can be read here Review of patient safety across the health and care landscape - GOV.UK

NHS Providers Chief praises our 24/7 Neighbourhood Mental Health Centre team

Daniel Elkeles, Chief Executive of NHS Providers, recently visited our new 24/7 Neighbourhood Mental Health Centre in East Birmingham. One of six national pilot sites, the centre serves a highly deprived area and offers a walk-in, round-the-clock service where guests can attend as often as needed and stay as long as they wish. Meals and creative therapies are central to the model, with colleagues supporting both mental health and wider life challenges.

Daniel described the service as 'totally extraordinary,' noting a reduction in inpatient bed use and fewer Emergency Department visits. The team have adapted to new ways of working, including managing communal spaces, responding to unpredictable attendance, and flattening traditional hierarchies. He praised the team's innovation and commitment and highlighted the potential for this model to be expanded across the city. Read Daniel's thoughts on BSMHFT Connect.

NHS Oversight Framework

The new NHS Oversight Framework sets out a revised approach to assessing integrated care boards (ICBs), NHS trusts and foundation trusts for 2025/26. Its goals are to enhance public accountability for performance and improve the identification of providers that require support to improve.

The NHS Oversight Framework 2025/26 replaces the version published in June 2022, which was operational for three years and emphasised system working.

You can read about the key points of the framework here 2025/26 NHS Oversight Framework: what you need to know | NHS Confederation

We understand that implementation and first publication is likely to be in early September.

CQC Development

The work of the CQC to develop its future operating model and address the longstanding issues highlighted in the review report published earlier this year continues. A number of new appointments have been made to the Board including that of Dr Arun Chopra to a new role of Chief Inspector of Mental Health.I had the privilege of meeting Dr Chopra with Midlands and East of England MH CEO colleagues when he joined us at our July network meeting.

Our session was very helpful, positive and hopeful and Dr Chopra is clearly committed to working with the sector to develop a model of regulation that is meaningful and rooted in supporting improvement.

10 Year Plan

The NHS 10-Year Health Plan, titled "Fit for the Future", was officially launched on 3 July 2025 by the UK government. It outlines a comprehensive vision for transforming the NHS in England over the next decade. You can read about the 10 Year Plan in depth here: 10 Year Health Plan for England: fit for the future - GOV.UK, however, below are the key highlights:

The plan is built around three radical shifts:

1. From hospital to community – Moving care closer to home and reducing reliance on hospitals.
2. From analogue to digital – Embracing digital tools, AI, and data to modernize services.
3. From sickness to prevention – Prioritizing public health and early intervention to reduce illness.

To support these shifts, the plan introduces:

- A new operating model for the NHS.
- Greater transparency and accountability.
- A reimagined workforce model, aligning staff roles with future needs.
- A reshaped innovation strategy, focusing on AI, genomics, and precision medicine.
- A revised financial approach, aiming for sustainability and efficiency

The plan was co-developed through Change NHS, the largest public engagement on the NHS's future, launched in October 2024. Over 250,000 contributions were received from the public, staff, and stakeholders.

The Department of Health and Social Care (DHSC) and NHS England (NHSE) are working together to develop the delivery plan and have started this by setting up eight working groups to consider some of the details of delivery. We expect these to report on progress during September.

Roisin Fallon-Williams	**Vanessa Devlin**
Chief Executive	*Executive Director Operations*

Report to Board of Directors							
Agenda item:	**8**						
Date	6 August 2025						
Title	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 Trust Board Assurance Framework (BAF) to the Board of Directors for review, constructive challenge, scrutiny, oversight and assurance. It reflects the dynamic and iterative nature of the BAF and underscores the fact that strategic risks linked to the delivery of the Trust`s Quality, Clinical Services, People and Sustainability strategic priorities/objectives are effectively mitigated and managed as per the Trust`s Risk Management Policy and best practice.

2. Introduction:

The Board sets the overall risk appetite framework of the Trust, monitors the management of the BAF including significant operational risks, ensures accountability and that there is a robust risk management infrastructure in place as well as creates an enabling environment for a positive risk-aware culture to thrive. In fulfilling its oversight function, the Board also seeks assurance that strategic risks to the delivery of the Trust`s strategic priorities/objectives are effectively managed. The BAF thus plays two critical functions here: -

1. It serves as a structured strategic tool for driving strategic oversight.
2. And it serves as an assurance tool in assuring the Board of Directors and its Committees that strategic risks to the delivery of the Trust's strategic objectives/priorities are effectively and robustly mitigated and managed.

Key changes to this iteration of the BAF include:

BAF SR5 – There was some discussion at the FPP around the difficult financial position of the Trust in the light of the request from NHSE for it to develop a financial recovery plan and after some debate, members agreed on the recommendation for the current risk score of SR5 to be increased from Impact = 5 x Likelihood = 4 = 20 to a 5 x 5 = 25. Further amendments to SR5 post-FPP are highlighted in appendix 3 pending approval from the RMG on 21st August 2025.

There was also a request for the extension of an action due date from *30th June* to 30th *Sept 2025* to enable finalisation of the draft policy which is currently under review.

BAF SR7 – Request an extension of action due date (for the action around agreeing on a set of metrics), from *31st May 2025* to *31st Oct 2025* to allow for the metrics to be agreed, completed & shared with QPES in Aug, the SLT in Sept 2025 and socialisation thereafter.

Further changes and progress notes are highlighted in orange.

3. **Key issues and risks:**
   The main issue worth recognising is the fluid nature of the national context as characterised by the ongoing changes to the NHS landscape especially with the publication of the 10 Year Plan, NHS Oversight Framework 2025/26 etc, hence, there is need to ensure constant realignment to ensure the BAF to remains strategic, relevant and fit-for-purpose.

Strategic Priorities

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

Recommendation

The Board is *requested to:*

1. ***REVIEW*** *and* ***SCRUTINISE*** *the content of this BAF report.*
2. ***GAIN ASSURANCE*** *that strategic risks linked to the delivery of the Trust`s Quality, Clinical Services, People and Sustainability strategic priorities are effectively mitigated and managed.*

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
Appendix 6: 5 x5 Risk Scoring Matrix with Impact and Likelihood descriptors

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	**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	**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 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**

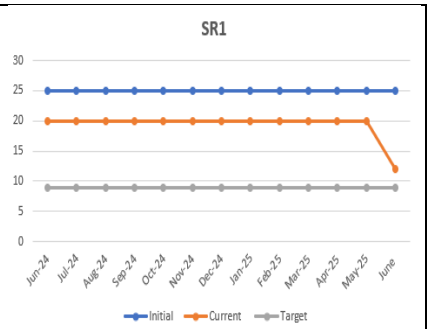
Table 2: Board Assurance Framework - Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic				SR5 SR6	
4 Major			SR1 SR2 SR4 SR8 SR9	SR3 SR7	
3 Moderate					
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	Likelihood	Risk score
					5	5	20
				DATE RISK WAS ADDED	June 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 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**	23rd June 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	▪ 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.

▪ Culture of Care-Incorporates Anti Racism ▪ Authentic Leadership programme	

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	• Diversity gaps in senior positions. • Gender pay gap. • Cost of living increases with AfC pay-scales not as competitive as some private sector roles.	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.

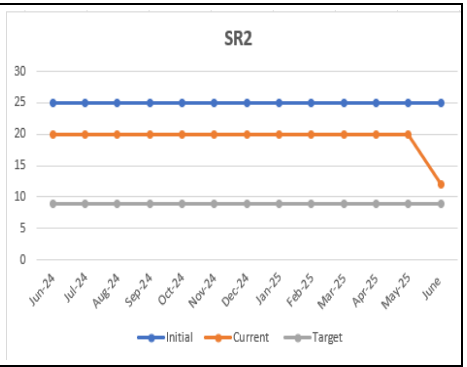
• Public Sector Equality Duty Report. • Reducing Health Inequalities Programme • Patient Carer Race Equality Framework. • Values In Practice feedback process. • Behavioral framework • Inclusive health & wellbeing offer. • Management essential and people related training. • Improved experience scores 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	• WRES and WDES indicators.		
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
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

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 4 x Likelihood 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	23rd June 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.

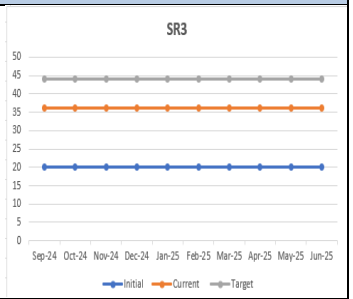
13 May 2025
Risk has been reviewed and a recommendation for a reduction in score suggested.

23rd June 2025
- Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

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	3rd July 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	• Clinical Governance structures from Ward/Team to Board. • Structure of recording on Rio means duplication and gaps – high admin burden.

• 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 Supervision	• Usability of ESR and documentation framework for RMS highlighted as a challenge. • 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 gaps at service and Trust level • Full implementation of Dialogue+ • Requirement to strengthen audit oversight with CEAG

ACTIONS PLANNED

Action	Lead	Due date	Update
Roll out of Culture of Care Programme across all in-patient areas during 2025/26	Executive Director Quality & Safety	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, commencing for Acute Wards in July. Culture of care (CofC) inpatients QI programme progressing well. Ardenleigh went live in June. Reaside and Hillis lodge's CofC – Live, Love, Life held first collaborative learning event. Acute care planning phase started, monthly Strategic Divisional group setup, soft launch planned July/August. First draft reviewed of the CofC QI programme measures dashboard based on the 12 CofC standards, supports the CofC Trust Assurance Framework in alignment with CQC 'I' statements. Four more pilot sites join the existing eight wards for National Culture of care (CofC) programme. Four Ward Managers undergoing the FoNS WM development programme. CofC Organisational support virtual sessions schedule finalised, focus on coproduction, Race equity, Trauma and LDA informed care, open to non-clinical and clinical colleagues. The Acute Wards will undertake the new self-assessment framework developed by the Trust for Culture of Care and CQC I and we Statements.
Ensure harm reduction and long-term support for physical health.	ED Q&S	26th March 2026	Physical health needs assessment completed, implementation plan to be completed
Improving safeguarding awareness and practice relating to service users and their	ED Q&S	27th February 2026	Designated safeguarding lead in place Domestic abuse quality account priority for 25/26

families/carers who experience domestic abuse.			We have collected data and intelligence (duty calls/incidents) from October 2025 and are undertaking benchmark analysis on this which will be presented to July SMB. This will inform the rest of the work (guidance, training, 7 min briefings etc. Met Dr John Kennedy as he is a subject matter expert and keen to support us with this work, to seek his support with this work.
Embed suicide prevention and safety planning approaches into routine clinical care across all services.	ED Q&S	31st March 2026	Implement Dialogue+ Training on safety planning Audit to follow Dialogue+ plus has been rolled out, to ensure long term sustainability it will be supported by video tutorials to aid understanding and delivery. A structured framework to support both clinical and management supervision has been constructed to embed practice and provide ongoing support. As part of our commitment to the National Collaborative for Safety Planning, we continue to engage in national support sessions and webinars, learning from best practice and shared experiences across the system. Key workstreams have now been identified, and we are in the process of developing a new safety planning form, which will be co-designed with service users over the coming months. Training modules have also been identified to support clinical assessment and formulation and planning. Conversations have started with our Safety Partners, who will be leading on the development of outcome measures, which will be coproduced. The overarching ambition is for the safety plans to be digitally accessible via the patient portal.

Ensure robust audit & assurance policies to ensure they are effective and reflect practice.	ED Q&S	26th March 2026	Policy review completed Audit framework in place aligning to all policies Policy audit proposal to go to Trust CGC in August 2025 with a commencement date of the proposed process from the 1st September through PDMG (paper available).
Improve Quality data and monitoring from a Trust and Divisional perspective (quality metrics and deep dives).	ED Q&S	27th February 2026	Culture of care metrics agreed for in-patient wards and a dashboard developed to reflect this. The draft assurance framework using the CQC 'I' and 'We' Statements mapped across the 12 Culture of Care Standards has been developed and specific metrics have been identified that determine success in each area. These have also been mapped across the 5 CQC domains of Safe, Caring, Responsive, Effective and Well-led. Initially this will be rolled out in the inpatient teams. The agreed framework will be used as the source of performance for teams and services.

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.	• Reaside regulatory notice environment and governance. • Reaside FTSUG Regional escalation. • Reaside CQC Report • External Audit Clinical Governance Review (18 recommendations). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation.	• 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.	• 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. • Staff training via e-learning and lack of assurance on competence

• Action in place in respect of the learning from Greater Manchester and Nottingham. • Physical Health Strategy	• Zinnia CQC report • PFD on learning identification through internal investigations • CQC Inspection 'North' Acute Wards • Serious incident Larimar Ward	• 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. • 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 • Safety Alert process	

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.

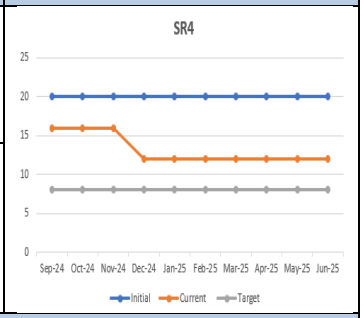
Transition of senior leadership roles in Nursing and Quality Directorate in support of new structure.

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.
10th June 2025 BAF risk reviewed, and new actions added following completion of the Quality Accounts.
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.
14th July 2025 BAF reviewed, Culture of Care Programme extended to Acute Wards, work on policy and audit happening with more pace.

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	23rd June 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**
Implement a range of opportunities and mechanisms for Service Users and Carers.	Chief AHP	31st March 2026	On track Patient councils underway in all divisions
Improve data collection and analysis to reduce patient inequalities.	Chief AHP	27th February 2026	On track – Dialogue + will support with this
Review oversight and reporting of quality metrics.	Chief AHP	31st March 2026	On track – Constructed in PEAR away day June 2025
To update the ToR of the PEAR Meeting to ensure a robust directorate representation and engagement.	Chief AHP	30th September 2025	On track – final refresh ready for launch in September 2025
To review the PEAR agenda and Forward plan to ensure these are robust.	Chief AHP	30th September 2025	On track – Constructed in PEAR Away day June 2025
Ensure a range of co-production and Co-delivery opportunities with EbEs – Optimise EbE resource pool.	Chief AHP	31st March 2026	On track – Recovery College, QI programme and EbE engagement pyramid in place

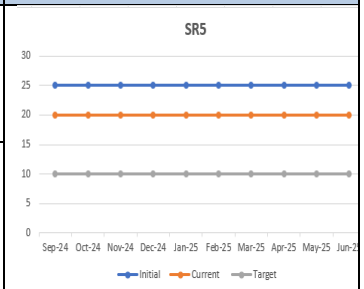
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• FFT • Healthwatch • EbE Observer project • Patient councils in Secure Care. Urgent care, CMHT and D&F.	• Community Mental Health survey 2024	• Monthly reports on participation and engagement presented QPES • QI Reports • Participation 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	• 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.

		escalated through PEAR.	
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.			
6th June New have been added as those which have been completed will be taken off.			
10th June 2025 BAF risk entries reviewed, and new actions added.			
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.			
11th July 2025 • Lead for actions changed to Chief AHP to reflect job description. • Terms of Reference for PEAR meeting are being refreshed to reflect chair as Chief AHP and co-chair once EbE has been recruited via expression of interest process. • New reporting process for PEAR meeting to ensure divisional participation is under constriction to be piloted in September 2026 meeting			

Appendix 3: 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	28th July 2025	

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.

• Development of Financial Recovery Plan	• Trust has not been able to develop a pipeline for delivery of savings. • Recovery Action Plans not having required financial impacts

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 Request extension of action due date till 30th Sept 2025 to enable finalisation of draft policy.	The financial management team have completed the first draft of the pricing policy, with input from the business development team, PMO and other teams, this is currently under review.
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	Actioned. Further amendments to improve efficiency of meeting and robustness of discussion to include merging Performance Delivery Group and the Strategy and Transformation Board – this should ensure discussions are aligned across all governance discussions
Financial Recovery Plan being compiled for submission to NHSE	Deputy Director of Finance	1st August 2025	NHSE have requested a financial recovery plan be submitted by 1st August 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.~~

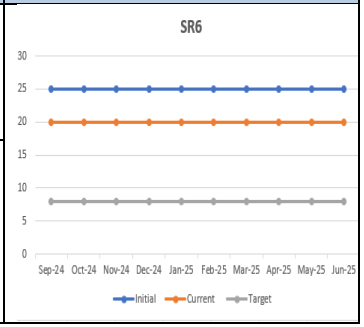
LINKED TO RISK REGISTERS/CRR RISKS	
108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.
112	The Trust does not secure the growth funding we require.
Update 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.	
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.	
11th July Actions have been reviewed and updated.	
28TH July – Financial Recovery Plan being developed for submission to NHSE on 1st August – once completed, an updated list of actions and assurances can be incorporated into BAF and relevant corporate risk register actions	

Appendix 4: 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	Likelihood	Risk score
					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 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	23rd June 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.
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

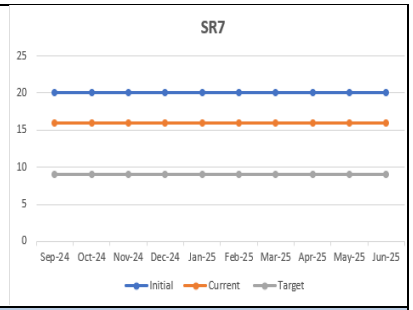
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Performance reported to FPPC. • Governance arrangements for monitoring the quality of care provided to patients in non-BSMHFT beds in place.	•	• 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.
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.	
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.	

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 • Regulatory oversight	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	3rd July 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 ▪ Not all wards covered by programme ▪ All ward self-assessment under new trust framework combining culture of care standards and CQC I and We Statements ▪ Use of Bank staff ▪ Training compliance for Bank staff

ACTIONS PLANNED

Action	Lead	Due date	Update
Culture of Care Develop an assurance framework reflecting the CoC standards and CQC "I statements".	Executive Director Quality & Safety	27th February 2026	Framework completed, to go to QPESC July 20205

Implementing NHSE/CQC Community Standards Develop and implement Clinical Education Framework aligned with CoC standards and Community standards.	ED Q&S	31st March 2026	NHSE standards not yet available, currently reporting on the learning from Nottingham
Promote models of visible leadership, civility and team building.	ED Q&S	27th February 2026	Executive and Non-Executive visits continue, QPESC visit planned for Reaside Clinic 16th July
Ensure and monitor utilisation of e-roster providing assurance on safer staffing and use of resources and build substantive teams, minimising the use of bank resources.	ED Q&S/CFO	31st March 2026	E-roster training completed E-roster rules agreed and monitored through the Safer Staffing Group Additional levels of authorisation agreed Bank reduced in professional services, ICCR and Acute, not yet to plan
Agree a set of metrics aligned to the programme.	EDQ&S/CFO	31st May 2025 Request extension of action due date till 31st Oct 2025 to allow for metrics to be agreed, completed & shared with QPES in Aug, the SLT in Sept 2025 and socialisation thereafter.	Work underway with National Programme to develop metrics. Alignment of CQC I Statements to the 12 core standards in the CoC Programme. The draft framework detailing the metrics has now been shared with Executives with positive feedback, and a meeting has been arranged for July 10th to discuss the proposed metrics with the Information Team to agree source of reporting for all identified metrics. The plan is to then share the finalised document firstly at QPESC in August and then at Senior Leaders Forum in September and commence the socialisation process.
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:	• Reaside regulatory notice environment and governance.	• Ongoing culture of care and leadership external review of Reaside.	• Lack of real time safety data to triangulate information.

• Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting. • Participation Experience and Recovery (PEAR) Group.	• Leadership and culture issues identified at Reaside which are being tackled. • Reaside FTSUG Regional escalation. • Zinnia regulatory notices. • Acute Wards Regulatory Inspections, patient acuity and incidents	• 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).	• 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.

10th June 2025
BAF risk entries reviewed, and new actions added.

23rd June 2025
- Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

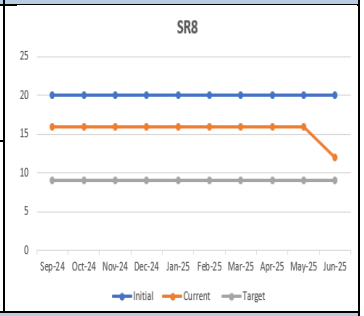
14th July 2025
Launch for Acute Wards this month, some leadership changes and additional matrons in recruitment, Improvement lead in place to support programme alongside Exec leadership, QI support and commissioning support

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 service user recovery and	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.	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	Likelihood	Risk Score
			4	5	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	23rd June 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity.	• Limited assurance from current approach to review of quality and governance metrics at Divisional level. • Limited reporting of Divisional quality reviews to QPES and Board.

• 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. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work.	• 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.

• 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	30th November 2025	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.	• Highlight and escalation reporting to	• Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard.	• The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on

• 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.	Strategy and Transformation Board. • Reports to QPES Committee.	• 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.	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.

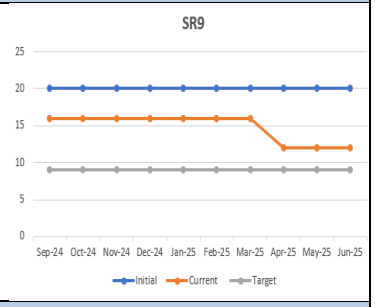
24th October 2024
Divisions have now completed their divisional health inequalities plans.

24th April 2025
Risk reviewed and new controls and actions have been added.

23rd June 2025

- Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

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.	• 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	QPES	Executive Director of Operations.	SR3 SR4 SR8

			• Lack of service user voice in informing service transformation. • Lack of support for and involvement of families and careers. • The difficult financial landscape.	community not available.			
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	23rd June 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.				• 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			

• System approaches to improving and developing services. • Solihull Children and Young People Transformation. • 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.	intelligence about our population and needs.

ACTIONS PLANNED

Action	Lead	Due date	Update
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.
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

Appendix 6: 5x5 Risk Scoring Matrix with impact and likelihood descriptors

The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) below provides a supportive framework and guidance for quantifying and scoring risks. Staff are encouraged to use this tool in reviewing and agreeing on risk scores!

Measures of likelihood – likelihood scores (non-financial risks):

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur **at least annually.**	Expected to occur **at least monthly.**	Expected to occur **at least weekly.**	Expected to occur **at least daily.**

Measures of Likelihood – likelihood scores (financial risks):

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur in the current or next year	Unlikely to occur during the current or next year.	Could easily occur during the current or next year.	Will probably occur during the current or next year.	Definitely will occur during the current or next year.

Measures of Consequence – Domains, consequence and examples of score descriptors

Type of Risk	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention. Requiring time off work <3days. Increase in length of hospital stay by 1-2days.	Moderate injury requiring professional intervention. Requiring time off work 4-14 days RIDDOR/agency reportable incident An event that impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work >14days. Increase in length of hospital stay by >15days. Mismanagement of patient care with long term effects.	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients.
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal	Overall treatment or service sub-optimal Formal complaint (stage 1)	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2)	Non-compliance with national standards with significant risk to patients if not resolved.	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if findings not acted on

Type of Risk	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
	Informal complaint or inquiry	Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved.	Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Multiple complaints / independent review Low performance rating Critical report	Inquest / Ombudsman inquiry Gross failure to meet national standards.
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day).	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>1day). Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objectives / service due to lack of staff. Unsafe staffing levels or competence.	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training / key training on an ongoing basis.
Statutory duty / Inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved.	Single breech in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breeches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable. public expectation.	National media coverage with >3days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Type of Risk	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget. Schedule slippage.	<5-10% over project budget Schedule slippage	Non-compliance with national 10-25% over budget project. Schedule slippage. Key objectives not met.	Incident leading >25% over project budget Schedule slippage. Key objectives not met.
Finance – including claims	Non delivery/Loss of budget to value of <£10K	Non delivery/Loss of budget between £10K and £100K.	Non-delivery/Loss of budget between £100K and £500K.	Non delivery/Loss of budget between £500K and £2M.	Non-delivery/Loss of Budget of more than £2M.
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Measures of Consequence – Additional guidance and examples relating to risks impacting on the safety of patients, staff or public.

Type of Risk	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information / communication on transfer of care	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation,	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis

Type of Risk	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		counselling – no time off work required	Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	fracture, blow to the head Loss of limb Post-traumatic stress disorder	Incident leading to long-term mental health problem Rape / serious sexual assault

5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)

	Almost Certain	5 Yellow	10 Yellow	15 Red	20 Red	25 Red
	Likely	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	Possible	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	Unlikely	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	Rare	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	9
Date	6 August 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 to note for consideration by the Committees on which they need to provide assurance to the Board are as follows:

- **NEW:** NHSE Oversight framework for 2025/26 published. Further technical guidance awaited.
- **NEW:** National target thresholds for Talking Therapies recovery rates have increased from April 2025
- 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.
- Inappropriate and Appropriate Out of area placements, remain a key priority area for improvement. June figure for inappropriate out of area placements at 12 PICU patients above trajectory of 10.
- Clinically ready for discharge remains high in both Adult and Older Adult services and continues to impact on available Trust capacity to repatriate out of area placements for adult inpatients. System level escalations continue to be taken.
- 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.
  As at Month 3 there is an income deficit of £206k related to underperformance on activity to date.
- 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. Adult and older Adult LOS below national trajectories this month.
  NEW: As requested at June 2025 FPPC, LOS data has been provided for active, current patients (Appendix 1 slide 4: Adults/ Older Adult LOS Trajectory 2025/26).
- Eating disorders routine waiting times performance at 90%, below 95% national target (1 patient).
- Both Talking Therapies waiting times targets for 6 and 18 weeks are sustainably being achieved.
- Formal review of service users within last 12 months now reliably in upper 90% levels.
- 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.
- Sickness – has remained at 4.9%.
- Bank and agency reduction – below trajectory for bank and just above for agency.
- Appraisals – has remained at same level.
- Vacancies – Vacancy rate at 7.5%, in May. June data not available
- Fundamental Training decreased in last month and below 95% target
- Incidents of Self Harm have decreased from 156 to 108
- Ligature incidents with anchor point – 1 incident this month

- Patient assaults have fallen from 59 to 35 in last month
- Prone restraints have fallen from 56 to 38 in last month
- Staff assaults have fallen from 116 to 96 in last 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 June 2025, there has been no Performance Delivery Group meeting, and two Service area deep dive meetings held. Updates and outcomes on both are provided in the report.

Members are reminded that at the request of FPPC, there is a continued focus on selected metrics for improvement. Table 1 below 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			Deterioration in last month and in line with national trajectory for the first time	1-2, 10-12
People				
Vacancies			June data not yet available	4
Sickness			June data has remained at 4.9%	4, 20-21
Appraisals			Remains at 80% and below improvement trajectory and 90% Trust standard	4, 22-23
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 (47.71%) and below national 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last month (43.60%) and below national target of 48%	3, 17-18
Talking Therapies Reliable improvement rate			Improving trend in last month (66.32%) and below national target of 67%	3, 15-16
Clinically Ready for Discharge: percentage of bed days			Improvement in last month. June 2025 at 14.15%.	3, 13-14
Clinically Ready for Discharge: Number of delayed days			Improving trend in last month. June 2025 at 2242 bed days.	3, 13-14
Eating Disorders National Access standard - routine			Deterioration in last 2 months to 90% (1 patient - small number effect)	3

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Deteriorating trend in last 2 months (92.7%) below trust target of 95%.	4, 24-25

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incidents resulting in self harm			Decreasing trend in last 3 months. Reviewed at QPES.	4, 26
Absconsion from inpatient units			Increased to 3 in last month from 2. Reviewed at QPES.	4, 27
Ligature with anchor point			Has decreased to 1 from 2 cases this month	4, 28
Patient assaults			Decreased from 59 to 35 in last month	4, 29
Prone restraints			Decreased from 56 to 38 in last month	4, 30
Staff assaults			Decreased from 116 to 96 in last month	4,31

Strategic Priorities

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

Recommendation

FPPC is asked to note the latest performance position and update on areas identified for improvement.

Enclosures

July 2025 Performance Report and Integrated Performance Dashboard

Appendix I FPPC July 2025 FPPC Performance Improvement Metrics

Appendix Ia FPPC July 2025 Talking Therapies Recovery Action Plan Summary

Appendix II FPPC July 2025 Performance framework update

Appendix IIa Secure and Offender Health (focus on Ardenleigh, HJVS and Offender Health services)

Appendix IIb Acute and urgent care (focus on North Inpatients service)

Integrated Performance Report

Context

The Integrated Performance Dashboard and 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.

Commentaries are provided by the KPI owners.

Ibased on previous FPPC feedback, t 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 two deep dive meetings focusing on Acute and Urgent care and Secure and Offender Health – see Appendix II.

NEW: NHSE Oversight Framework 2025/26

NHS England recently published a one-year framework that will be reviewed in 2026/27 to take account of ICB reorganization and the 10-year plan.

In summary, the 2025/26 framework sets out how NHSE will assess providers and includes a range of metrics covering 6 domains which will be used to provide each organisation with an individual delivery score of between 1 (high performing) - 4 (low performing). A financial override will also be used to limit organisations to no higher than segment 3 where they are in deficit or in receipt of deficit support. The domains include:

- Access to services
- Effectiveness and experience of care
- Patient Safety
- People and Performance
- Finance and Productivity
- Improving health and reducing inequality (non scoring)

Not all the metrics in the domains contribute to the scoring.

Each provider's organisational delivery score and final segmentation will be published alongside the individual metric scores used to calculate them.

Technical guidance is awaited to understand the scoring methodology and the metric definitions before we can further assess the trust's current position. NHSE's segmentation score for Trust's has yet to be published.

Organisations with low segment scores will receive additional scrutiny and support from the ICB and NHSE experts in the areas underperforming.

Trust Performance in June 2025

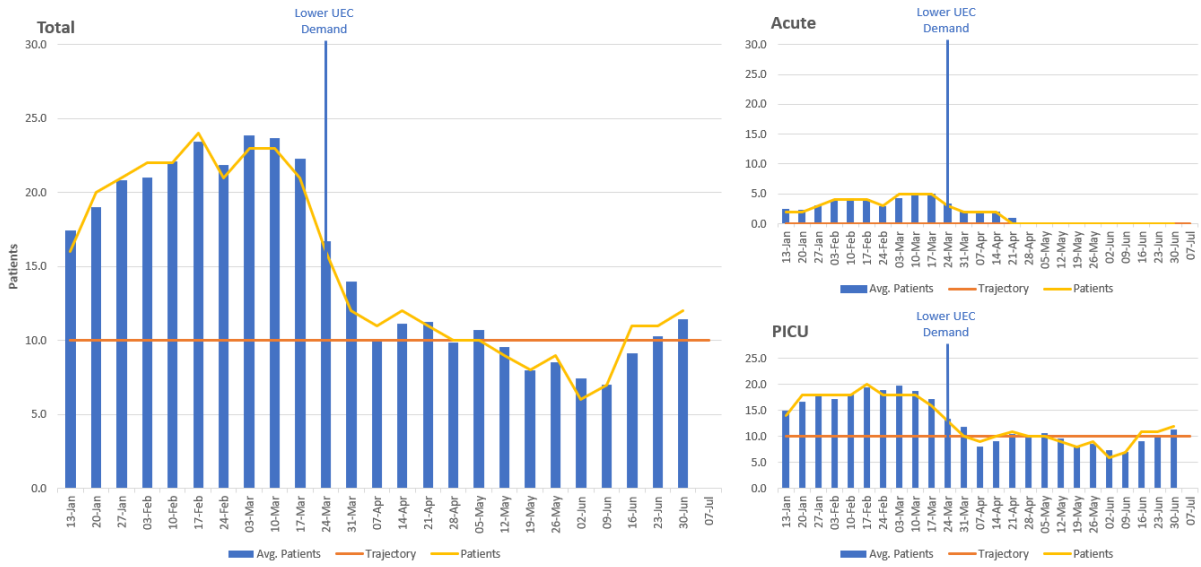
In summary, the key performance issues facing us as a Trust have changed little over the last few years, although there have been improvements against some of the metrics in recent months:

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 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 June 2025, there were 0 acute (target 0) inappropriate placements and 12 PICU (target 10) patients. The number of new inappropriate admissions during the month was 12, an increase from the previous month.



A more detailed update on the productivity plan and actions for 2025/26 was provided by the lead Associate Directors at May FPPC's meeting and an update on the quarter 1 action plan has been provided in Appendix 1. Quarter 1 actions focused on reviewing existing plans with confirmed 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. The adult and Older adult LOS remains under trajectory for June with non-trusts beds being slightly over trajectory.

Based on FPPC feedback at the June 2025 meeting additional information has been provided showing the trajectory, a comparison to current Length of stay and the number of discharges. This can be found in Appendix 1, slide 4; Adults/ Older Adult LOS Trajectory 2025/26

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 was shared at May's FPPC meeting and this month's report has been updated on June's position on activity and income trajectory. The action plans remain in place. In summary, these are focused on:

- 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.

The local activity and income trajectory for Birmingham Healthy Minds is above trajectory but remains under the ICB activity plan requirements, incurring a deficit of £206,038 for April - June 2025.

NHSE have increased the target thresholds for talking therapies recovery rates. These are

reflected in the performance report. Reliable Recovery rate standard has increased to 50% (from 48%) and Reliable Improvement rate to 68% (from 67%).

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 14.15% (a small reduction). The main drivers for this are delays in both adult and older adult acute services. CRFD in June 2025 in Adult Acute & Urgent Care was at 15.3% (57 patients) and in Older Adult Services at 36.1% (31 patients).

The main reasons for the delays in adult acute care are delays in allocation of a social worker and supported accommodation 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 to support escalated discussions are also continuing.

Eating Disorders National Access Standard – Routine referrals (to be seen within 28 days):

Performance is marginally below the national 95% standard this month, reducing to 90%. However, it should be noted that due to overall small volumes of patients in this cohort, this reduction relates to one patient who was assessed and commenced treatment outside the 28-day target.

Quality - The detailed position on these metric areas is discussed at QPES committee. For information, a summary of the key performance changes is outlined below.

- Incidents of self harm have reduced from 156 to 108 in last month (decrease in Acute inpatients, Secure CAMHS)
- Absconsions from inpatient units have increased from 2 to 3 this month
- Ligature with anchor point – has reduced to 1 (from 2) this month
- Patient assaults have fallen from 59 to 35 in last month (decrease in Acute inpatients)
- prone restraints fallen from 56 to 38 in last month (decrease in Secure women and Acute inpatients)
- Staff assaults have fallen from 116 to 96 (decrease in acute inpatients & older Adult 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 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 June show that bank WTE is below trajectory at 615 WTE and agency is just above trajectory at 39 WTE

- Staff Appraisals at 80.0% as at June 2025, below improvement trajectory and below the 90% Trust standard.

  L&D are ccontinuing to raise compliance and Monitoring and reviewing the system and process to improve user experience.

- Staff vacancy levels Vacancy rate at 7.5% in May. June data not yet available.

- Mandatory Training at 92.7%, deterioration in month below the 95% target. The reduction is due to the grace period for patient safety level 1 and 2 coming to an end.

Sustainability – (details in finance report)

Integrated Performance Dashboard

June 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	2242 ↓
Clinically Ready for Discharge: Bed Days (%)	14 ↓
CPA 3 Day Follow Up (%)	83
CPA 7 Day Follow Up (%)	91
Eating Disorders: Waiting Time - Routine (%)	90 ↓
Eating Disorders: Waiting Time - Urgent (%)	100 ↑
First Episode Psychosis: Waiting Time (%)	100
Out of Area: Inappropriate Placement Bed Days	264 ↑
Out of Area: Inappropriate Placements Active	12
People on CPA with a Formal Review in last 12 Months (%)	96 ↑
Referrals over 3 Months with no Contact	3651 ↓
Talking Therapies: Reliable Improvement Rate (%)	66
Talking Therapies: Moving to Recovery (%)	48
Talking Therapies: Reliable Recovery Rate (%)	44
Talking Therapies: Seen in 18 Weeks (%)	100 ↑
Talking Therapies: Seen in 6 weeks (%)	94 ↑

People

Bank & Agency Fill Rate (%)	95 ↑
Fundamental Training (%)	93
Staff Appraisals (%)	80 ↑
Staff Sickness (%)	5 ↑
Staff Turnover: Rolling 12m (%)	5 ↑

Quality

Absconsions from Inpatient Units	3
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	2 ↓
Failure to Return	14
Harm (physical) – patients (%)	16
Harm (physical) – staff/third party (%)	4 ↑
Harm (psychological) – patients (%)	16
Harm (psychological) – staff/third party (%)	2
Incidents of Self Harm	108 ↑
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	17
Ligature with Anchor Point	1
Patient Assaults	35 ↑
Patient Assaults / 1000 OBDs	1.9 ↑
Physical Restraints	246 ↗
Physical Restraints / 1000 OBDs	13.1
Prone restraints	38
Prone restraints / 1000 OBDs	2.0 ↗
Reported Incidents	2697
Staff Assaults	96
Staff Assaults / 1000 OBDs	5.1

Sustainability

Agency as % of Pay Spend	1
Agency Staff Spend	£320k ↑
Bank as % of Pay Spend	9 ↑
Capital Expenditure	£370k
Cost Improvement Programmes	£2,189k
Group Cash Balance	£83,597k
Info Governance (%)	100
Operating Surplus	-£384k

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

Last refreshed 14th July 2025

Integrated Performance Dashboard

June 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Clinically Ready for Discharge: Bed Days		2140	1968	2716	2405	2543	2242 ↓
Clinically Ready for Discharge: Bed Days (%)		13	13	17	15	16	14 ↓
CPA 3 Day Follow Up (%)	80	80	81	89	78	85	83
CPA 7 Day Follow Up (%)	95	87	92	96	90	94	91
Eating Disorders: Waiting Time - Routine (%)	95	92	88	100	100	90	90 ↓
Eating Disorders: Waiting Time - Urgent (%)	95	100	100			100	100 ↑
First Episode Psychosis: Waiting Time (%)	60	50	100	100	100	100	100
Out of Area: Inappropriate Placement Bed Days	328	591	646	765	379	345	264 ↑
Out of Area: Inappropriate Placements Active	10	20	25	20	12	10	12
People on CPA with a Formal Review in last 12 Months (%)	95	97	97	97	97	97	96 ↑
Referrals over 3 Months with no Contact		3920	3959	3893	3758	3789	3651 ↓
Talking Therapies: Reliable Improvement Rate (%)	68	61	59	65	67	63	66
Talking Therapies: Moving to Recovery (%)	50	48	50	48	49	46	48
Talking Therapies: Reliable Recovery Rate (%)	50	45	46	44	45	43	44
Talking Therapies: Seen in 18 Weeks (%)	95	98	100	99	100	100	100 ↑
Talking Therapies: Seen in 6 weeks (%)	75	92	93	95	94	93	94 ↑

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

Integrated Performance Dashboard

June 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Bank & Agency Fill Rate (%)		91	94	94	96	95	95 ↑
Fundamental Training (%)	95	95	95	96	96	94	93
Staff Appraisals (%)	90	80	81	79	79	80	80 ↑
Staff Sickness (%)	4	6	6	5	5	5	5 ↑
Staff Turnover: Rolling 12m (%)		6	6	6	6	6	5 ↑
Staff Vacancies (%)		9	9	8	8	8	

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

Integrated Performance Dashboard

June 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	
Absconsions from Inpatient Units		5	2	2	2	2	3	
Commissioner Reportable Incidents		0	0	0	0	0	0	
Community Confirmed Suicides		0	0	0	0	0	0	
Community Suspected Suicides		1	1	3	2	0	2	↓
Failure to Return		15	13	16	9	11	14	
Harm (physical) – patients (%)		21	21	21	23	19	16	
Harm (physical) – staff/third party (%)		5	6	5	6	6	4	↑
Harm (psychological) – patients (%)		17	19	16	17	15	16	
Harm (psychological) – staff/third party (%)		1	2	2	2	2	2	
Incidents of Self Harm		224	205	223	213	156	108	↑
Inpatient Confirmed Suicides		0	0	0	0	0	0	
Inpatient Suspected Suicides		1	0	0	0	0	0	
Ligature no Anchor Point		20	11	25	20	29	17	
Ligature with Anchor Point		0	2	2	4	2	1	
Patient Assaults		33	27	26	28	59	35	↑
Patient Assaults / 1000 OBDs		1.7	1.5	1.4	1.5	3.1	1.9	↑
Physical Restraints		227	293	347	277	259	246	↗
Physical Restraints / 1000 OBDs		11.7	16.8	18.2	14.8	13.4	13.1	
Prone restraints		56	67	77	57	56	38	
Prone restraints / 1000 OBDs		2.9	3.8	4.0	3.1	2.9	2.0	↗
Reported Incidents		2642	2410	2605	2495	2535	2697	
Staff Assaults		91	79	94	112	116	96	
Staff Assaults / 1000 OBDs		4.7	4.5	4.9	6.0	6.0	5.1	

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

Integrated Performance Dashboard

June 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	
Agency as % of Pay Spend		2	2	1	3	1	1	
Agency Staff Spend		£372k	£372k	£482k	£348k	£383k	£320k	↑
Bank as % of Pay Spend		11	11	8	12	10	9	↑
Capital Expenditure		£1,333k	£1,705k	£3,620k	£56k	£597k	£370k	
Cost Improvement Programmes		£2,586k	£2,102k	£1,732k	£1,263k	£2,166k	£2,189k	
Group Cash Balance		£88,234k	£87,860k	£86,352k	£76,375k	£78,998k	£83,597k	
Info Governance (%)		94	96	86	95	95	100	
Operating Surplus		£378k	£1,016k	£7,864k	-£1,070k	£1,204k	-£384k	

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

Out of Area: Inappropriate Placements Active

June 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

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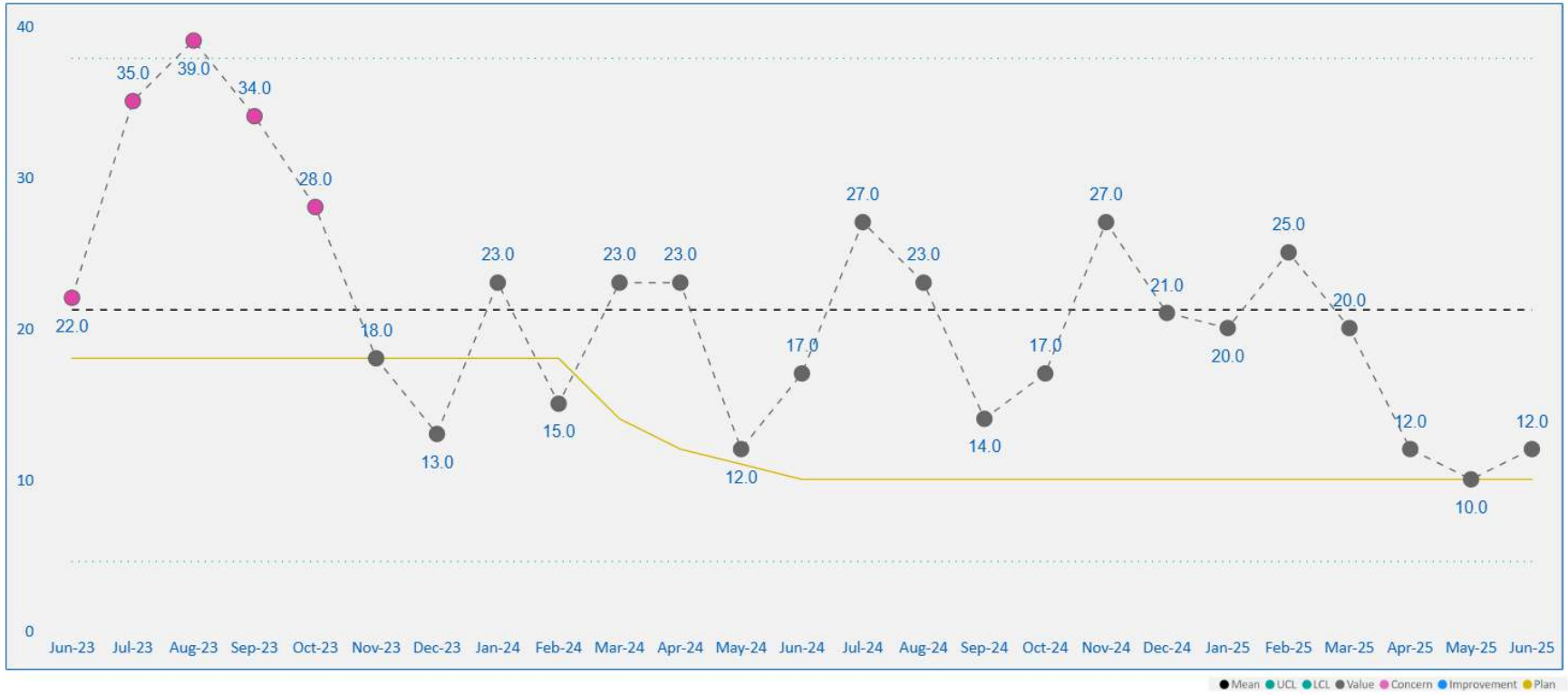
Trust

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. June has shown a small increase to 12 placements with 0 in acute beds and 12 in PICU beds above the trajectory of 10 for June 2025. There were 12 inappropriate admissions during June, a small increase from last month with 0 acute and 12 PICU. 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 2242 overall in June with adults at 1,023 lost bed days which equates to 15.3%, a reduction of 2.1%. Adult bed occupancy has remained at 97.5% and length of stay has decreased to an average of 107 days in June. 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.

Question	Answers
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?	A OOA reduction programme is in place with 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 and Q1 actions include: Admission avoidance • Commence Bed Management medical oversight. Impact: Ensures efficient use of bed resources, supporting purposeful admissions and avoiding unnecessary ones. • Adopt new admissions process where no admission from 10pm-9am unless it's a planned warrant for a patient we don't know. Impact: Reduction in inappropriate admissions • Revise and update Locality/Gatekeeping SOP. Impact: Ensure key documents reflect current/agreed processes that standardises good practice. Actions inlcude: The locality and Gatekeeping SOP has been revised. strengthening link with ICCR and CMHTs to support earlier intervention, processes to reduce spot purchase of out of area beds and high level clinical and executive support to manage pressures from general hospitals to admit ED patients Inpatient Care & Reducing Length of Stay • Implement Out of Area In-Reach SOP. Impact: Standardises processes for managing out-of-area patients, improving care coordination and reducing length of stay. • Introduce a protocol where NO spot purchase beds permitted to utilise. Hold 1 male bed per ward to enable repatriation. Impact: Aligns to the financial recovery plan to achieve required cost reduction. Actions include: Recruitment to Advanced Clinical Practitioner roles underway to assist in increasing workforce capacity to support at ward level and processes to reduce spot purchase of out of area beds. Paper written outlining plan to use 2 additional beds at weekends to avoid spot purchaseing of beds. Working version of inreach SOP is in place and being ammended to reflect CYP. Discharge Planning and Support • Introduce tighter structure and mechanism for accountability, monitoring and reporting. Impact: Clear goals and processes in place for LOS and Discharge Actions inlcude: List of service users with a length of stay of over 100 days has been forwarded to LA team to actively support discharge planning and discharge readiness discussions and a forum has been set up with the LA to discuss challenges in delayed discharges and how this can continue to be actively supported by their priority discharge team. Planned increase to matron roles with less wards to focus efforts and improve flow.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Clinically Ready for Discharge: Bed Days

June 2025

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Click here to follow link

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 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. June has seen a decrease from last month to 2242 days with Adults moved from 1,204 days in May to 1,023 days in June, which related to 57 patients, with a main delay reason of Social Worker allocation and suported accomodation and older adults moved from 874 days in May to 739 in June and related to 31 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 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 have been 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

June 2025

PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Click here to follow link

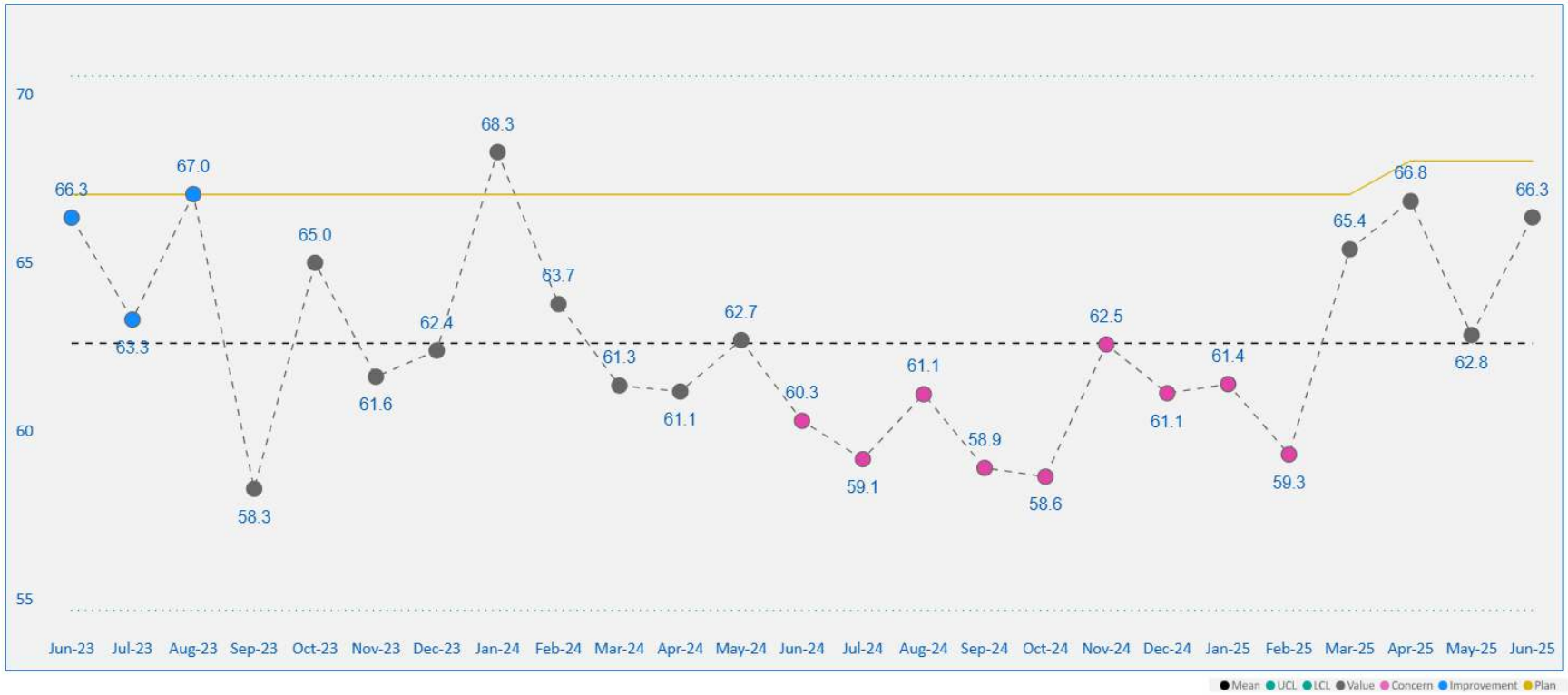
Trust

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?	This was a new national metric for 2024/25 with an increased focus on recovery and the target has increased 68% from April 2025. June 2025 has shown an increase to 66.32%, below the 68% 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 68% 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 68% Reliable Improvement rate.

Talking Therapies: Reliable Recovery Rate (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

June 2025

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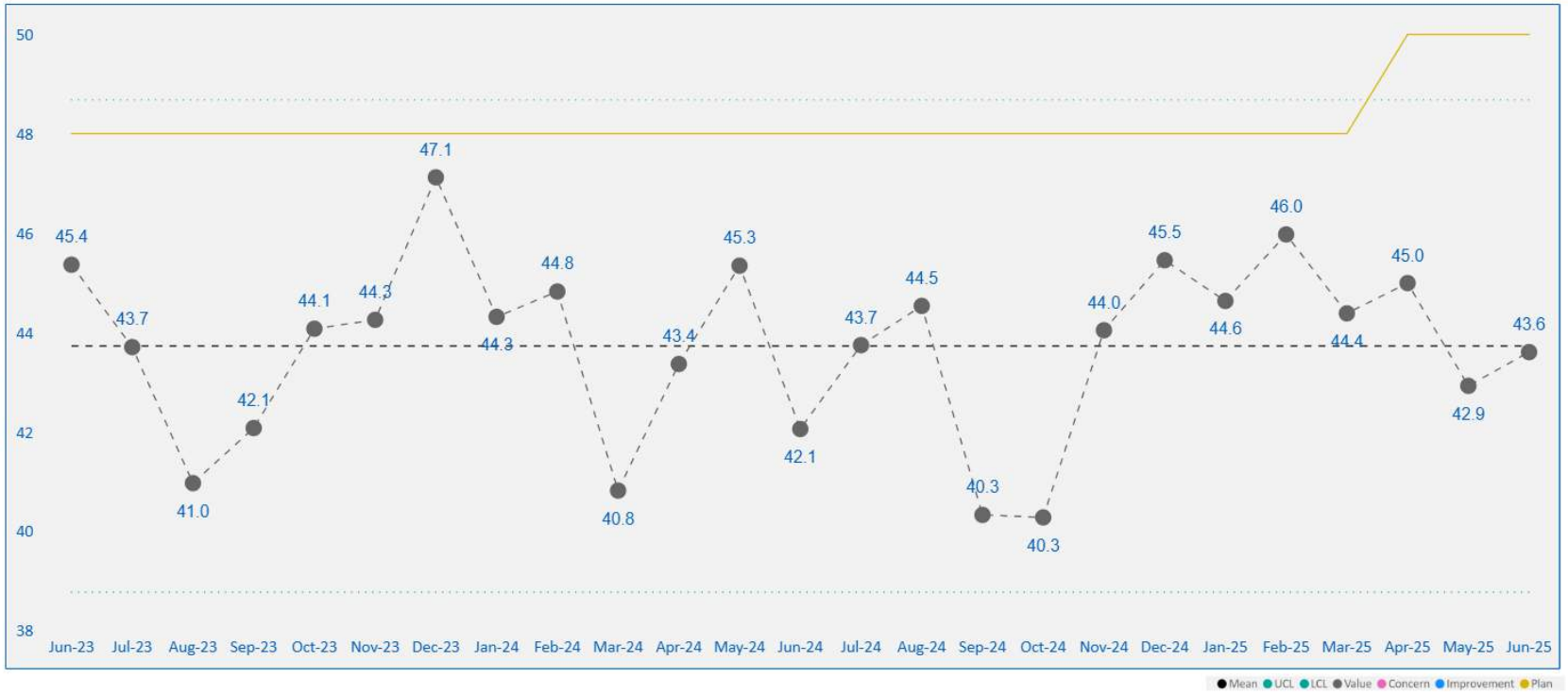
*All means and SPC control limit calculations are based on data for the last 25 months



Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery and the target has increased 50% from April 2025. The Reliable Recovery rate has fluctuated and is not meeting the 50% target. June 2025 position has increased to 43.6% 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 50% 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 50% 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 50% Reliable Recovery rate.

Staff Sickness (%)

May 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 June 2025 has remained at 4.9% the same as the previous month
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 targeted 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.

Staff Appraisals (%)

May 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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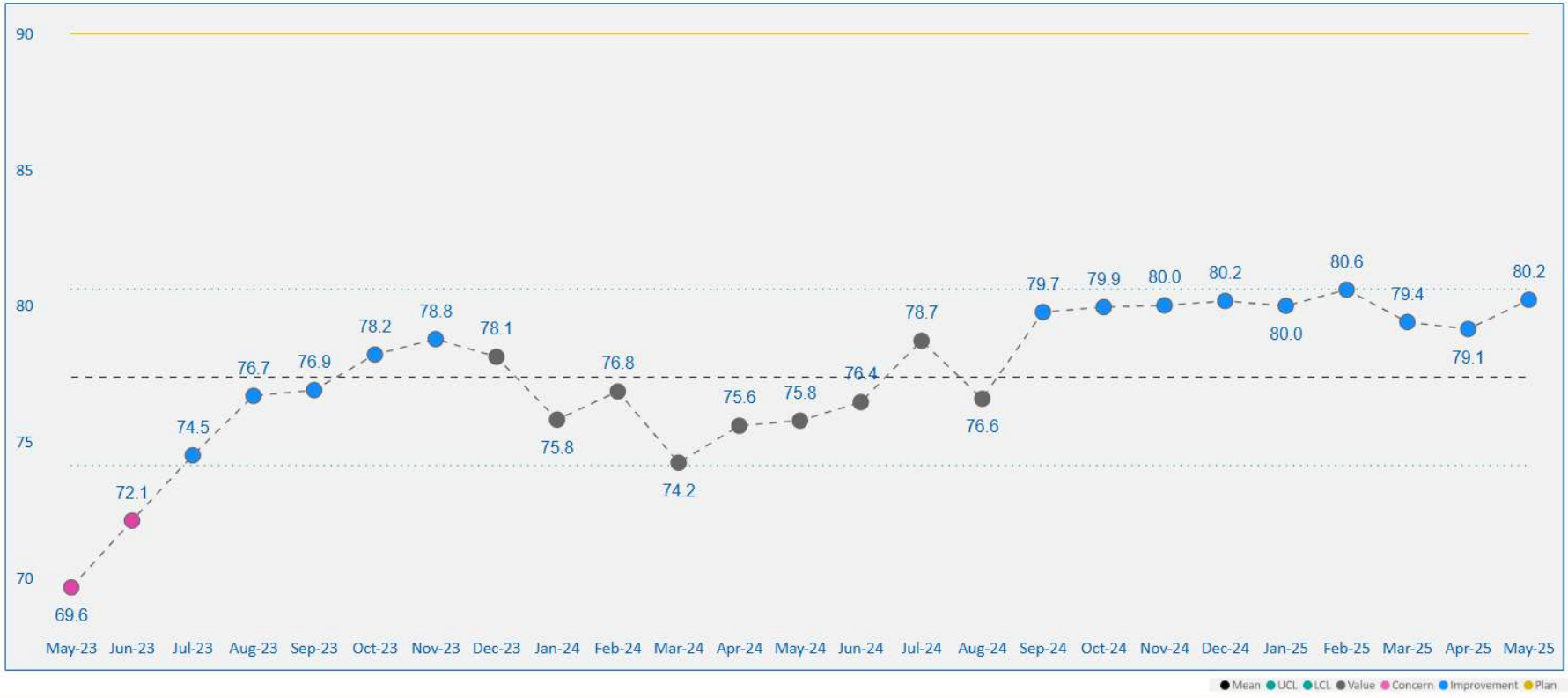

Question	Answers
A: What has happened?	Data for June showed overall compliance at 80% from 80.01% in May. This remains below Trust target of 90 % and commissioners target of 85%.
B: Why has it happened?	Hot spot areas have been target and managers contacted (teams call) to offer support if no response initial chase email.
C: What are the implications and consequences?	The above information is not indicative of a trend as only one month. But would expect appraisal compliance to continue improve if the wrap around support for team managers and staff is influencing the rise in compliance
D: What are we doing about it?	Continuing current practice to raise compliance and Monitoring. Continue to review system and process to improve user experience. L&D are supporting the exclusion of the psychology trainees from overall report as this should improve overall compliance NB- FTB compliance will potentially have a negative impact on overall compliance.
E: What do we expect to happen?	would expect appraisal compliance to continue improve
F: How will we know when we have addressed issues?	When we have 3 months consistently at 85% compliance. FTB areas will be treat as hot spot areas August onwards to mitigate against fall in compliance.

Fundamental Training (%)

June 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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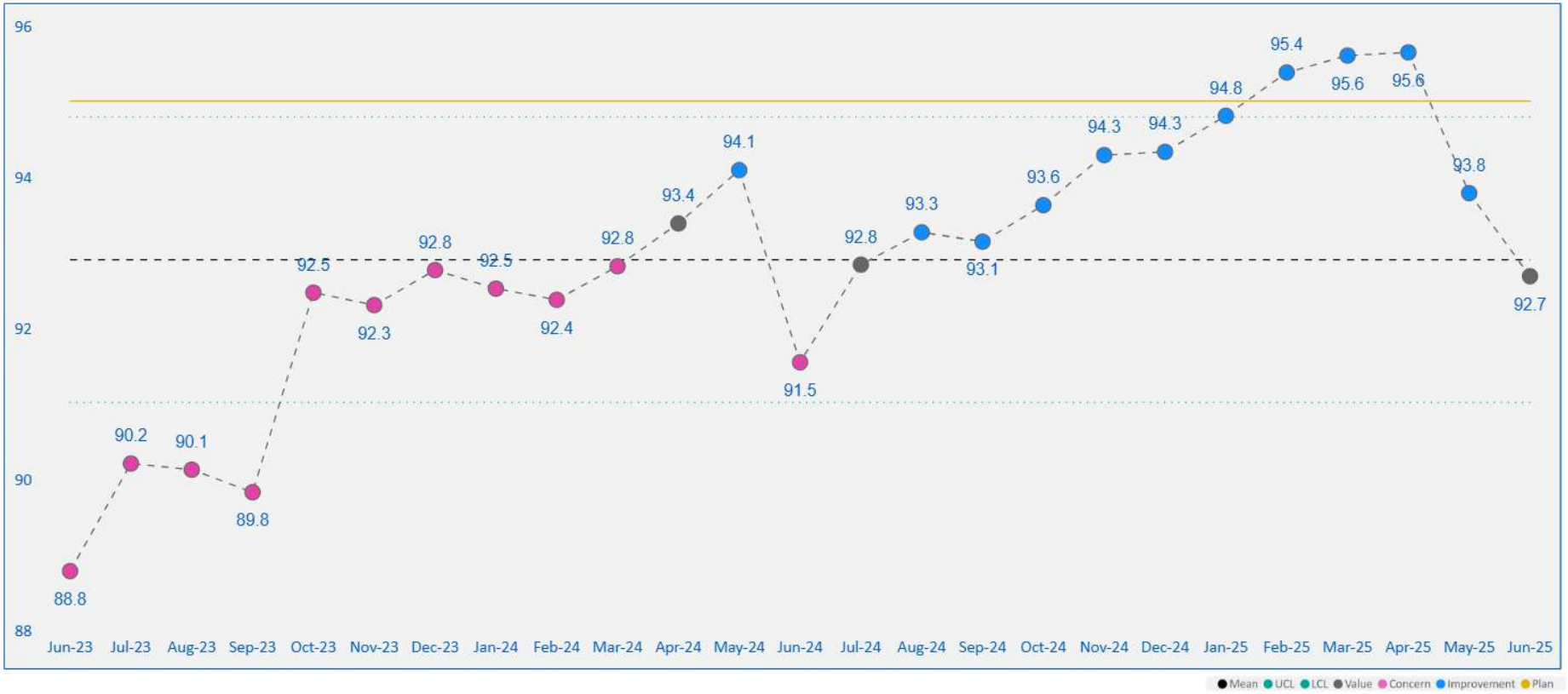

Question	Answers
A: What has happened?	Fundamental Training compliance decreased from 93.8% in May to 93.1% in June, falling below the Trust's 95% target for substantive staff, though remaining above the Commissioners' target. Areas currently below 95% compliance include: - Chief Exec - 77.1%, - Exec Director - Medical- 91.8% -Exec Director - Nursing - 92.1% - Acute and Urgent Care- 93.3% -ICCR 93.4% -Specialties - 93.5% -Exec Director - Resources 94% - New Care Models - 89.1%, - Strategy, People and Partnerships - 91.2% Temporary staffing compliance also declined from 91.5% to 87.7%, but remains above the Trust's 75% target.
B: Why has it happened?	We continue to have a recovery plan in place for all courses that are below 95% however we have not met the 95% target this month due to the grace period for Patient Safety Level 1 and Patient Safety Level 2 coming to an end last month and in June Dual Diagnosis's grace period came to an end. This training had a significant impact on compliance because all staff must be complete Patient Safety Level 1 and 1695 staff must complete Patient Safety Level 2. Dual Diagnosis is required by 3649 staff. We have a few subjects that are currently in their grace period but will effect compliance once the grace periods come to an end (Moving and Handling Level 2 November 2025 Oliver McGowan Tier 1 and 2 August 2026). The following subjects are below 90%: CRAM 89.8%, Dual Diagnosis 83.1%, MCA 83.9%, MHA 83.9%, PS L1 84.3%, PS L2 70.2%, ELS 81%, ILS 88.5%, SRS 61%
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 and this can impact on the overall Trust compliance. • 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 the rest of 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 below 95% due to the end of the grace period for Dual Diagnosis. 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

June 2025

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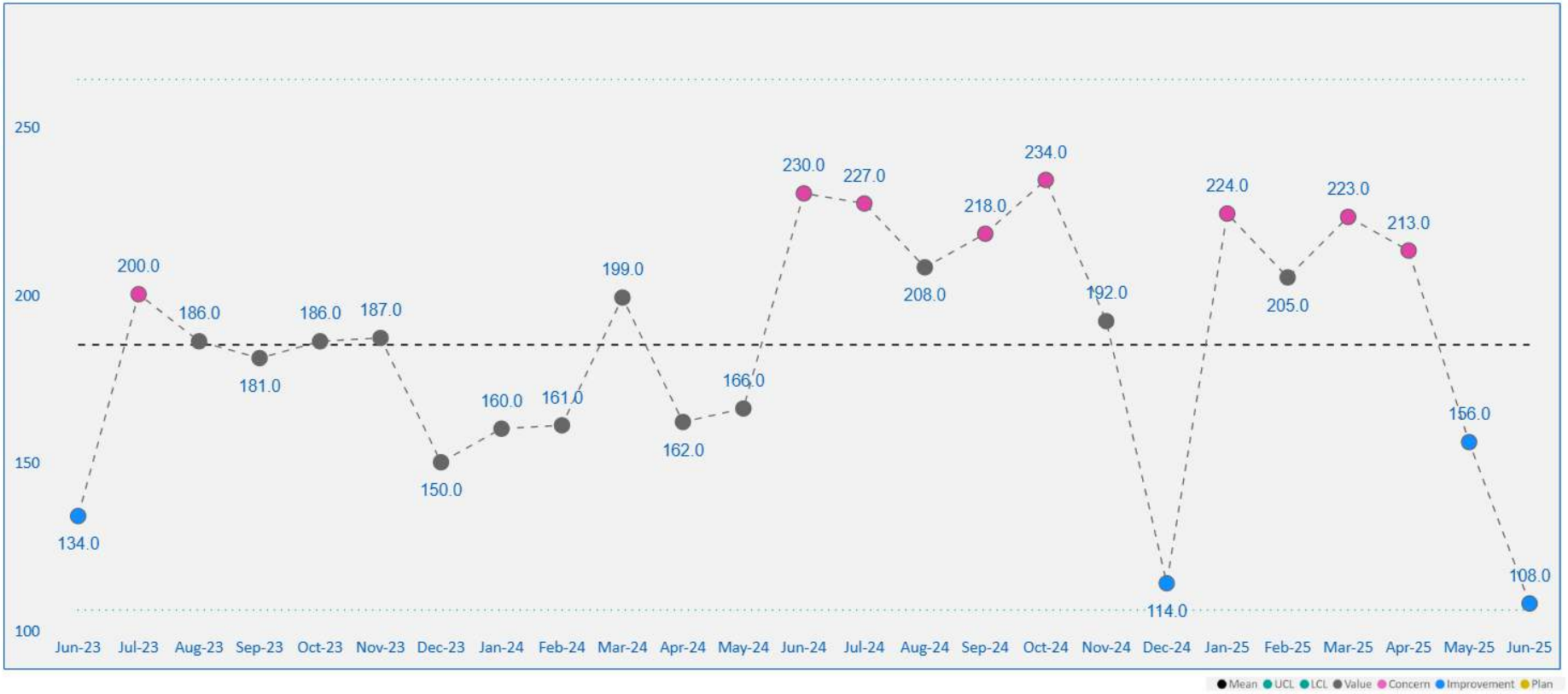

Absconsions from Inpatient Units

June 2025

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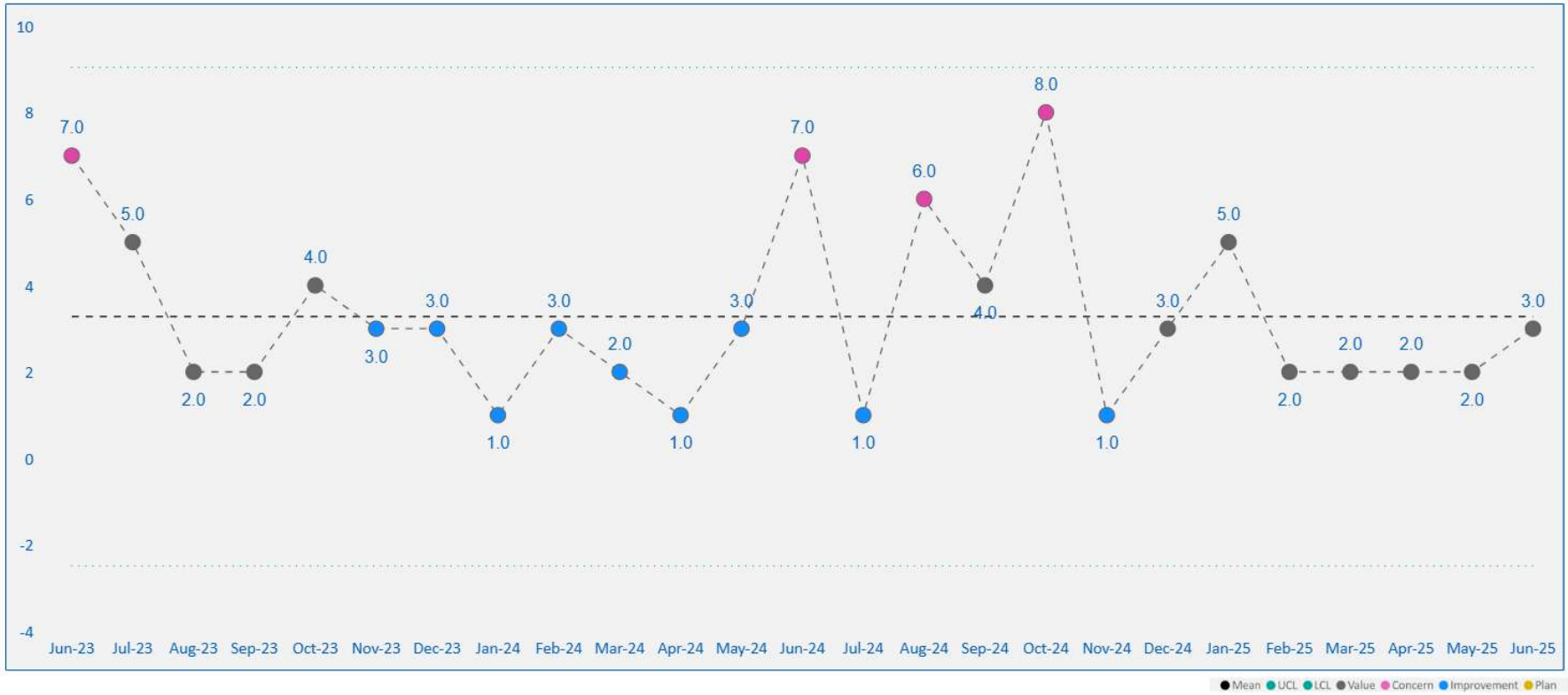

Ligature with Anchor Point

June 2025

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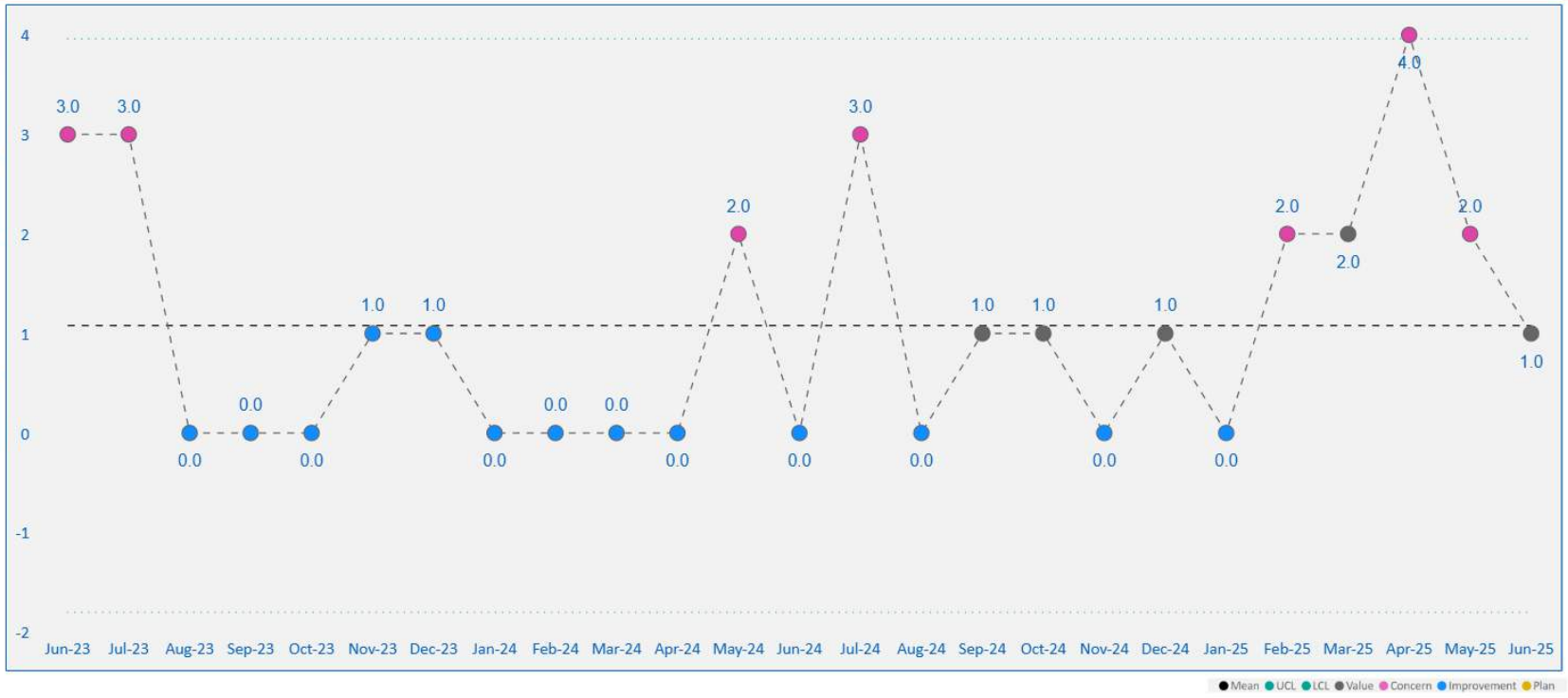

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Patient Assaults

June 2025

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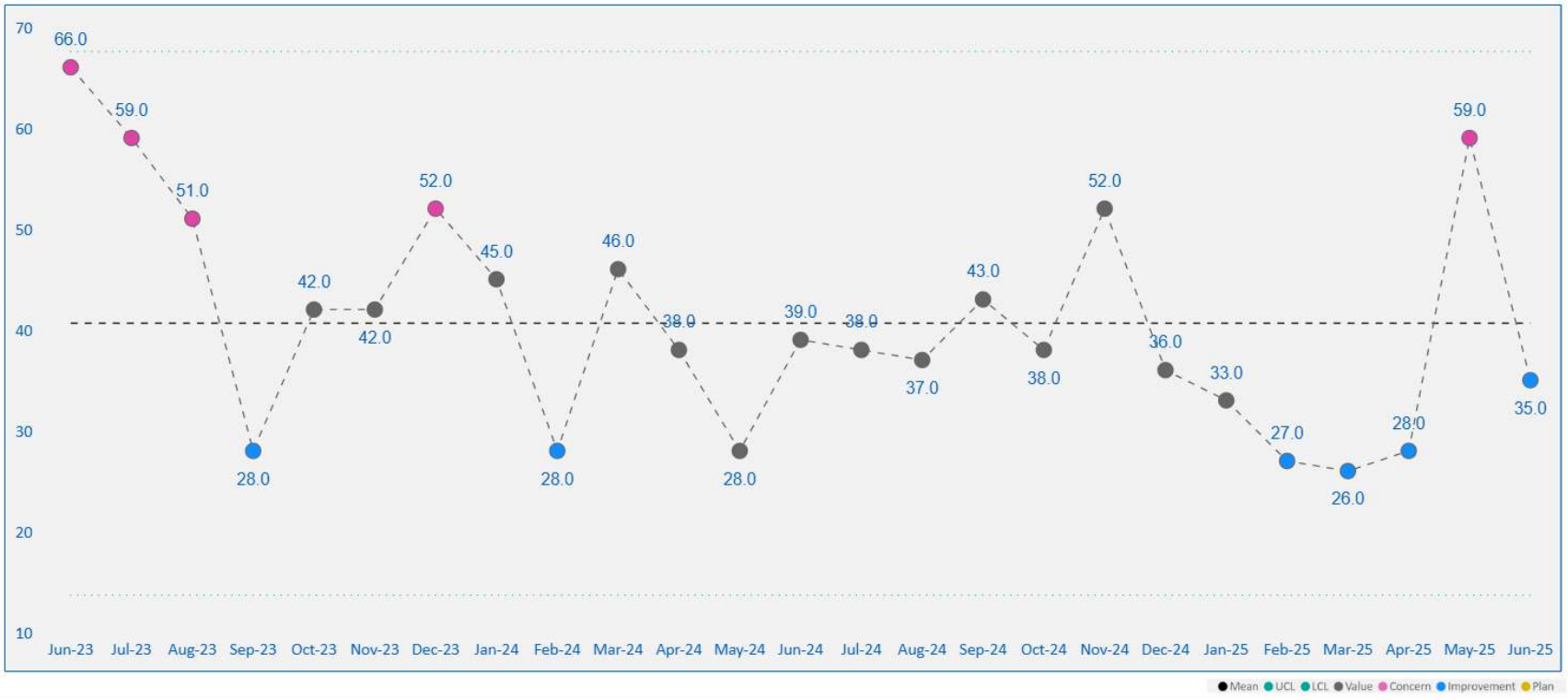

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Prone restraints

June 2025

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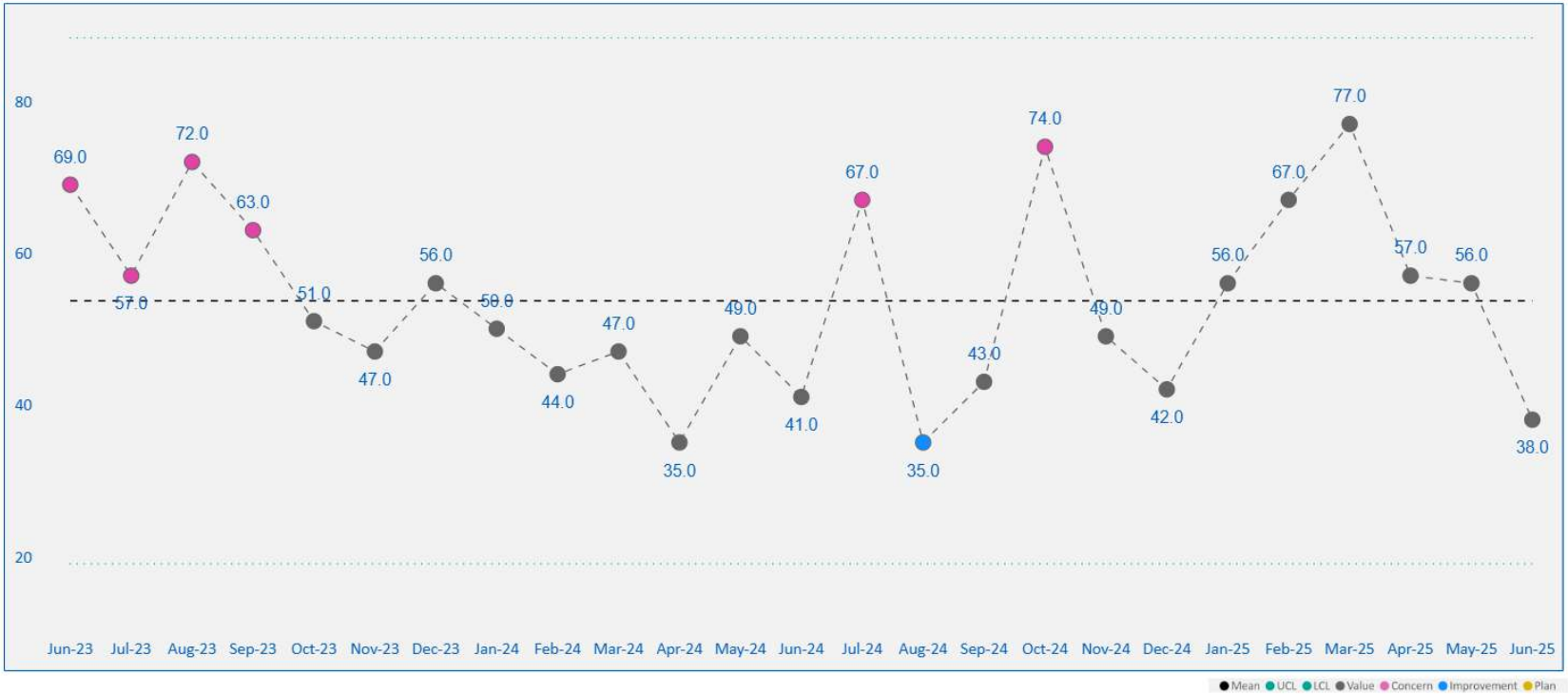

Staff Assaults

June 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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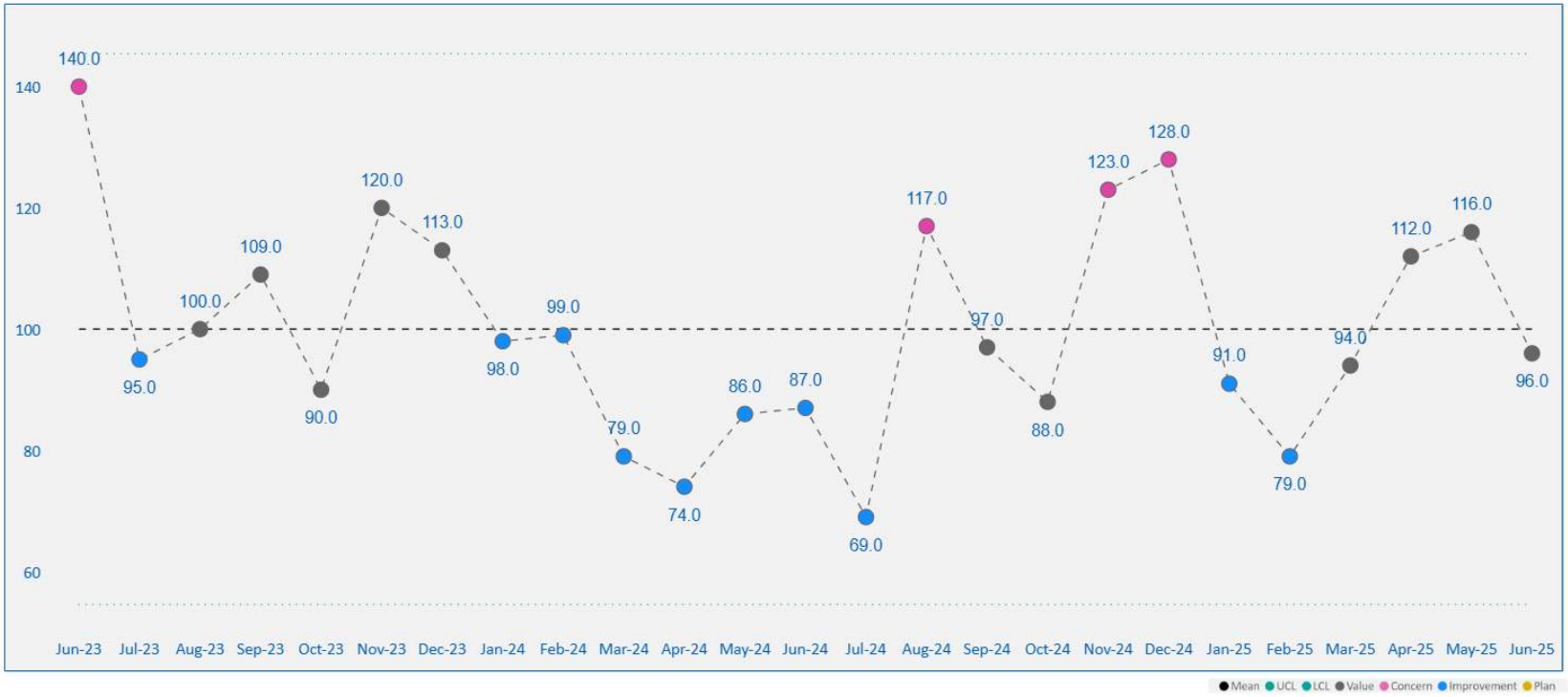


Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - FPPC 22nd July 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.

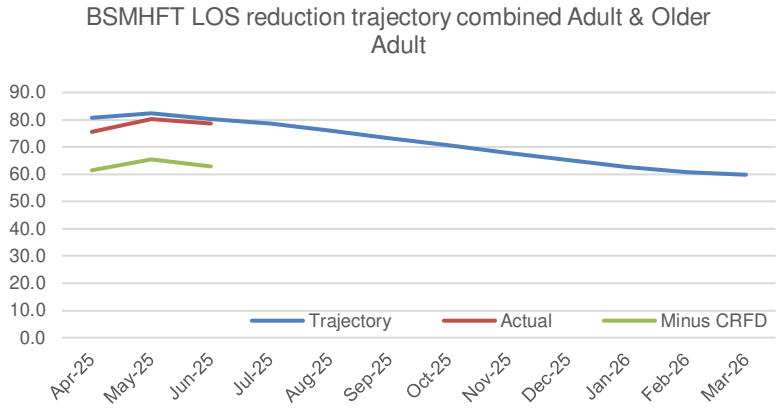
NHSE methodology – Factors to note:

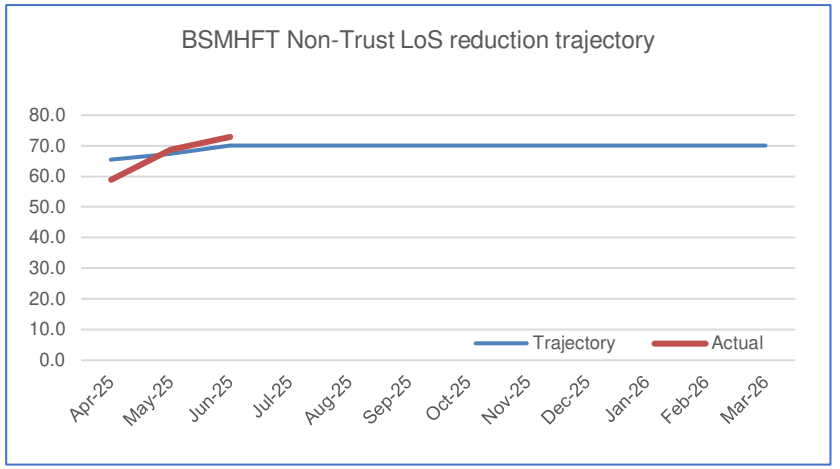
- As the methodology is based on discharge, discharging service users with long lengths of stay will have a negative impact on performance against trajectory.
- Achieving significant length of stay reductions on this methodology will require more discharges of people with longer lengths of stay during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

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

The delivery of the improvement trajectories are reliant on progressing the Trust's Productivity plan and 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 2025/26 Length of Stay Reduction Trajectories





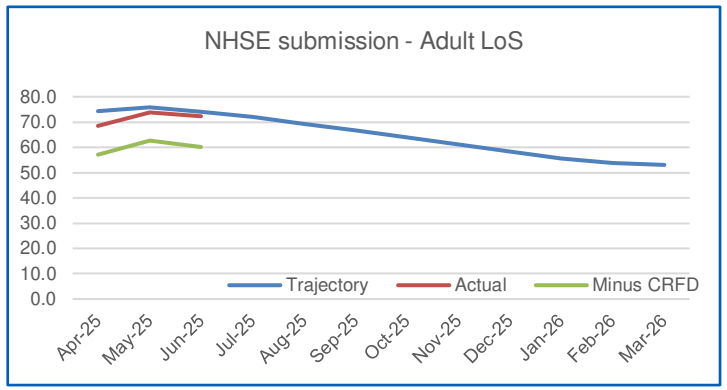
The 3-month rolling length of stay has seen a small decrease in the period April – June and the non trust has seen a small rise.

NHSE Methodology: Based on:
- Discharged patients
- Rolling 3 month view
- Entire inpatient spell
- Trust, FTB and BSMHFT non-Trust spells are separate
- Includes leave

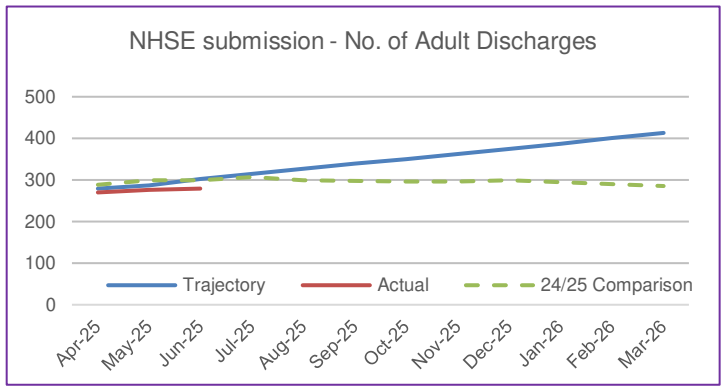
NEW – As requested at June 2025 FPPC meeting, additional data has been added (see next slide 4) which includes the NHSE LOS measures compared to 'active' current length of stay position as well as showing the impact of CRFDs on LOS.

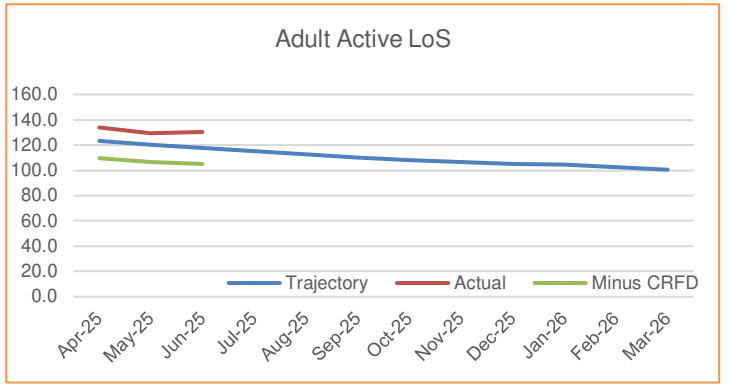
NEW SLIDE

Adults/ Older Adult LOS Trajectory 2025/26

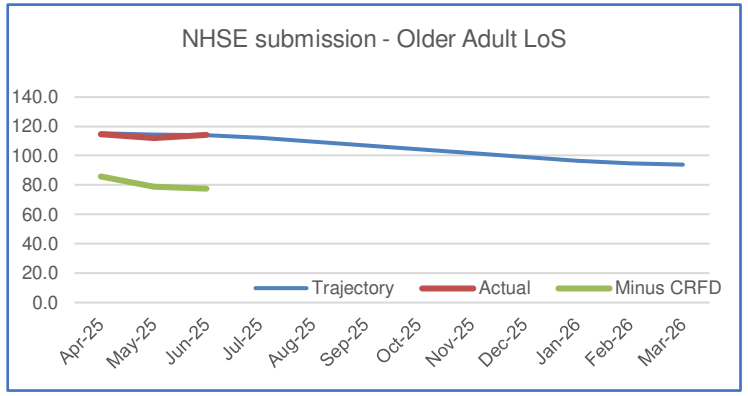


length of Stay- 3 month rolling based on discharge

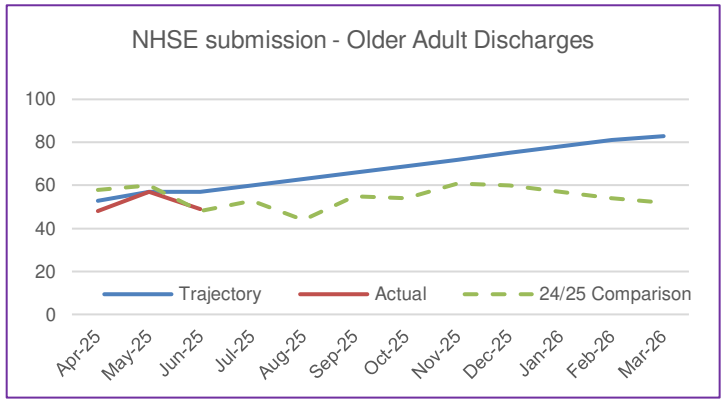


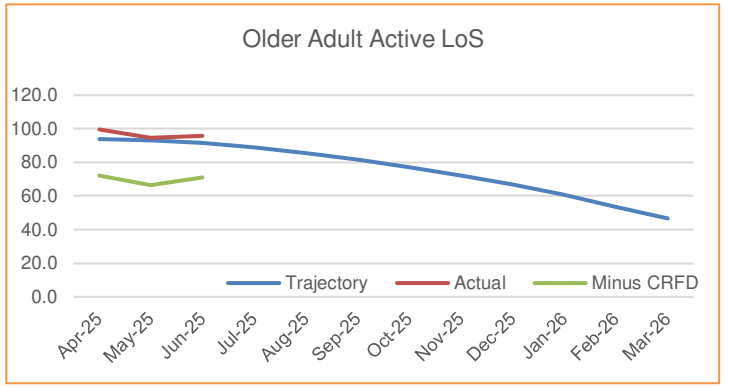


Current length of Stay- month end figures



length of Stay- 3 month rolling based on discharge





Current length of Stay- month end figures

The graphs show the 3 month rolling LOS on discharge, the number of discharges (rolling 3 months) and the current length of stay at month end and the impact the current CRFDs have on LOS.

NEW 'Active' Current LOS based on entire inpatient spell, including leave, at each month end.

The Adult rolling 3-month LOS is lower than the current LOS indicating those discharged have had shorter lengths of stay.

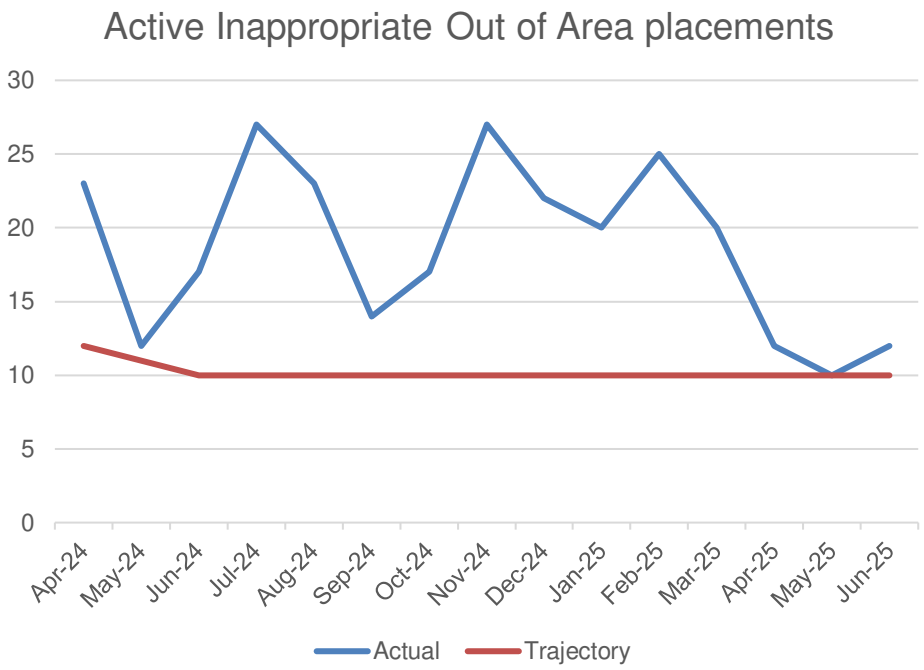
The older adult rolling and current are more balanced.

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

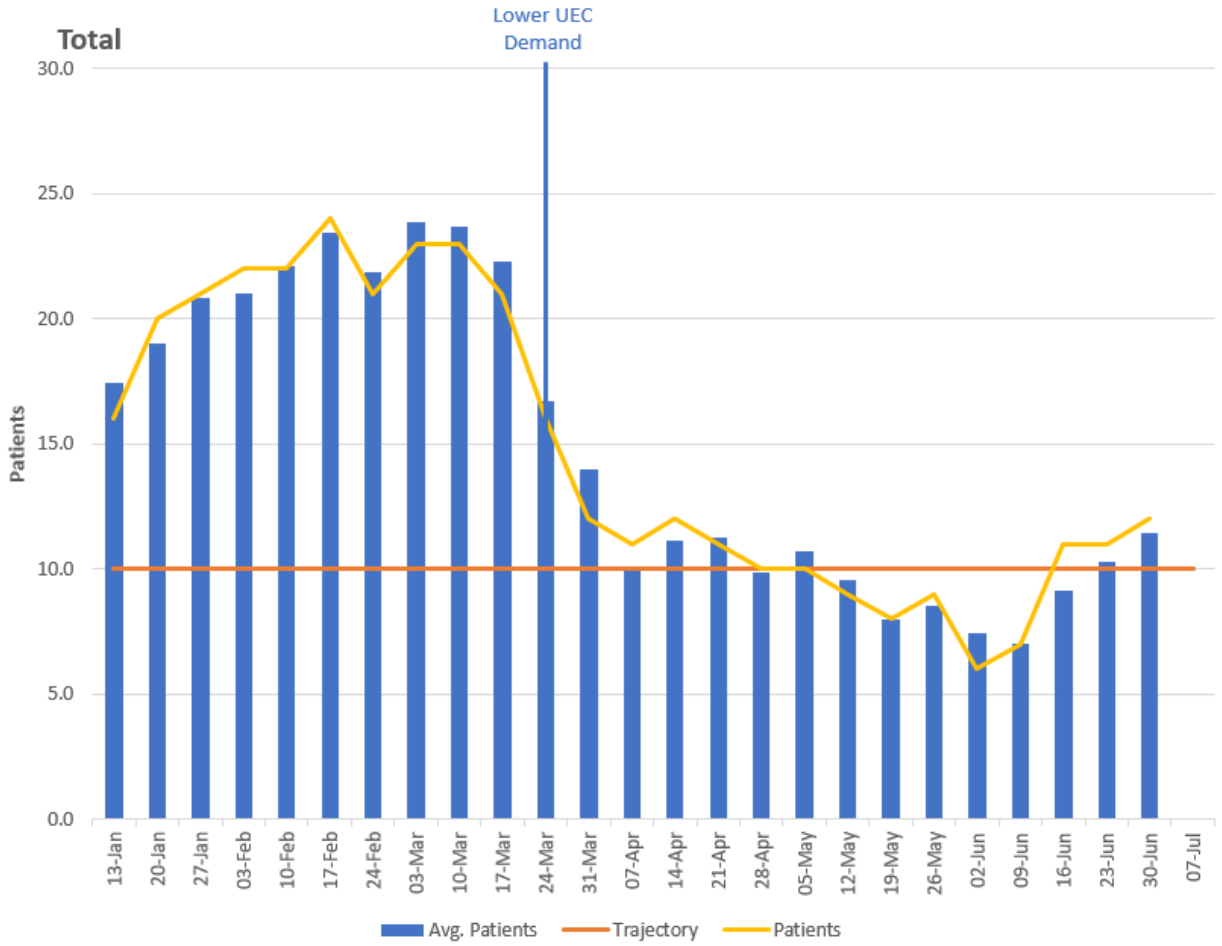


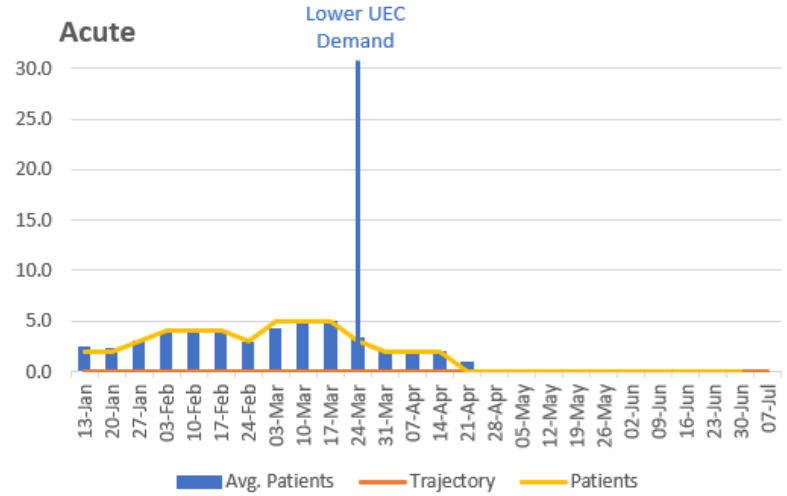
The Trust trajectory agreed with NHSE as part of the 2025/26 national planning requirements remains at zero acute inappropriate placements and to not exceed 10 PICU placements.
June 2025 position – Total inappropriate number of placements at 12 (target 10), 0 acute (target 0) and 12 PICU (target 10).

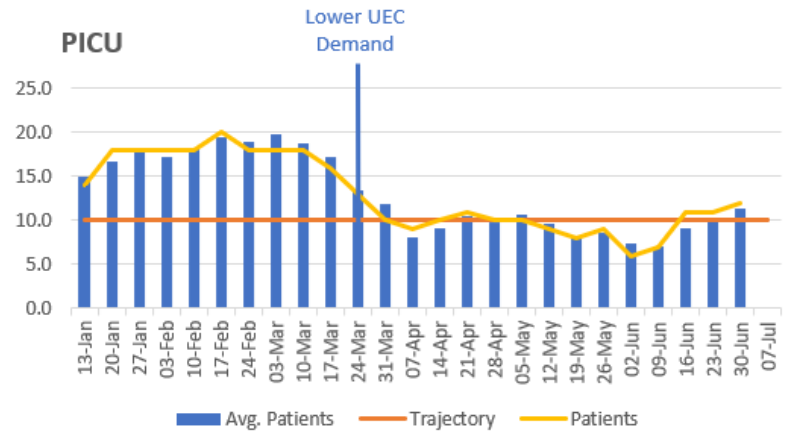
The Trust's productivity action plan continues to focus on workstreams to better manage demand, focus on reducing CRFD patients, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available.

Slide 7 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 8-9 outline a summary of key actions from the productivity plan for Q1.

Productivity Plan – update

FPPC is asked to note that a detailed update on the Productivity Plan was provided by the AD for Acute & Urgent Care at May 2025 FPPC. Actions Updated in July 2025.

Commence	Adopt	Implement	Revise and update	Introduce	Introduce
Commence Bed Management medical oversight •**Impact:** Ensures efficient use of bed resources, supporting purposeful admissions and avoiding unnecessary ones. •**Assumption** **Impact:** Requires dedicated medical staff and resources to oversee bed management, which may impact other areas of care.	Adopt new admissions process where no admission from 10pm-9am unless it's a planned warrant for a patient we don't know •**Impact**: Reduction in inappropriate admissions. •**Assumption** **Impact:** May require adjustments in staffing schedules and protocols to accommodate the new admissions process.	Implement Out of Area In-Reach SOP •**Impact:** Standardises processes for managing out-of-area patients, improving care coordination and reducing length of stay. **Assumption** **Impact:** Requires training and adherence to the new SOP by all relevant staff members.	Revise and update Locality/Gatekeeping SOP •**Impact:** Ensure key documents reflect current/agreed processes that standardises good practice. •**Assumption** **Impact:** Requires collaboration and agreement among stakeholders to update and implement the revised SOP.	Introduce tighter structure and mechanism for accountability, monitoring and reporting •**Impact:** Clear goals and processes in place for LOS and Discharge. •**Assumption** **Impact:** Requires establishment of new reporting mechanisms and accountability structures, which may require additional resources.	Introduce a protocol where NO spot purchase beds permitted to utilise. Hold 1 male bed per ward to enable repatriation •**Impact:** Aligns to the financial recovery plan to achieve required cost reduction. •**Assumption** **Impact:** May require adjustments in bed allocation and management practices.
In place and making a difference. With CYP joining revamp bed call and implement clinical prioritisation RAG rating system.	This has been challenged with additional spot purchase after initial improvements- strengthening Gatekeeping in Q2 will enhance. Use of George Ward additional 2 beds at weekends and avoid Spot Purchase	A working version is in place (amendments need to reflect FTB/CYP merger)	SOP is in place – review subsequent to improvement plans	This is planned and part of Culture of Care priorities. Matron roles with less wards to focus efforts and improve flow.	Use of George Ward additional 2 beds at weekends and avoid Spot Purchase Acute * paper attached

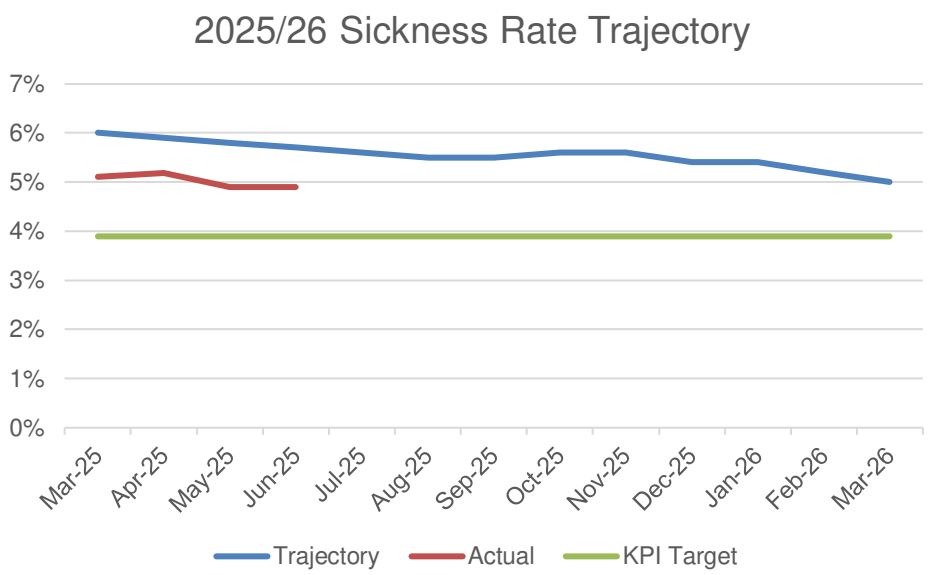
Birmingham and Solihull Mental Health NHS Foundation Trust

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.
June 2025 at 4.9% below the improvement trajectory of 6%.

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.

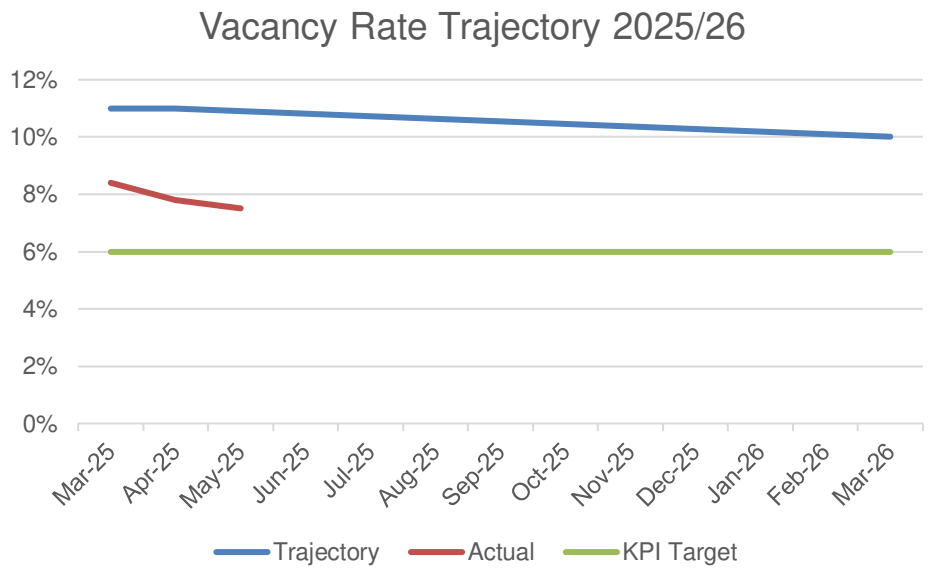
Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling.

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%. May at 7.5% below the trajectory. June data not yet available.

Following on from presenting to Nursing Students at the University of Birmingham and hosting stands at the Birmingham City University Nursing Careers event, students in placements with us, in their final year who had offers made to them following successful interviews - 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.

A bespoke band 6 Recruitment event held by the RCN, specifically targeting band 6 and 7 RMN's is currently in the planning stages.

Vacancies

Action Plan update cont:

The trust, in conjunction with universities, education facilities, and with the assistance of ICB members, is currently rolling out actions from its eleventh working group meeting for the Careers Event Process for the 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.

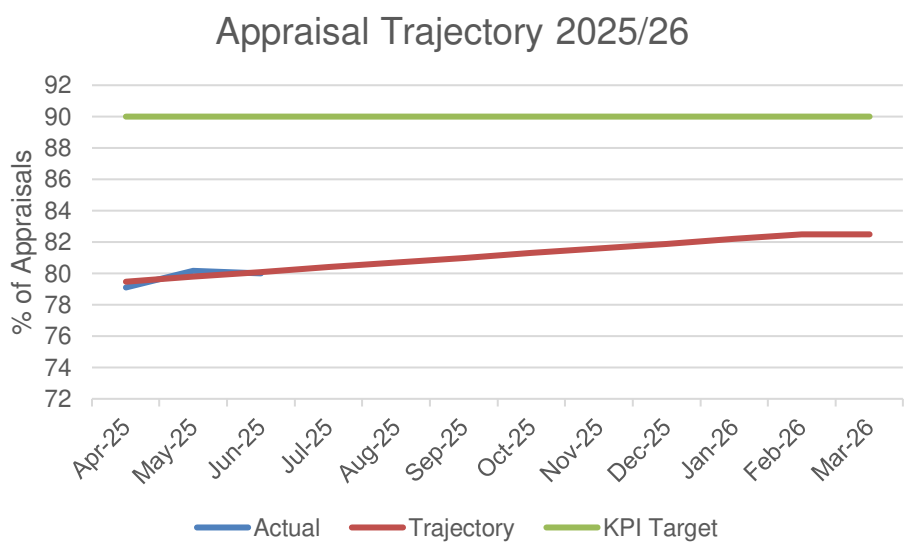
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 June to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.

Appraisals

Updated 2025/26 Appraisal trajectory



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.

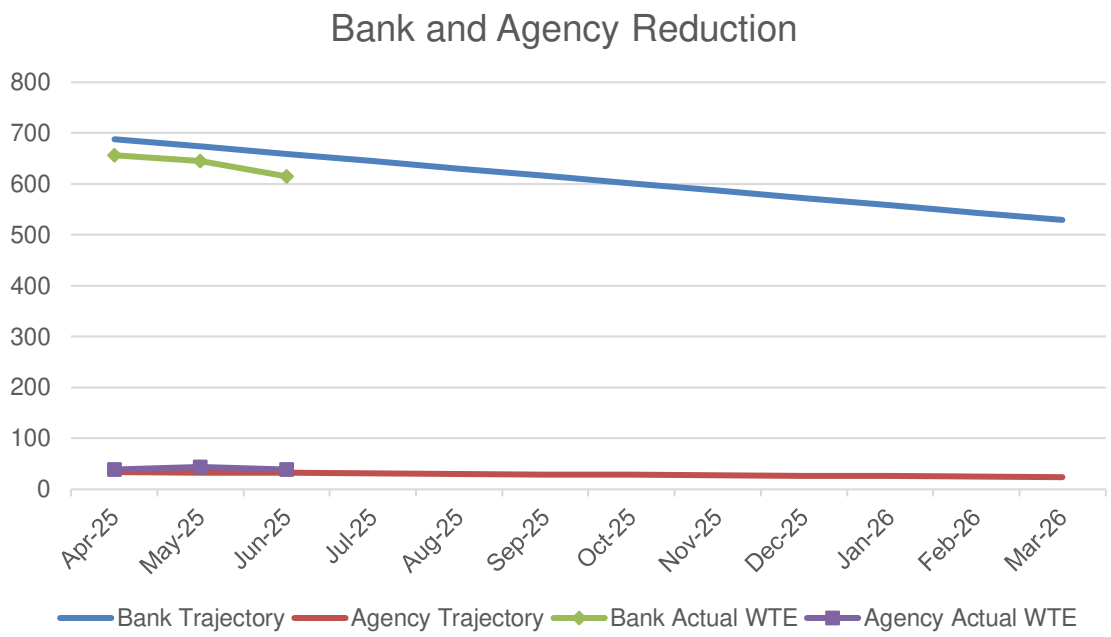
June 2025 appraisal performance maintained at 80% just below trajectory.

Summary of actions planned to support improvement:

- Continuing current practice to raise compliance and Monitoring.
- Continue to review system and process to improve user experience.
- L&D are supporting the exclusion of the psychology trainees from overall report as this should improve overall compliance
- NB- FTB compliance will potentially have a negative impact on overall compliance.

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

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.

Bank has been under trajectory for the last 3 months with June at 615 WTE
Agency has been just above trajectory for the last 3 months with June at 39 WTE

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 has a significant effect on fill rates and also have significant, tangible cost saving implications.

- In June 25 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 July 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
  - 5 PWP and 3 high intensity workers have joined the service and further staff are going through recruitment checks.
  - CSM to meet with finance to confirm number of posts to be recruited to
  - Initial OD work has commenced with 2 teams
  - Implementation of step 2 webinar has been delayed due to ICT problems with Zoom.
- National waiting time standards of 6 (75%) and 18 weeks (95%) have been maintained
- Ensure number of people accessing service increases -
  - BHM attending joint triage meetings with CMHT/NMHT
- Reduction of in-treatment waits – aim to reduce to below 10%
  - Waits remain above 10% and support offers are in place 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.

A number of actions are in place including:

- 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
  - This is continuing and consideration being given to a formal written contract with service users
- Overbook appointments where there are high DNA rates is continuing
- Scoping of use of AI Systems to increase capacity
  - Met with local providers who use AI who shared processes they use.
- DNA rate for May at 12%

Recovery rates

- Ensure clinicians are aware of their recovery rates
  - Clinicians can monitor their recovery rates and discussed in supervision
  - Good practice in high performing teams is shared
- Organisational Development – promote team cohesion & help teams to perform to their optimum
  - Initial OD work has commenced with 2 teams
- Data has been analysed to understand root causes impacting negatively on recovery rates i.e. complex trauma, newly qualified staff
  - Draft power BI report being developed to bring all aspects of performance together
- Arranging additional drop-in sessions for staff working with complex trauma
  - Training in triage and trauma has been completed and shared with teams
- Review recovery rates within different ethnic groups within East
  - Clinical lead has met with BAME champions to generate ideas on how to improve recovery rates within specific groups which have lower recovery rates

Activity and Income Trajectory

Birmingham and Solihull Mental Health NHS Foundation Trust

2025/2026 Activity and Income Trajectory (based on £637.89 per case)							
BHM activity trajectory lower than ICB plan to allow time to create capacity. Deficit is being compared to ICB full plan							
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	742	£427,386	£473,314	£517,966	-£44,652
May	812	710	720	£452,901	£459,280	£517,966	-£58,686
Jun	812	710	651	£452,901	£415,266	£517,966	-£102,700
Jul	812	750		£478,417		£517,966	
Aug	812	670		£427,386		£517,966	
Sep	812	760		£484,796		£517,966	
Oct	812	800		£510,312		£517,966	
Nov	812	800		£510,312		£517,966	
Dec	812	800		£510,312		£517,966	
Jan	812	812		£517,966		£517,966	
Feb	812	812		£517,966		£517,966	
Mar	804	812		£517,966		£517,966	
Total	9,736	9,106	2,113	£5,808,621	£1,347,860	£6,215,600	- £206,038

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 June 2025, no Performance Delivery Group was held but the following service area deep dives have taken place:

- Secure and Offender Health on 20th June 2025 focusing on Ardenleigh, Offender Health and the Health and Justice Vulnerability Service (HJVS)
- Acute and Urgent care on 3rd July 2025 focusing on North Inpatients.

Service Area Deep Dive Meetings – Update

1. Secure and Offender Health Services – 20th June 2025

The service leads focused their deep dive on the Offender Health, HJVS and Ardenleigh services. 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
Women's Secure Blended Service	Amber	Amber	Green	Amber	Green	Amber
CAMHS	Amber	Red	Green	Amber	Amber	Red
Youth First	Amber	Amber	Amber	Amber	Green	Amber
Offender Health (RAG rating revised at the meeting)	Amber	Amber	Green	Amber	Green	Amber
HJVS	Amber	Amber	Amber	Amber	Green	Amber

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Women's Secure Blended service

- Increased acuity with rise in clinical incidents and restrictive interventions due to new admissions.
- Workstreams in place to address reducing restrictive practices and service have noted that the use of seclusion has reduced over the last 5 years.
- Commenced Culture of Care programme.
- Estates work on bathrooms and en-suites has commenced.
- Vacancies reduced due to success in recruiting newly qualified international nurses – training ongoing to embed staff. Clinical educators and learning labs have been put in place to support staff.
- Improved operational performance including workforce KPIs noted.
- External facilitated session with staff on values and behaviours, ongoing area of work.
- Dawn House project (Community forensic step-down accommodation) – approval process planned via Reach Out Collaborative.

- Request – strategically closing of the WEMSS (Women's Enhanced Medium Secure service) nationally there is pressure to repatriate patients who have high acuity.
- As part of Trust-wide action, noted that deep dives are planned for the top 20 wards with high bank usage to understand the drivers, risks, actions and management going forward.

Low Secure Service:

- Service remains highly acute, and Adriatic ward remains closed to new admissions.
- Strategic discussion requested with Executive Directors on the future of the service as losing the critical mass to run the service and recruitment being a national challenge, issue further impacted by ParkView not transferring across to BSMHFT as part of the CYP transfer.

Offender Health service:

- Quality and Safety - Environment continues to be a concern, estate works requested, funding support via NHSE conformed. Executive Director of Nursing to escalate delays with Estates Leads to aid progress.
- Service experiencing waits to admit service users to medium secure and PICU beds.
- Workforce – Vacancy rates reduced in Birmingham Recovery Team by 20%.
- Staff survey action plan in place and wellbeing space for staff is working well.
- Turnover in the Prison's Senior Leadership Team has been destabalising.
- Actions arising from the CQC and HSE need to be taken forward with leadership from the Prison staff leads.
  ACTION: Executive Director of Nursing to support actions required by BSMHFT on this occasion to avoid delays.
- Partnership working with BCHC – interface meeting to be arranged to review joint working arrangements and governance requirements to support.

Health Justice Vulnerability Service (HJVS):

- Interface working across partners including the Police and Prison service challenging, increase in police charging of individuals resulting in a increase in unwell patients into prison requiring increased levels of support to manage.
  NHSE commissioning of medium secure beds being raised to manage.
- Quality and Safety – Issues with the environment, with rooms not being disability friendly need to be addressed.
- Workforce – Recruitment and retention good.
- Strategy- Developing business case for third custody suite and expansion of community team.
- Mental Health Treatment Requirement (MHTR) Psychology service in place - to be evaluated over the year with the aim to bid for recurrent funding.

2. Acute and Urgent Care – 3rd July 2025

The service focused their deep dive on North inpatients. 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
George ward	Amber	Amber	Amber	Amber	Red	Amber
Eden PICU	Amber	Amber	Amber	Amber	Red	Amber
Larimar	Red	Red	Red	Red	Red	Red
Eden Acute	Red	Red	Red	Red	Red	Red
Endeavour House	Green	Green	Green	Green	Green	Green

Quality

- Recent CQC visits identified that risk management plans in place but not specific in terms of detail regarding mitigations in place and that active management in place.
  ACTIONS:
  Quality support team to partner up with relevant leads to ensure appropriate governance and management is in place.
  Culture of Care programme to be launched.
  Rolling out plan to ensure all ward managers attend all ward rounds.
  Recruitment to roles to progress at pace.
- Psychology support in conjunction with EBEs have undertaken an evaluation of the programmes provided, recommendations made for review and action.
- Working with CYP colleagues to review practises and standards to support alignment.

Finance

- Action led by the Chief Nursing Officer to review Trust-wide bank use in top 20 wards planned including use of rosters.

3. 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
21-Mar-25	Acute & Urgent care	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
3-Jul-25		George ward	Amber	Amber	Amber	Amber	Red	Amber
3-Jul-25		Eden PICU	Amber	Amber	Amber	Amber	Red	Amber
3-Jul-25		Larimar	Red	Red	Red	Red	red	Red
3-Jul-25		Eden Acute	red	red	red	red	red	red
3-Jul-25		Endeavour House	Green	Green	Green	Green	Green	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
12-May-25	Secure	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		Womens Secure Blended Service	Amber	Amber	Green	Amber	Green	Amber
20-Jun-25		Secure CAMHS	Amber	Red	Green	Amber	Amber	Red
20-Jun-25		Youth First	Amber	Amber	Amber	Amber	Green	Amber
20-Jun-25		Offender Health	Amber	Amber	Green	Amber	Green	Amber
20-Jun-25		Health Justice Vulnerability Service	Amber	Amber	Amber	Amber	Green	Amber
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

Secure and Offender Health Accountability Framework domains self assessment

Service	**Overall**	Quality and Safety	**Operational Performance**	**Workforce and Culture**	**Finance**	**Strategy, Transformation & External**
Women's secure Blended service		Increased clinical acuity across the acute wards. Greater use of AVERTS, Seclusion and enhanced observations to manage risk. Culture of Care work launched. Event planned for 25th June. Bathroom works have began to upgrade en suites across Women's service. PH rooms & Clinic works nearly completed.	General progress within KPI's across all areas. Increased adherence to ADR's and clinical supervision.	Continued improvement regarding recruitment. Multiple challenges with lots of NQN and IEN's within the service – Improvement since learning labs, buddy system and individual support plans Training sessions in place. Sessions have taken place with George Smalling. Multiple staff out of clinical areas resulting in increased TSS expenditure.	We continue to have increased TSS expenditure, largely due to sickness and staffing pressures.	Progress with the Dawn House proposal. Women's Transformation pathway work in progress

Secure CAMHS		**LSU** – Service remains highly acute, with complex risks. Currently closed to admissions.	**LSU and MSU -** Improvement across both services. KPI's have increased and are in target range for both wards. Significant shift in attitude towards clinical supervision.	**LSU –** Improved recruitment.	**LSU/ MSU** Significant expenditure for bank/ agency staffing due to ongoing vacancy rates in addition to enhanced observations and increased clinical acuity. EPC's are again in place for LSU.	**LSU** – new commissioning agenda does not have a place for LSU. Site would not be able to support the blended model for CAMHS. Escalation of the concerns around the current LSU.
		MSU – Stability within the service, very low service user numbers. Reduction in LTS this month. Culture of Care work launched. Event planned for 25th June		**MSU** – OD/ EDI work has now commenced. Several Long-term sickness remain in place. 2 B5 vacancies left.		**MSU** – Nationally is held in high regard.
Youth First		Despite sickness challenges, working well as a team to meet deadlines for referrals High risk within their caseload.	Adherence to training fluctuates. Some of this is due to sickness and the complexity of increased caseloads. Team manager is working to address this with her team.	Workforce are generally cohesive and skilled at working together.	No current concerns within this area.	Development of the in reach pathway- Recruitment has now started for this.

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
HMP Birmingham		Environment continues to present as a major concern. 2 hatches not fit for purpose, plan to fix D+K hatch, funding agreed with NHSE however Amey are not being responsive. Issues on some wings of feeling unsafe and poor support/supervision from officers. General civility from officers can be poor in certain areas. Increase in people with mental health problems being red routed into custody. Increase in mentally unwell men being managed on the wings due to limited space on Healthcare as people are waiting to be transferred to hospital.	Q+P meetings indicate good contractual compliance with data sets and standards, in some areas we are overperforming over benchmarks Psychology less than 2 week waits, GP 5 days. Dental waits less than community equivalence Some issues with enablement and clinics needing to be closed due to flooding resulting in lower compliance with secondary screening, however, overall would still rate this as green. NHSE appear to be content with performance, and action plans in place.	Vacancy rates in MH and pharmacy remain good Vacancy rate in BRT has reduced to around 20%, more staff expected as well Staff survey has picked up some issues within the pharmacy team which is good to be aware of and now have tangible results to use to plan some work . Management have met with John Travers regarding the results.	Currently small overspend due to late pay award. Improved system for Bed watches and escort data in place	Lack of oversight from BCHC AD on performance and recruitment. Meeting held with senior BCHC to escalate concerns and impact.

		Late receptions (operation safeguard) introduce significant risks.. Increase in AM arrivals, whom we cannot screen until afternoon, also not transferring out on Saturdays. This places additional pressure on clinicians		Staff survey action plan in place and being carried out OD work completed in BRT. Feedback session in July for team.	Clinical constant watch data has reduced from circa 100k a year to less than 15k for last 2 years	Working relationship has improved dramatically with HMP, however, with constant changes to their SLT, and issues around enablement this remains a system issue.
		6 DICs from December 24 to now. Working through any learning, 4 appear to have a clear COD, however, 2 look likely to be related to NPS.		Operational and HR KPIs have steadily increased over the last 12 months, and are now being sustained	Meeting held with NHSE who are considering a 500k hold back in funding due to prison not being at capacity. Due to changing needs of population, NHSE have agreed to not withhold the money. A health needs analysis needs to be completed.	Culture of integration has improving. This is a piece of work which continues.
		Improvement noted in overall BBV screening, however, Hep C has reduced due to not using oral screens now.		Concerns raised formally with BCHC in terms of PC. Have filled vacancies, however, concerns regard		

				quality and competency with newer staff. Met with senior BCHC team and have a clear plan in place with expectations.		
Overall RAG rating						

Acute and Urgent Care : North Inpatients

- Actions from 31/05/2024

Date	Division	Focus	Issue
31/05/2024	Acute & Urgent Care	North inpatients	The service leads requested additional clinical and HR support for both George ward and Eden PICU on a temporary basis to provide additional management and senior leader oversight. There was agreement to provide this support to the service, with the service managers to discuss and finalise this with the Director of Operations.
31/05/2024	Acute & Urgent Care	North inpatients	Deputy Director Finance to review the drugs budget with service leads.

Action 1

After a period of enhanced monitoring, we have observed notable improvements on George ward. However, Eden did not make the expected progress. As a result, we revised the leadership arrangements. The new leadership team started on July 14th and includes additional support through new matron roles. These roles are crucial for staffing development, ensuring quality, and improving patient flow. This change acknowledges that having one matron cover five wards is not feasible.

Acute and Urgent Care Directorate Accountability Framework domains self assessment

Service July 2025	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
George						
Eden PICU						
Larimar						
Eden						
Endeavour						

Training

Ward	ELS	ILS	Safeguarding adults	Safeguarding Children	RMS	Clinical supervision
Eden Acute	63.6%	100%	76.9%	92.3%	81.5%	79.2%
Eden PICU	81.3%	75%	68.8%	62.5%	76.5%	70%
Endeavour House	100%	100%	92.9%	92.9%	96.2%	100%
George Ward	100%	93.8%	93.3%	100%	85.2%	91.7%
Larimar	92.3%	91.7%	83.3%	100%	74.1%	62.5%

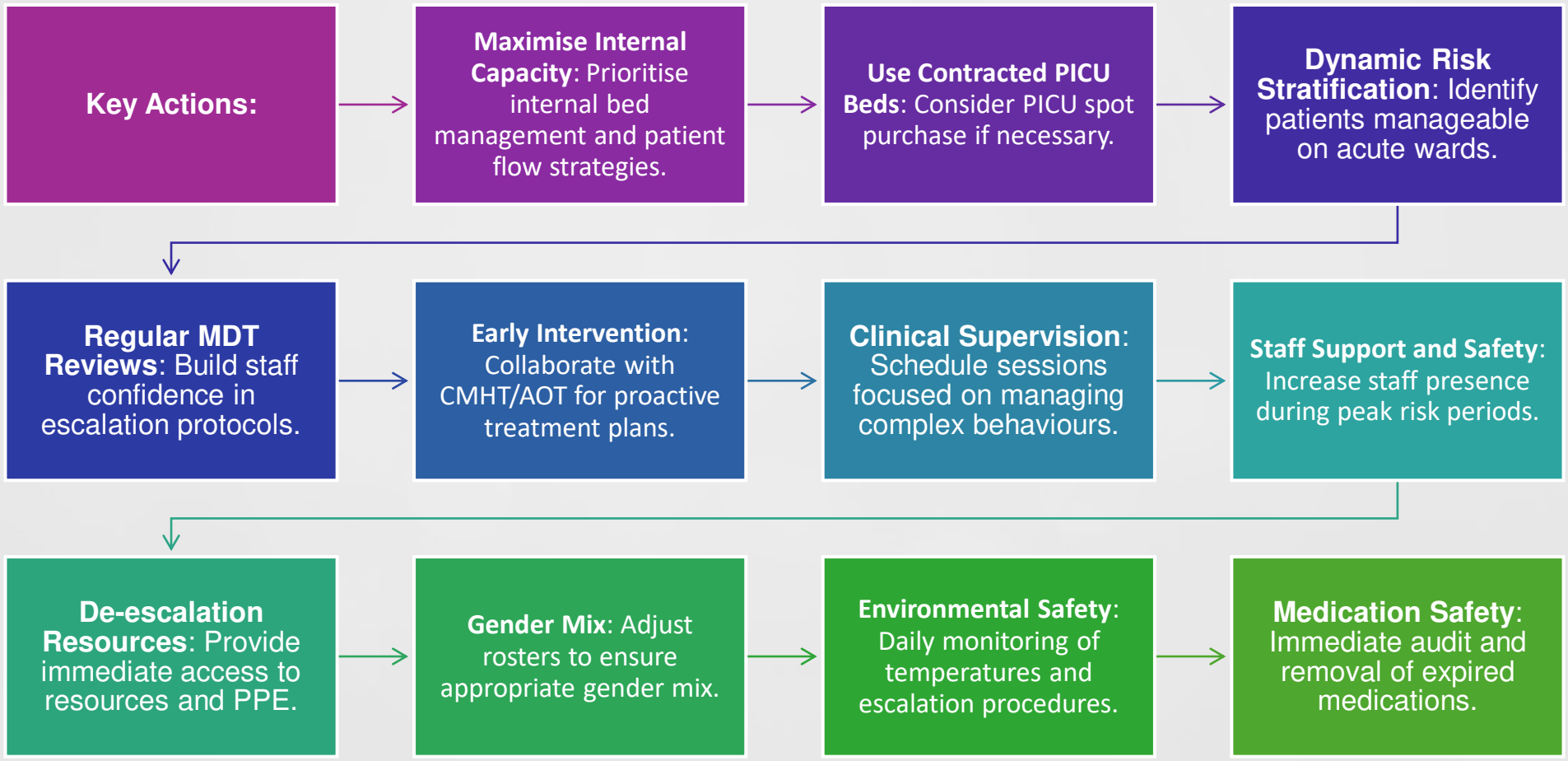
- There have been significant improvements in training across all wards, as evidenced by these figures.
- Established Reflective Practice offer- but currently on planned leave.
- Several staff from Eden PICU are on the roster, but not currently in work (due to various reasons). This is affecting the % completion figures for Eden PICU. The compliance team are in the process of trying to ‘exempt’ these staff from the total compliance figures.

Quality and Safety

- CQC visited Eden Acute & PICU on 17/06/25-19/06/25. An action plan has been drafted to address the issues raised, which includes:
  - High acuity of patients on the acute ward & lack of access to PICU beds, resulting in staff having difficulty to manage risk and are sustaining injuries.
  - Lack of management plans for patients who required specific support
  - Leadership/management challenges, including a lack of senior leadership presence when required (e.g., after incidents)
  - High level of male staff on a female ward
  - Lack of activities/staff engagement for patients

- Provider collaborative (ICB) visit to Larimar identified the following areas that require focus:
  - Therapeutic Observations – concerns were raised about the lack of clinical rationale, outdated prescription, and incomplete risk documentation
  - Care plans – care plans were often generic, lacked personalisation and did not consistently reflect MDT discussions.
  - Risk assessments and Risk Management Plans – risk documentation was not robustly updated through the MDT process, and staff awareness of patient risks was inconsistent.

Immediate actions – in 1 month



Medium and Long Term Actions (1+ months)

- **Culture of Care Programme**
- **Review Care Plans**: Comprehensive review and update of care plans.
- **Monthly Audits**: Conduct audits of PBS plans and risk assessments.
- **Leadership Training**: Train leaders on appropriate responses to staff conduct.
- **Senior Leadership Presence**: Implement ward rounding schedule.
- **Activity Schedule**: Enhance weekly activity schedule on wards.

Long Term Actions (2+ months):

- **New Build Seclusion Facilities**: Include 2 seclusion facilities in the new build.
- **Quality Improvement Project**: Focus on purposeful admissions and reducing incidents.
- **Patient Flow Analysis**: Conduct thorough analysis of patient pathways and lengths of stay.

Service User / Carer Experience

- Regular attendance of patients from all wards at the Acute Care Patient Council.

Ward	SU Feedback (June 2025)	
	Positive	Suggested Improvements
Eden Acute	• Activity Worker has returned and so hopefully activities will increase • OT engaged with patients	• Inconsistent activities and poor resources to deliver them, particularly linked to staffing shortages
Eden PICU	• Activities include those who are on continuous observations/very unwell • Patients comment how kind the staff are	
Endeavour House	• Patient experience appears to underpin all the work that the staff do • Good communication between staff and patients • Patients are settled and ward environment is supportive	
George Ward	• Events for patients have been well received e.g., Quiz, Recovery College Sessions • Positive improvement seen in patient & staff morale over last 12 months	• Suggestion that patients & staff eat together once per week • Focus on the 'Culture of Care' work
Larimar	• Patients enjoy the range of activities, including going to the park	• Patients asking why there are a lack of staff on the ward • HCAs don't engage or offer activities • Concerns about staff morale

Work in Progress

Culture of Care Programme

Significant strides have been made in enhancing training across all wards, as reflected in the improved figures. This initiative is part of our broader Culture of Care Programme, aimed at fostering a supportive and effective care environment.

Weekly EHIP - Patients Review

Our weekly EHIP - Patients Review meetings have been instrumental in identifying and addressing discharge barriers, as well as operational and clinical challenges. These reviews facilitate timely communication of discharge plans to patients, their carers, and other professionals involved in their care. This process has been crucial in freeing up local beds and repatriating patients with lengthy stays in out-of-area private beds.

Improving Roster Utilisation

Focused efforts on optimising the utilisation of our over-recruit roster have resulted in a downward trend in the use of bank staff. While we are not yet meeting our current financial trajectory, these improvements indicate positive progress.

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**22 July 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Health, Safety, Fire, Security and Regulatory Compliance Annual Report • Culture of Care Progress Update • PEAR Assurance Report • Patient Safety and Customer Relations Report • PSIRF Annual Report • Manchester and Nottingham Review Action Plan • Integrated Performance Report • Clinical Governance Committee Assurance Report • Pharmacy and Medicines Optimisation Annual Report • Freedom to Speak Up Guardian Quarterly Report • CYP Assurance Report • Quality 2024/25 Year End and Q1 2025/26 Strategy Report • Clinical Services 2024/25 Year End and Q1 2025/26 Strategy Report • Assertive and Intensive Action Plan
Alert:	• The Committee noted the new National Oversight Framework 2025/26, which had been published in June and would assess providers and determine segmentation from September. • The Committee noted the rapid review into Larimar ward and highlighted the recommendation to strengthen the leadership team. The Committee also discussed the serious incident response process and impact of police investigation. • The Committee noted the slightly improved position in relation to non-contracted beds, but acknowledged the continued pressure.
Assure:	The Committee was assured on the following areas: • Culture of care standards were being finalised for implementation across the organisation. • The Committee was assured by the PSIRF Annual Report, noting that the Trust was meeting requirements. • The Committee took assurance from the Medicine and Pharmacy Optimisation Annual Report • The Committee received a positive CYP Assurance Report, noting the smooth transition of the service.

Advise:	The policy framework, training and audit work was acknowledged and the Committee was particularly encouraged by the work to address variation across the organisation. The Committee noted the reported increase in complaints, particularly in relation to ADHD waiting times, but acknowledged the work that was ongoing to reduce response times, including the early resolution framework. The Committee received the Assertive and Intensive action plan, noting progress against complex case reviews and business as usual processes for continued monitoring. The Freedom to Speak Up Guardian report highlighted the More Voices initiative which aimed to explore alternative communication, feedback and engagement models to ensure all staff could access a mechanism to provide feedback or raise concerns.	
Board Assurance Framework	The Committee scrutinised the following risks: • Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery. • Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services. • Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities. • 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 user needs.	
	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	
Date(s) of Committee Meeting(s) reported	**18 June 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 • Patient Safety Report • Psychology Deep Dive • Suicide Prevention • Integrated Performance Report • Clinical Governance Committee Assurance Report • Medicines Management • Right Care Right Person • Children and Young People Assurance Report
Alert:	The Committee wished to alert the Board of Directors to the following: • The number of open formal complaints has increased approximately 4% compared to the previous month. This is the highest number of active / open formal complaints over a 24month reporting period. It was agreed the data needs to be reflected in the development of the new matrix that will support staff in addressing concerns being raised and set clear roles and responsibilities to enhance local resolution. • Waiting times and access to services remains a high risk and area of focus for the Committee. • PEAR engagement and lack of service users and carers at the group was highlighted as a concern. The Participation and Experience team continue to work to engage with these groups to increase membership.
Assure:	The Committee was assured on the following areas: • Right Care, Right Person updated provided overall assurance as relationships with West Midlands Police continue to be developed. The Committee were assured the conversion data for S136's continues to be developed and will clarified in future reports. • Positive compliance with 15 steps and alignment on visits. The schedule for the year has been drafted and issued. • Culture of Care at Reaside continues to improve with the report mapping changes and driver diagrams as a positive reflection of ongoing improvements.

	• PSIRF reporting improved with a new format developed to showcase and highlight relevant and reflective updates. • Children and Young People planning and scheduled oversight assurance report provided positive assurances in readiness for the transaction planned for 1 July.	
Advise:	• Board Assurance Framework refocus on health inequalities. • Partnership support for fire safety and medical devices is being explored across BSoL. • Positive Psychology Deep Dive received and agreed oversight again in January 2026.	
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:	Linda Cullen Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance Manager

Report to Board of Directors							
Agenda item:	**11**						
Date	6 August 2025						
Title	Quality and Safety Report						
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse						
Executive Director	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse	**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 Trust Board with a progress report on quality and safety within BSMHFT Services and activities and to provide assurance on regulatory responsiveness and progress, continuous learning and quality improvement.

Regulatory Compliance

Acute Care Inpatient Wards – Care Quality Commission Inspection June 2025

The CQC conducted a focused inspection on George Ward, Eden PICU, Eden Acute Ward and Larimar Ward. The inpatient wards at the Zinnia Centre, Saffron and Lavendar were also re-inspected to review the findings from the previous inspection in October 2024.

The initial high-level feedback from the CQC is a mixed one where they highlighted some immediate concerns around staff behaviour and attitude on Eden Acute Ward and action was taken by the Trust to support a patient who had raised concerns and address the attitude of the Ward Manager. George Ward received positive feedback with a recognition of the progress being made by the Ward Manager and staff with their Culture of Care Programme and inclusion of Inspectors in patient activities. Feedback on Eden PICU (psychiatric intensive care unit) acknowledged improvements in staff culture though they raised concerns about the high staffing levels and gender mix. The Ward manager who was on leave at the time of the inspection was able to have a follow up meeting with the CQC and discussed the approach to allocation of staff and how personal care support and dignity were afforded to patients.

The CQC fed back that they observed considerable improvements at the Zinnia Centre but also recognised and highlighted the increased levels of acuity that staff were dealing which have a risk of being isolated from timely support. The Ward Managers were commended and the Inspectors tested all newly installed door alarms and

sought assurance on staff competence in door alarm checks. The ward was inspected during the hot weather alert period and there were concerns that there was a lack of awareness in senior staff on the actions that should be taken in respect of medicines safety, the Trust has an action card in respect of the actions to take in the event of extreme heat and this was re-communicated to leaders and staff. The Trust has a remaining s29a warning notice in respect of clinical supervision and regular management supervision and the Trust has provided the CQC with evidence of assurance on compliance in these areas.

There was a pause in the Inspection due to the very serious incident on Larimar Ward. The CQC completed an inspection of this ward and provided feedback on the responsiveness of the ward to recent learning in respect of risk assessment, care planning and observation level prescriptions. A number of visits have taken place following the incident by the Mental Health Provider Collaborative, the Integrated Care Board Quality Team and the CQC. Findings identified concerns that risk assessments and care planning was not up to date, prescriptions for therapeutic observation required updating, very complex patients were being managed on the unit, there was limited access to psychology and the controlled drug register and ward board was not being appropriately updated. Where digitised checks are in place for equipment such as ILS/ELS (immediate/emergency life support) they were up to date and we will consider where there may be additional areas where compliance may be digitally supported. Larimar has senior support in place on a day to day basis and provides a weekly safety assurance report to the Trust Safety Huddle.

We recognise as a Trust that though ongoing work has been taking place with the division, there are still improvements required for the Acute Wards, and that there is evidence of the positive impact of the Culture of Care Programme which is being fully rolled out in all wards. There is assurance that the improved recruitment and retention of staff is having a positive impact on both patients and staff, however, experience and at times competent and confident practice remains a risk with training and development being a key workstream going forward. The pivotal role of Ward Managers in shaping culture on the ward, effectively utilising and supporting their team, organising the day and improving standards was a theme.

Prior to the inspections ongoing performance meetings with the Acute & Urgent Care Division highlighted leadership capacity issues and three additional Matron posts were allocated to the Acute Division to strengthen knowledge, experience and capacity, the posts have now been recruited to. Following inspections a further strengthening of Nursing and Quality leadership for the Division has been implemented with the addition of a second Head of Nursing to focus on leading the Acute Wards, and the existing Head of Nursing to lead Urgent & Emergency Care & Home Treatment. In addition to strengthening coaching and support for services this will provide additional capacity for our focus on reducing waiting times in the Emergency Departments across Birmingham and improved support for complex case management and reducing length of stay for Acute and complex inpatients. An experienced senior nurse has also been seconded for twelve months to provide leadership and capacity for the delivery of the Culture of Care programme, taking the learning from the work commissioned for Reaside Clinic.

A Rapid Quality Review was chaired by the ICB in respect of the concerns raised by regulators and commissioners about Larimar Ward and the Trust provided a comprehensive response to inspection findings and plans for further improvement. The outcome was the establishment of a monthly quality assurance meeting to be chaired by the ICB and the Trust will continue a monthly improvement assurance approach through the Culture of Care programme, reporting into the Quality, Patient Experience & Safety Committee.

The completion of door alarm installation has provided an increased level of environmental safety for patients and we would like the Board to acknowledge the significant and timely work completed by the Director of Estates and Team, Head of Compliance and Acute Ward Leaders in their focus, drive and commitment to this programme of works.

DIALOG+ and Safety Planning

The implementation of Dialog+ has been completed across the Community Mental Health Teams and inpatient wards in Secure Care and Acute Care. Training Champions have been identified and progress on delivery and assurance on effectiveness is reported through the Clinical Effectiveness Assurance Group chaired by the Deputy Medical Director and reports into QPESC.

- The tool is person-centred and Recovery-Focused:
  DIALOG+ ensures care planning reflects what matters most to service users, improving engagement and satisfaction.
- Evidence-Based Improvement:
  Research shows DIALOG+ improves quality of life, treatment satisfaction, and therapeutic alliance compared to traditional CPA models.
- Structured Yet Flexible:
  Offers a consistent, structured conversation framework while being adaptable to individual needs and contexts.
- Co-Produced Risk Management:
  Safety Planning supports a collaborative approach to identifying triggers, early warning signs, and agreed coping strategies.
- National Policy Alignment:
  Reflects NHS England's call to shift away from outdated "risk prediction" models toward dynamic, therapeutic safety planning (e.g. NICE NG225, Zero Suicide Alliance guidance, Staying Safe from Suicide Guidance).
- Demonstrates modern, proactive care planning and risk management in line with the focus on co-production and reducing restrictive practice.

Very Serious Incidents & Learning from Deaths

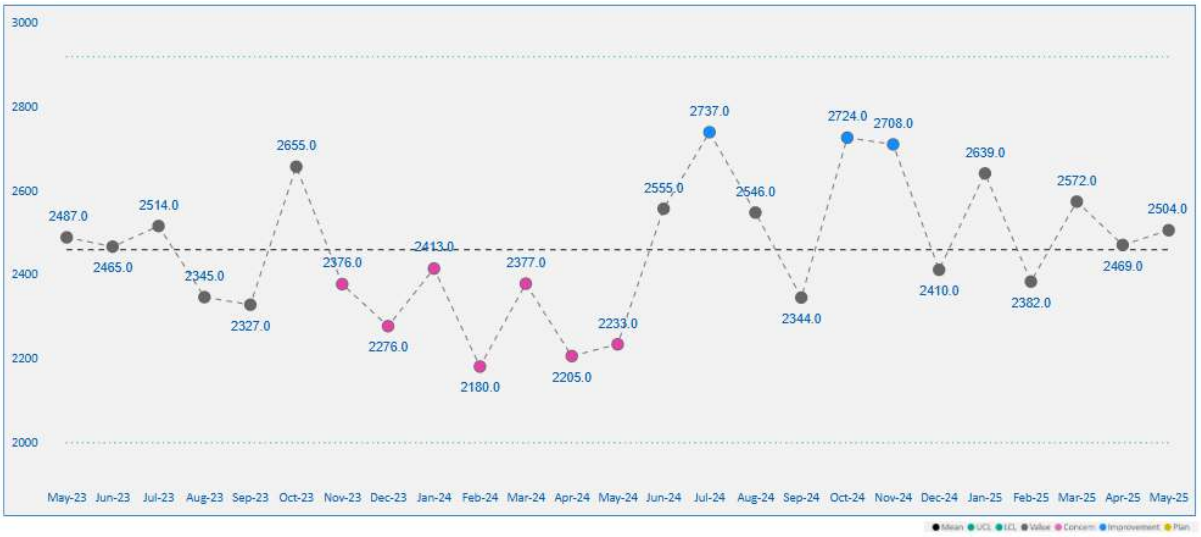
An inquest is scheduled for October 2025 for a service user who died at Hertford House, after gaining access to the roof was found deceased on the ground having sustained catastrophic injuries. Immediate learning identified restricting access to the roof, which the Estates team have completed and the Health and Safety Team have checked for compliance. The Trust has also reviewed all other buildings to ensure this is not a risk elsewhere. This is incident is being reviewed through a Structured Judgement Review.

There will also be an inquest held for a young person who died whilst being cared for on Larimar Ward, following ingestion of a toxic substance. The formal opening of this was held on 26th June 2025. The Trust has issued a Safety Alert on handling of parcels and reviewed the processes for each ward other than those in Secure Care on parcel handling. The incident is subject to a Police enquiry and the Trust has commissioned an investigation led by an independent external reviewer. Additional learning centres on training competence compliance assurance for all staff in the Acute Division in accordance with the Acute Mental Health Inpatient Competency Framework.

Duty of Candour has been completed in all cases and family members assigned a liaison officer and had meetings with the Responsible Clinician.

Incident Reporting

Incident reporting should not be seen as a good single indicator of safety in the clinical environment; however, these can provide an early indication of incident change in specialities or even across the Trust. The Safety Team will be including benchmarking data for QPESC in the future and are working on aligning the national metrics associated with Mental Health Services aligning with the Integrated Performance Report and Divisional level reporting and accountability.



There were 2504 incidents reported during the month of May of which 1.2% (31) were reported anonymously, which is an indicator of whether there is psychologically safe reporting.

Increased reporting was seen in Older People Inpatient Services for the 5th consecutive month and Offender Health for the 3rd consecutive month. Older People CMHTs (community mental health teams) continue their downward trend of reporting fewer incidents with 44 being reported this month.

Overall, the Trust has seen no significant changes in reporting levels over the last 12 months as can be seen in the SPC.

The top 3 reported cause groups remain as:

- Assaults, Violence and Harassment
- Self harm and Patient Behaviour
- Medications

There are quality Improvement groups in place to address the areas of concern which report into the Clinical Effectiveness Assurance Group. In addition to averts training we are utilising the Culture of Care Programme to enable safer cultures on the wards and a Staff Safety Strategy is in consultation which considers a comprehensive approach to effective and safe therapeutic relationships and use of safety equipment from universal precautions to personal alarms. During the 'Summer Games' held by the Acute Wards patients were enabled to complete almost 1000 hours of sports and games activities and early evaluation has identified a reduction in reported incidents of 75% over the 9 days.

Customer Relations

Formal complaints continue to run at the highest volume reported in 24 months. Averaging 75-80 open at any one time.

- Throughout the month of June, the team received 2044 emails, which is an increase of 260 emails (plus 15%) compared to the previous month.
- There are 13 formal complaints that are over 6 months old, which is an increase of 5 since the previous reporting period. The Customer Relations Manager will be undertaking a focused piece of work through July to address the complaints over the 6 months old.

Feedback has been received in relation to complaints not always being approached in a culturally sensitive manner. We are working with Catalyst4Change on an effective approach to culturally sensitive liaison and responses.

- The response time for Acute and Urgent Care has reduced by 112 working days compared to the previous month. The new proposed way of working on formal complaints with the Division is having a positive impact.
- The complaints proposal was approved through June 2025 Trust CGC (Clinical Governance Committee) and will be commencing in the remaining four Directorates from 1 July 2025.
- The response time for ICCR (Integrated Community Care & Recovery) has also reduced by 41 working days compared to the previous month. This has been driven by a focused piece of work in the Adult ADHD (attention deficit hyperactivity disorder) service.
- The transfer of CYP (Children's & Young Persons) occurred on 1 July 2025.
- At the time of reporting there are 41 open PALS cases which is a decrease of 13 (-24% since the previous month). The introduction of a new introduction process for PALS cases is effectively working and impacting on the figures.

Adult ADHD Service receives the highest number of formal complaints. A deep dive has been undertaken by the Customer Relations Team (46% of the PALS concerns access to treatment or drugs, 29% are attributed to clinical treatment). Formal complaints at 67% are attributed to clinical treatment and dispute over diagnosis. The Customer Relations Manager and Associate Chief Nurse are meeting with the ADHD team to agree how to better support patients. We are considering how we adopt some positive work doner in Coventry and Warwick who have implemented a pre-assessment consultation to understand patient expectations and provide information early in the pathway about diagnosis and the support available.

Culture of Care Programme

The programme is now live across all Hospital Sites in Secure and Offender Health. The involvement of patients and consistent use of patient councils and daily ward meetings is creating a shift in the cultural dynamic between patients and staff, increasing activities, therapeutic interventions and respect between colleagues. There is still more work to do on improving the multi-disciplinary team culture and engaging front line staff fully in the programme, particularly those who have been working permanent night duties. Staff rotation is now in place and the next steps this month at Reaside Clinic include tailored sessions on anti-racist practice supported by Catalyst4Change and a deep dive utilising the 'Token Exit Poll' in support of improving the working day/night for staff. The assurance meeting at Reaside Clinic this month gained assurance that all twelve domains of the

programme are being addressed with actions, and that connections with carers and the community are being developed, a Carers Event was held and celebrated at the meeting.

The programme is now being implemented at scale with the sixteen Acute Wards, a plan is in place identifying priority areas. Through the work at Reaside we have created an assurance framework aligning the Twelve standards with the CQC 'I and we' statements and this will provide a baseline assessment for all wards and ongoing assurance monitoring. Priorities include; leadership, staff skills and development, patient voice and activities, governance and assurance.

Recommendation

Board is asked to:

Receive the report and consider the contents and work being completed to learn and improve safety, experience and outcomes for patients.

Identify any areas for further consideration, improvement or assurance reporting

Thank the colleagues involved in successful implementation of the door alarm programme

Enclosures

Nil

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

Board Assurance Framework *updated June 25		
Strategic Risk	**Tick ✓**	**Comments**
SR3	✓	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Report to Board of Directors

Agenda item:	**12**					
Date	6 August 2025					
Title	Quality Account 2024/25					
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse					
Executive Director	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse	**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 Board of Directors has a duty to receive the Quality Account; as part of the governance process, the Board is asked to receive the Quality Account 2024/25 and note that it had been formally approved by Council of Governors and Quality, Patient Experience and Safety Committee in May.

The Quality Account 2024/25 was formally published in June 2025, in line with the statutory deadline.

Recommendations

The Board is asked to formally receive the Quality Account 2024/25 for assurance.

Enclosures

Quality Account 2024/25 – Reading Pack

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**13**						
Date	6 August 2025						
Title	Research and Development Annual Report Summary 2024/2025						
Author/Presenter	Emma Patterson, Head of R&D and Prof Alex Copello, Associate Director for Research and Development						
Executive Director	Dr Fabida Aria, Executive Medical Director	**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 and Introduction: This report serves to provide an overview of the work undertaken by the Research and Development Department on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust in 2024/2025, together with future plans for 2025/26.

Key Issues and Risks: None to report.

Recommendation

The Board is asked to receive the Annual Report 2024/25 for information and assurance.

Enclosures

Annual Report 2024/25 – available in the Reading Pack

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	**Improved patient outcomes and clinical care**
People	✓	**Staff retention and development**
Quality	✓	**Increase rapid access to evidence-based interventions**
Sustainability	✓	**Retention of staff, ability to generate more income**

Annual Report Summary 2024/25

We have grown our Research Capabilities exponentially through new partnerships and collaborations and by attracting more income to invest in the Trusts research infrastructure.

We brought in just under £1 million in income from grants, bids and trial activity to be spent in year and this is set to increase to a minimum exponentially next year, with the addition of the Children and Young Peoples (CYP) research portfolio and additional funds from the CYP element of the Mental Health Mission. We continue to invest in our staff, offering a development pathway from Band 4 to Band 6, and we will be offering up to two Band 7 posts in the next financial year. Both posts will be externally funded and will provide an opportunity for internal growth.

Our researchers have been successful on grant awards of almost £16 million, with approximately £2million of these funds coming directly to the Trust, over the course of the award. Again, this is set to increase within the next financial year, with the addition of the CYP grant portfolio, and with a number (6) grants submitted pending outcome, and two awards made to date.

Our governance team have supported over 100 different research teams during the financial year, across all stages of the research pathway from protocol development support, costing advice, through to regulatory approvals and delivery set up. Studies are approved and set up in an average of 43 calendar days with amendments to projects being arranged in 35 days. We have been working with Birmingham Health Partners (BHP) as part of their streamlining clinical trials approvals and have identified anomalies in the data dashboards they've produced. Their data shows a sharp increase in the time to taken to set up our studies which does not marry with our own data. We will undertake an audit of activity to ensure that the data captured by BHP is accurate and reflects our swift and efficient set up.

As a Trust, 85 articles were published in high quality academic peer reviewed journals ensuring wide dissemination of findings and impacts.

In the financial year we have recruited 347 participants to a number of complex National Institute for Health Research portfolio trials. Trusts that are research active have better outcomes for all patients, reduced mortality and improved overall quality of care not just those who are participating in clinical trials. In addition, it reduces burnout amongst staff and benefits the wider care system, transforming care by improving clinical practice and ultimately reducing the cost of healthcare. Some of the feedback received from service users involved in research is captured in the full report, but in summary, patients are grateful to receive potential treatment more quickly as a result of being selected for clinical trials, they have found their experience empowering, providing them with useful tools to aid discussion with their health practitioner and for some, they are simply keen to participate to provide hope and improved healthcare for people in the future.

For research that is developed and led by academics and clinicians within the Trust, the impacts are summarised below:

Research on supporting family members affected by addictions interventions based on the 5 Step method developed by Prof Alex Copello continue to inform clinical practice locally, in the UK and internationally, including through the Addiction and the Family International Network (AFINET).

The evidence synthesis conducted as part of a Health Technology Assessment grant for which Alex Copello was an Investigator (publication listed) has informed care models and clinical delivery for co-existing serious mental health and alcohol and drug problems.
We have supported Dr Ed Day to recruit service users on trials that have helped to lead the recommendation for the use of Naloxone as part of a front-line response to prevent drug-related overdoses.
Dr Ed Day has worked on Government guidance on supporting lived experience initiatives and recovery support service to help people start and sustain recovery from problem drug and alcohol use.
Through research funding, Dr Jed Jerwood has been appointed as the trusts first Clinical Academic in Art Psychotherapy at the Trust.
Dr Manny Bagary has introduced WatchPat technology for reliable portable sleep apnoea testing and diagnostics.
Through capital research funding, we have installed a Transcranial Magnetic Stimulation (TMS) machine for the treatment of drug-resistant epilepsy and sleep.
Through ongoing research, Dr Lizzie Newton and team have developed the Highly rated Mood on Track online service meaning we provide a high-quality service in line with NICE guidelines.
Through research infrastructure and capital funding, and led by Prof Steven Marwaha, we are the only Trust in the West Midlands offering a specialist Ketamine service to patients with Treatment Resistant Depression (TRD) and we will soon be the only Trust offering TMS to patients with TRD.
We have a strong track record of delivering research trials in Huntingtons Disease (HD), meaning Prof Hugh Rickards continues to be selected for all available trials including 'first in human' trials. We are the only service offering accesses to complex HD trials in the West Midlands.
Dr Clare Eddy is leading work to develop a tool to assess the impact of social cognition on the quality of life for service users with HD; again, as will all HD work, it is about improving QoL, longevity and hope.
Dr Analisa Smythe is leading work to meet the needs of international nurses to ensure integration in clinical teams, which is essential in ensuring a stable, qualified and reliable clinical workforce.
Through the perinatal mental health service, Dr Jelena Jankovic is supporting a multidisciplinary programme grant team to prevent preterm birth through cervical length screening.

The department have approved 35 Service Evaluations this year, with 23 currently ongoing. The impacts of these evaluations will be realised in the new financial year. Of the evaluations undertaken in 2023/24, there were a variety of impacts as outlined in section 10.0. However, some of the impacts are summarised below:

Interventions to engage patients at risk of metabolic syndrome have been introduced for patients under the Solihull Early Intervention Service
A pilot pathway for dads, partners and carers in the perinatal service was deemed to be not cost effective and the standard Carers Engagement Tool has been introduced instead
Initiatives have been introduced in among the Psychological Services staff to build confidence and the required skillset to consider gender, sexuality and relationship diversity in their clinical work
An Art Psychotherapy service has been embedded within the Steps to Recovery and Intensive Community Rehabilitation Teams
Working with the R&D team, a consultant practitioner has been appointed who will be responsible for the development, provision, and evaluation of a psychological professions' Research, Development & Innovation programme

Sharing the impacts from both research and service evaluations will be added to our departmental communications plan.

Finally, our Lived Experience Action Research Group (LEAR) continue to be a critical friend to R&D, ensuring that research priorities are focussed, that research is designed with the needs of the service user in mind, and by allowing the group to develop research based on their priorities. In addition, we want to build on this fantastic infrastructure by identifying sustainable and supportive pathways for our service users to be involved in research delivery and in paid employment.

Throughout the annual report we have identified actions and future work which are later summarised in the table overleaf.

Departmental Goals 2025/26

This section provides as summary of the goals for the department as outlined in this annual report and identifies the lead member of staff to take each item forward. This is effectively the departments Business Plan for 2024/25, the delivery of which will be overseen by the R&D Management Board.

Finance and Resources:	
R&D and Finance joint SOP	Head of Research & Development
Pharmacy to use EDGE	Research Governance Manager
Implementing the NIHR income distribution model	Research Governance Manager
Embed FTB Research team into department – reporting structure, financial management	Head of Research & Development/R&D Finance & Business Manager/HR
Increase income to cover overheads, margins and non-pay	Head of Research & Development
New departmental appointments:	
Delivery Team Manager (B7) – (externally funded)	Implementation & Performance Manager
Mood Disorders Delivery Team Manager (B7) – (0.5 WTE externally funded)	Implementation & Performance Manager
TRIDENT Trial Manager – (externally funded)	Senior Operations and Programme Manager
COMBINER Trial EBE Post (Band tbc) – (externally funded)	Implementation & Performance Manager
Review staffing requirements/funding to deliver 5 new addictions grants across Solihull and Wolverhampton	Head of Research & Development/ Implementation & Performance Manager
Support appointment of Trials Pharmacist (externally funded)	Research Governance Manager
Research Governance:	
Training the existing Service Evaluation lead to support research governance and approvals.	Research Governance Manager
Update the 'Issuing of Honorary Research Contracts and Letters of Access for Research within BSMHFT'	Research Governance Manager
Standard Operating Procedures (SOPs) to be developed:	

Archiving Essential Documentation – Research Studies	Research Governance Manager
Auditing – Research Studies	Research Governance Manager
Undertake audit to ascertain legitimate delays in study set up	Research Governance Manager
NIHR Objectives:	
Implement Research Champion programme	Implementation & Performance Manager
Strategy to engage all research teams in PRES	Implementation & Performance Manager
Service Evaluations:	
AMAT- localised use of AMAT tool to manage SE approvals and collate impacts	Head of Research & Development
Birmingham Health Partners:	
Review and implement Clinical Trials Dashboards	Research Governance Manager
Implement EDGE Clinical Trials management tool	Research Governance Manager
Oxford BRC:	
Use of DECODE to collect national dataset.	Senior Operations and Programme Manager
Central and North West Midlands Awarded Prestigious NIHR Commercial Research Delivery Centre (CDRC):	
Ensure MH represented at Partnership group and implement policies/processes as required	Head of Research & Development
UK-CRIS:	
IG arrangements with FTB due to shared Rio/explore FTB usage	Senior Operations and Programme Manager
Increasing our local investigator pool:	
Locally developed PI training	Implementation & Performance Manager
Increasing Clinical Research Nurse Capacity	
Research Nurse Mentoring/Shadowing opportunities	Nurse Researcher/Lead Nurse
Student Nurse Research Taster Days	Nurse Researcher/Lead Nurse
Delivery the West Midlands Wide NIHR WM Internship Programme	Nurse Researcher
Increasing the research capacity of Clinical Psychologists	
Work with the R,D&I Lead for Psychological Professions to increase research capacity	Head of Research & Development
Application for University/Teaching Trust Status:	
R&D Management Board Sub-Committee/working group established	Head of Research & Development and Associate Director of Research & Development

LEAR (Lived Experience Action Research) Group:	
Develop a business case to obtain funding to make the group sustainable in the long term	Implementation & Performance Manager
Create member 'profiles' to raise awareness of the skills and experiences in the group	Implementation & Performance Manager
Continue to develop members research skills with a program of tailored training in research methods	Implementation & Performance Manager
To co-produce a revamped Research Strategy and to explore key areas of research that align to the Trust's strategic priorities as well as areas of those that are of importance and interest to the group.	Implementation & Performance Manager
To update the evaluation documentation used by the LEAR group to monitor their impact on research grant proposals	Implementation & Performance Manager
Working with the trust recovery for all team to develop appropriate transition pathways for members to use their skills and experiences in opportunities beyond LEAR.	Implementation & Performance Manager
R&D Profile and Communications:	
Engage the new CYP directorate in R&D; ensuring staff know who to contact for approvals/support and delivery	Implementation & Performance Manager
R&D Showcase 2025	Implementation & Performance Manager
Seminar Series	Implementation & Performance Manager
Impacts of Research and Service Evaluations in R&D Communications plan	Implementation & Performance Manager
Develop Research Champion Programme	Implementation & Performance Manager
Mental Health Mission:	
Difficult to Tread Depression Platform build platform begin regulatory approvals, data collection and testing	Senior Operations and Programme Manager
TMS research service running and being evaluated (research grade)	Senior Operations and Programme Manager
Continue the evaluation of the Ketamine Clinic – support clinical nurse Manager (south) to develop business case for a Ketamine Service	Senior Operations and Programme Manager
Establish the Depression Research Clinic for Primary Care referrals	Senior Operations and Programme Manager
Designated facilities for Children and Young People's research	Senior Operations and Programme Manager
Implementation and Launch of EPICARE	Senior Operations and Programme Manager
Rebranding the centralised MHM Research Delivery Team	Senior Operations and Programme Manager

	Senior Operations and Programme Manager
Impacts on national/local guidance, changes to local practice and key achievements:	
Ongoing collection of impacts of research	Associate Director of Research & Development
Impact of NIHR Portfolio Participation on staff, service users and/or carers:	
Ongoing collection of impacts of research	Associate Director of Research & Development

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**22 July 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 • People Goals Q1 Report • CYP Transfer Report • Freedom to Speak Up Guardian Quarterly Report • Health Inequalities Report • WREs and WDES Annual Report • Multi-Professional Education and Training Group Assurance Report • Safer Staffing Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The financial scoping reviews for cost efficiency savings were reported to be affecting staff members' feeling anxiety around job security. Staffing vacancy was on a downward trajectory, which the Committee would continue to monitor to review any impact of leavers. • CYP data would be integrated into regular reporting from September, to monitor impact on data reporting for bank and agency use and vacancy levels. • The increase in use of AI bots in recruitment was impacting workload and the amount of time taken to complete recruitment processes due to the need for increased scrutiny of applications.
Assure:	• The Committee noted that there had been a reduction in vacancies. • The Committee was assured by the positive report into the CYP transfer, with 530 staff now part of team BSMHFT. The process was smooth and staff felt well-supported during the transfer. • The Committee was assured by the significant progress that had been made over the two years in relation to health inequalities, highlighted by the WRES/WDES report. Continued work was required to address racism and discrimination from members of the public, and a review of strategies was underway to address this.
Advise:	The People strategy goal progress was noted, with strategy refresh and timelines highlighted. Positive progress had been seen in cultural work elements, including

	active bystander and restorative just culture. The Committee was particularly mindful of the need to incorporate CYP into the new strategy. The Committee was advised of the national decommissioning of the Freedom to Speak Up Guardian Office, and the impact this may have on local progress.	
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.	
	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 Strategy Session**
Report presented at	**Board of Directors**
Date of meeting	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**17 June 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee held a strategy session on Sickness Absence and Values-Based Appraisals.
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Highest sickness related absence was reported within Secure Care and Offender Health with 30,516 FTE days lost. • Sickness absence for colleagues who identified as BME staff was higher in musculoskeletal conditions (62%). • Colleagues who identified as white reported higher sickness absence relating to stress, anxiety, depression (53%). Further aggregation of the data in these areas was required to understand the root cause of both these sickness conditions as in the working conditions, working environment and personal/home matters. • Some negative feedback on the use of the ESR system for recording appraisal details remained.
Assure:	• There was a reported year on year reduction in sickness over the past three years. The Committee was keen to understand the themes and patterns of increased sickness periods. • The Committee was assured by the QI approach to values-based appraisals, which had received positive uptake with 46 members of staff involved from a diverse pool of disciplines.
Advise:	The Committee was advised on the targeted actions being taken to support divisional leaders and managers in addressing sickness absence and return to work conversations with team members following absence. The new Occupational Health team had received positive feedback since launching on 1 April 2025. The Committee noted that a launch of an appraisal app pilot to navigate some ESR challenges was planned to support managers. Values-Based Appraisal tools were being introduced at staff inductions, including introduction to coaching conversations and half-day training workshops.
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

Report to Board of Directors

Agenda item:	15a					
Date	6 August 2025					
Title	Guardian of Safe Working Hours Quarterly Report (Q4)					
Author/Presenter	Hari Shanmugaratnam, Guardian of Safe Working					
Executive Director	Fabida Aria, Medical Director	**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**	✓

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

- No immediate safety concerns were raised during this quarter.
- Exception reporting rates have remained stable this quarter. 11 unique exception reports were raised during this quarter, of which 8/11 related to overtime working.
- 2 fines were levied against the Trust for breaches in safe working hours.
- The number of outstanding reports carried forward has increased to 7.
- The number of vacant shifts continues to be high. 280 locum bookings occurred in Q4 (Q1 had 370, Q2 had 260, Q3 had 191). 27% of the gaps were due to post vacancies. 280/280 on call locum vacancies during this period were filled.

Recommendations

The Board is asked to receive the report for assurance.

Enclosures

N/A

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

April – June 2024

High level data
Number of doctors / dentists in training (total): 148

Number of doctors / dentists in training on 2016 TCS (total): 148

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

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

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	4	0	4
CT1-3	1	5	3	3
ST 3-6	0	2	2	0
GPVTS	0	0	0	0
Total	1	11	5	7

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	1	9	3	7
ST North	0	1	1	0
ST South	0	0	0	0
ST Forensic	0	1	1	0
Total	1	11	5	7

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	4
CT1-3	0	2	1	3

ST3-6	1	0	1	0
GPVTS	0	0	0	0
Total	1	2	2	7

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 11 exception reports were raised in total.

Of the 11 exception reports; 8 related to working overtime. 1 was related to breaches of natural breaks and 2 were related to difference in educational opportunities.

c) Work Schedule Reviews

Status;

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST3-6	0
GPVTS	0
Total	0

d) Locum bookings and vacancies

Locum bookings JANUARY 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	8	8	88.50	88.50
Rota 2	9	9	86.50	86.50
Rota 3	10	10	105.00	105.00
Rota 4	6	6	59.00	59.00
Rota 5	6	6	67.00	67.00
Rota 6	3	3	13.50	13.50
ST4-6 North & East	8	8	76.00	76.00
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 South & Solihull	19	19	199.00	199.00
Total	72	72	750.50	750.50

Locum bookings FEBRUARY 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	9	9	100.50	100.50
Rota 2	13	13	126.00	126.00
Rota 3	3	3	29.00	29.00
Rota 4	11	11	126.00	126.00
Rota 5	13	13	113.00	113.00
Rota 6	9	9	95.00	95.00
ST4-6 North & East	11	11	102.00	102.00
ST4-6 Rea/Tam	0	0	0	0
ST4-6 South & Solihull	23	23	241.50	241.50
Total	92	92	933.00	933.00

Locum bookings MARCH 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	10	10	120.00	120.00
Rota 2	12	12	123.50	123.50
Rota 3	13	13	149.00	149.00
Rota 4	11	11	109.50	109.50
Rota 5	17	17	168.00	168.00
Rota 6	13	13	147.50	147.50
ST4-6 North & East	10	10	84.00	84.00
ST4-6 Rea/Tam	2	2	32.00	32.00
ST4-6 South & Solihull	28	28	287.00	287.00
Total	116	116	1220.50	1220.50

Locum bookings JANUARY 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	42	42	419.50	419.50
ST4-6	30	30	331.00	331.00
Total	72	72	750.50	750.50

Locum bookings FEBRUARY 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked

CT1-3	58	58	589.50	589.50
ST4-6	34	34	343.50	343.50
Total	92	92	933.00	933.00
Locum bookings MARCH 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	76	76	817.50	817.50
ST4-6	40	40	403.00	403.00
Total	116	116	1220.50	122.50

Locum bookings JANUARY 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	23	23	234.50	234.50
Sickness	15	15	163.50	163.50
Off Rota	16	16	156.00	156.00
Emergency Leave / Bereavement	4	4	42.00	42.00
Maternity / Paternity / Paternal Leave	1	1	12.00	12.00
Prebooked Leave based on Rotas from Aug 24 to Feb 25	5	5	38.00	38.00
Acting Up Consultant	8	8	104.50	104.50
Total	72	72	750.50	750.50

Locum bookings FEBRUARY 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	1	1	12.00	12.00
Vacancy	24	24	230.00	230.00
Sickness	34	34	350.50	350.50
COVID	0	0	0	0
Off Rota	8	8	97.00	97.00
Comp Leave /	1	1	4.50	4.50

Bereavement				
Prebooked Leave based on Rotas from Aug 24 to Feb 25	6	6	74.00	74.00
NOT AVAILABLE	2	2	25.00	25.00
Emergency Leave	4	4	40.50	40.50
Acting Up Consultant	12	12	99.50	99.50
Total	92	92	933.00	933.00

Locum bookings MARCH 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	29	29	292.50	292.50
COVID	3	3	36.00	36.00
Sickness	35	35	376.00	376.00
Off Rota	34	34	371.50	371.50
Emergency Leave	1	1	4.50	4.50
Acting up Consultant	3	3	29.50	29.50
Prebooked Leave based on Rotas from Dec 24 to Apr 25	11	11	110.50	110.50
Total	116	116	1220.50	122.50

Fines levied

two fines have been levied in Q4. Ideas for disbursement of previously accrued fines will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has remained stable, with 11 unique reports submitted during the quarter. Similar to the previous quarters for the year 2024-2025, the majority of exception reports related to overtime (working beyond scheduled hours) or not achieving natural breaks rather breaches of core rest requirements overnight.

The number of vacant shifts continues to be high. 280 locum bookings occurred in Q4 (Q1 had 370, Q2 had 260, Q3 had 191). 27% of the gaps were due to post vacancies. 280/280 on call locum vacancies during this period were filled.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. Exception reporting rates have increased. 11 unique exception reports were raised during this quarter, of which 73% related to overtime working.

The number of exception reports being raised is likely to represent the exception report system being under utilised by resident doctors.

Two fines were levied against the Trust for breaches in safe working hours.

Out of the reports closed, only 20% were within 48 hours and a further 40% were within 7 days.

The number of vacant shifts continues to be high. 280 locum bookings occurred in Q4 (Q1 had 370, Q2 had 260, Q3 had 191). 27% of the gaps were due to post vacancies. 280/280 on call locum vacancies during this period were filled.

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	15b					
Date	6 August 2025					
Title	Guardian of Safe Working Hours Annual Report 2024/25					
Author/Presenter	Hari Shanmugaratnam, Guardian of Safe Working Hours					
Executive Director	Fabida Aria, Medical Director	**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**	✓

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

The number of vacant shifts has in 2024-2025 was 1101. This is significantly lower than 2023-2024 when it was 1583.

Vacancies were fairly evenly distributed across most rotas, with the highest number of gaps on the ST South and Solihull rota (201) and ST North rota (178) and the lowest on the ST Forensic rota (39).

Recommendations

The Board is asked to formally receive the Guardian of Safe Working Hours Annual Report 2024/25 for assurance.

Enclosures

N/A

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING (2024-25)

High level data (from August 2023 onwards)

Number of doctors / dentists in training (total): 375 training posts available

Number of doctors / dentists in training on 2016 TCS (total): 338

Annual vacancy rate among this staff group: 9.9%

Annual data summary

Rotation	Grade	Total posts available	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Apr-24	FY1	14	13	N/A	1	0
	FY2	13	10	3	0	1
	GPVTS	20	16	4	0	3
Aug-24	FY1	15	14	0	0	0
	FY2	14	13	1	0	0
	GPVTS	20	15	5	0	4
Dec-24	FY1	15	15	0	0	0
	FY2	14	12	2	0	0
	GPVTS	20	18	2	0	3

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Aug-24	CT1	19	16	0	3	4
	CT2	10	9	1	0	0
	CT3	24	20	1	3	4
Feb-25	CT1	19	16	0	3	5
	CT2	10	8	2	0	3
	CT3	24	23	0	1	5

Higher Training

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Feb-24 To Aug 24	ST GA	25	21	0	4	5
	ST OA	5	5	0	0	0
	ST Forensic	12	10	0	2	2
	Psychotherapy	3	2	0	0	0
Aug-24 to Feb 25	ST GA	25	23	0	2	5
	ST OA	5	5	0	0	0
	ST Forensic	12	12	0	0	3
	Psychotherapy	3	2	0	1	1
Feb-25 to Aug 25	ST GA	25	22	0	3	4
	ST OA	5	4	0	1	0
	ST Forensic	12	12	0	0	3
	Psychotherapy	3	2	0	1	0

Rota gap summary

Rota	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)	Number of shifts uncovered (over the year)
1	38	19	28	27	2.2	0
2	37	13	12	34	1.8	0
3	13	25	16	26	1.5	0
4	57	36	20	28	2.7	0
5	29	23	25	36	2.2	0
6	48	39	29	25	2.7	0
ST North and East	80	50	19	29	3.4	0
ST South and Solihull	52	47	32	70	3.8	0
ST Forensic	16	8	10	5	0.8	0
TOTAL	**370**	**260**	**191**	**280**	**21.1 (30.4 in 2023-24)**	**0**

Reason for rota gap	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)
Vacancies and backup rota used	8	0	0	0	0.2
Vacancy	212	133	37	76	8.8
Sickness	38	37	74	84	4.5
COVID-19	2	0	4	3	0.2
Maternity/Paternity Leave	19	8	3	1	0.6
Off Rota	56	42	39	58	3.8
Compassionate/ Emergency/ Bereavement Leave	8	8	10	10	0.7
Training/Exam	2	0	0	0	0.0
Acting up Consultant	11	11	11	23	1.1
New Intake	11	21	10	1	0.8
Not contactable	2	0	0	0	0.0
Pre-booked leave agreed	0	0	2	22	0.5
Not filled	0	0	1	0	0.0
Not available	0	0	0	2	0.0

Issues arising

The number of vacant shifts has in 2024-2025 was 1101. This is significantly lower than 2023-2024 when it was 1583. The three biggest causes of vacant shifts were Vacancy (458 shifts), sickness (233) and people who are off rota (195).

When comparing the rotas, the ST North and East, and the ST South and Solihull rotas have significantly higher rota gaps than the other rotas.

High vacancy rates are multi-factorial in cause. Training post recruitment is via a national rather than local process.

Summary

The number of vacant shifts has in 2024-2025 was 1101. This is significantly lower than 2023-2024 when it was 1583.

It is important to note that 55 out of the 338 (16.2%) doctors in training employed in 2024-2025 were LTFT. It was 13.1% of doctors in training in 2023-2024. As workforce patterns continue to change, it may have increasing effects on vacant shift rates.

Appendix 1: Locum Bookings By Rota

Locum bookings APRIL 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	203.50	203.50
Rota 2	12	12	122.50	122.50
Rota 3	3	3	36.00	36.00
Rota 4	20	20	203.50	203.50
Rota 5	10	10	90.00	90.00
Rota 6	15	15	135.00	135.00
ST4-6 North & East	21	21	239.50	239.50
ST4-6 Rea/Tam	4	4	80.00	80.00
ST4-6 South & Solihull	23	23	219.00	219.00
Total	128	128	1329.00	1329.00
Locum bookings MAY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	10	10	97.50	97.50
Rota 2	13	13	103.75	103.75
Rota 3	6	6	73.00	73.00
Rota 4	19	19	183.50	183.50
Rota 5	8	8	82.00	82.00
Rota 6	18	18	164.00	164.00
ST4-6 North & East	27	27	251.00	251.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 South & Solihull	17	17	159.50	159.50
Total	127	127	1282.25	1282.25

Locum bookings JUNE 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	8	8	88.50	88.50
Rota 2	12	12	107.00	107.00
Rota 3	4	4	42.00	42.00
Rota 4	18	18	165.00	165.00
Rota 5	11	11	116.75	116.75
Rota 6	15	15	166.00	166.00
ST4-6 North & East	32	32	283.00	283.00
ST4-6 Rea/Tam	3	3	48.00	48.00
ST4-6 South & Solihull	12	12	116.00	116.00
Total	115	115	1132.25	1132.25

Locum bookings JULY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	6	6	45.50	45.50
Rota 2	5	5	45.00	45.00
Rota 3	3	3	36.00	36.00
Rota 4	15	15	144.00	144.00
Rota 5	8	8	74.50	74.50

Rota 6	28	28	255.50	255.50
ST4-6 North & East	29	29	336.50	336.50
ST4-6 Rea/Tam	6	6	112.00	112.00
ST4-6 South & Solihull	18	18	181.00	181.00
Total	118	118	1230.00	1230.00
Locum bookings AUGUST 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	11	11	110.00	110.00
Rota 2	8	8	81.00	81.00
Rota 3	10	10	114.00	114.00
Rota 4	17	17	152.50	152.50
Rota 5	9	9	63.50	63.50
Rota 6	9	9	87.00	87.00
ST4-6 North & East	14	14	131.50	131.50
ST4-6 Rea/Tam	2	2	40.00	40.00
ST4-6 South & Solihull	13	13	147.00	147.00
Total	93	93	926.50	926.50

Locum bookings SEPTEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	2	2	16.50	16.50
Rota 2	0	0	0	0
Rota 3	12	12	130.50	130.50
Rota 4	4	4	40.50	40.50
Rota 5	6	6	57.50	57.50
Rota 6	2	2	17.00	17.00
ST4-6 North & East	7	7	55.00	55.00
ST4-6 Rea/Tam	0	0	0	0
ST4-6 South & Solihull	16	16	155.00	155.00
Total	49	49	472.00	472.00

Locum bookings OCTOBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	78	78
Rota 2	0	0	0	0
Rota 3	6	6	57.50	57.50
Rota 4	4	4	40.50	40.50
Rota 5	4	4	34.00	34.00
Rota 6	7	7	70.00	70.00
ST4-6 North & East	2	2	16.50	16.50
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 South & Solihull	12	12	92.00	92.00
Total	45	45	444.50	444.50
Locum bookings NOVEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	8	8	66.50	66.50
Rota 2	4	4	49.00	49.00

Rota 3	6	6	65.00	65.00
Rota 4	5	5	38.50	38.50
Rota 5	12	12	92.50	92.50
Rota 6	10	10	106.00	106.00
ST4-6 North & East	4	4	41.00	41.00
ST4-6 Rea/Tam	3	3	64.00	64.00
ST4-6 South & Solihull	10	10	107.00	107.00
Total	62	62	629.50	629.50

Locum bookings DECEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	13	13	134.00	134.00
Rota 2	8	8	74.50	74.50
Rota 3	4	4	41.00	41.00
Rota 4	11	11	126.50	126.50
Rota 5	9	9	85.50	85.50
Rota 6	12	12	129.50	129.50
ST4-6 North & East	13	13	137.00	137.00
ST4-6 Rea/Tam	4	4	72.00	72.00
ST4-6 South & Solihull	10	10	115.00	115.00
Total	84	84	915.00	915.00

Locum bookings JANUARY 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	8	8	88.50	88.50
Rota 2	9	9	86.50	86.50
Rota 3	10	10	105.00	105.00
Rota 4	6	6	59.00	59.00
Rota 5	6	6	67.00	67.00
Rota 6	3	3	13.50	13.50
ST4-6 North & East	8	8	76.00	76.00
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 South & Solihull	19	19	199.00	199.00
Total	72	72	750.50	750.50
Locum bookings FEBRUARY 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	9	9	100.50	100.50
Rota 2	13	13	126.00	126.00
Rota 3	3	3	29.00	29.00
Rota 4	11	11	126.00	126.00
Rota 5	13	13	113.00	113.00
Rota 6	9	9	95.00	95.00
ST4-6 North & East	11	11	102.00	102.00
ST4-6 Rea/Tam	0	0	0	0

ST4-6 South & Solihull	23	23	241.50	241.50
Total	92	92	933.00	933.00

Locum bookings MARCH 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Rota 1	10	10	120.00	120.00
Rota 2	12	12	123.50	123.50
Rota 3	13	13	149.00	149.00
Rota 4	11	11	109.50	109.50
Rota 5	17	17	168.00	168.00
Rota 6	13	13	147.50	147.50
ST4-6 North & East	10	10	84.00	84.00
ST4-6 Rea/Tam	2	2	32.00	32.00
ST4-6 South & Solihull	28	28	287.00	287.00
Total	116	116	1220.50	1220.50

Appendix 2: Locum bookings by grade

Locum bookings APRIL 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	80	80	790.50	790.50
ST4-6	48	48	538.50	538.50
Total	128	128	1329.00	1329.00

Locum bookings MAY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	74	74	703.75	703.75
ST4-6	53	53	578.50	578.50
Total	127	127	1282.25	1282.25

Locum bookings JUNE 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	68	68	685.25	685.25
ST4-6	47	47	447.00	447.00
Total	115	115	1132.25	1132.25

Locum bookings JULY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	65	65	600.50	600.50
ST4-6	53	53	629.50	629.50
Total	118	118	1230.00	1230.00

Locum bookings AUGUST 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	64	64	608.00	608.00
ST4-6	29	29	318.50	318.50
Total	93	93	926.50	926.50
Locum bookings SEPTEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	26	26	262.00	262.00
ST4-6	23	23	210.00	210.00
Total	49	49	472.00	472.00

Locum bookings OCTOBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	28	28	280.00	280.00
ST4-6	17	17	164.50	164.50
Total	45	45	444.50	444.50

Locum bookings NOVEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	45	45	417.50	417.50
ST4-6	17	17	212.00	212.00
Total	62	62	629.50	629.50
Locum bookings DECEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	57	57	591.00	591.00
ST4-6	27	27	324.00	324.00
Total	84	84	915.00	915.00

Locum bookings JANUARY 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	42	42	419.50	419.50
ST4-6	30	30	331.00	331.00
Total	72	72	750.50	750.50

Locum bookings FEBRUARY 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	58	58	589.50	589.50
ST4-6	34	34	343.50	343.50
Total	92	92	933.00	933.00
Locum bookings MARCH 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	76	76	817.50	817.50
ST4-6	40	40	403.00	403.00
Total	116	116	1220.50	122.50

Appendix 3: Locum Bookings by Reason

Locum bookings APRIL 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	10	10	90.00	90.00
Vacancy	55	55	586.00	586.00
COVID	2	2	25.00	25.00
Sickness	8	8	78	78
Off Rota	28	28	330.50	330.50
Emergency Leave	1	1	4.50	4.50
Maternity Leave	17	17	160.50	160.50
Exam Leave	2	2	24.00	24.00
Acting Up Consultant	5	5	30.50	30.50
Total	128	128	1329.00	1329.00

Locum bookings MAY 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	1	1	4.50	4.50

Vacancy	78	78	818.25	818.25
Sickness	14	14	116.50	116.50
Not Contactable	2	2	8.50	8.50
Off Rota	18	18	187.50	187.50
Compassionate Leave	4	4	40.50	40.50
Paternity Leave	2	2	17.00	17.00
Emergency Leave	1	1	12.00	12.00
Acting Up Consultant	6	6	73.00	73.00
Total	127	127	1282.25	1282.25

Locum bookings JUNE 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancies & Back Up Rota Used	8	8	89.00	89.00
Vacancy	79	79	738.00	738.00
Sickness	16	16	167.25	167.25
Off Rota	10	10	114.00	114.00
Emergency Leave	2	2	24.00	24.00
Total	115	115	1132.25	1132.25

Locum bookings JULY 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	77	77	787.50	787.50
Sickness	15	15	160.50	160.50
Off Rota	10	10	105.00	105.00
Emergency Leave / Compassionate	5	5	53.00	53.00
Maternity / Paternity Leave	2	2	25.00	25.00
Exam Leave	0	0	0	0
Acting Up Consultant	9	9	99.00	99.00
Total	118	118	1230.00	1230.00

Locum bookings AUGUST 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	21	21	162.00	162.00
Vacancy	31	31	322.50	322.50
Sickness	15	15	159.00	159.00
Not Contactable	0	0	0	0
Off Rota	23	23	230.50	230.50
Comp Leave	0	0	0	0

Maternity / Paternity Leave	1	1	12.50	12.50
Emergency Leave	0	0	0	0
Acting Up Consultant	2	2	40.00	40.00
Total	93	93	926.50	926.50

Locum bookings SEPTEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Maternity/Paternity	5	5	52.50	52.50
Vacancy	25	25	219.50	219.50
Sickness	7	7	63.00	63.00
Off Rota	9	9	101.00	101.00
Emergency Leave	3	3	36.00	36.00
Total	49	49	472.00	472.00

Locum bookings OCTOBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	16	16	124.50	124.50
Sickness	18	18	174.00	174.00
Off Rota	8	8	90.00	90.00
Emergency Leave / Compassionate	0	0	0	0
Maternity / Paternity Leave	0	0	0	0
Exam Leave	0	0	0	0
Acting Up Consultant	3	3	56.00	56.00
Total	45	45	444.50	444.50

Locum bookings NOVEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	13	13	113.00	113.00
Sickness	32	32	302.00	302.00
COVID	4	4	48.00	48.00
Off Rota	8	8	97.00	97.00
Comp Leave / Bereavement	2	2	25.00	25.00
Maternity / Paternity Leave	0	0	0	0
Emergency Leave	1	1	4.50	4.50
Acting Up Consultant	2	2	40.00	40.00
Total	62	62	629.50	629.50

Locum bookings DECEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Maternity/Paternity	3	3	36.00	36.00
Vacancy	8	8	89.00	89.00
NEW DEC INTAKE	10	10	75.00	75.00
Sickness	24	24	267.50	267.50
Off Rota	23	23	263.00	263.00
Comp Leave / Bereavement	6	6	65.00	65.00
Emergency Leave	1	1	4.50	4.50
Actg up Consultant	6	6	85.50	85.50
Pre-Booked Leave Agreed	2	2	17.00	17.00
NOT FILLED	**1**	**1**	**12.50**	**12.50**
Total	84	84	915.00	915.00

Locum bookings JANUARY 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	23	23	234.50	234.50
Sickness	15	15	163.50	163.50
Off Rota	16	16	156.00	156.00
Emergency Leave / Bereavement	4	4	42.00	42.00
Maternity / Paternity / Paternal Leave	1	1	12.00	12.00
Prebooked Leave based on Rotas from Aug 24 to Feb 25	5	5	38.00	38.00
Acting Up Consultant	8	8	104.50	104.50
Total	72	72	750.50	750.50

Locum bookings FEBRUARY 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	1	1	12.00	12.00
Vacancy	24	24	230.00	230.00
Sickness	34	34	350.50	350.50
COVID	0	0	0	0
Off Rota	8	8	97.00	97.00
Comp Leave / Bereavement	1	1	4.50	4.50

Prebooked Leave based on Rotas from Aug 24 to Feb 25	6	6	74.00	74.00
NOT AVAILABLE	2	2	25.00	25.00
Emergency Leave	4	4	40.50	40.50
Acting Up Consultant	12	12	99.50	99.50
Total	92	92	933.00	933.00

Locum bookings MARCH 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	29	29	292.50	292.50
COVID	3	3	36.00	36.00
Sickness	35	35	376.00	376.00
Off Rota	34	34	371.50	371.50
Emergency Leave	1	1	4.50	4.50
Acting up Consultant	3	3	29.50	29.50
Prebooked Leave based on Rotas from Dec 24 to Apr 25	11	11	110.50	110.50
Total	116	116	1220.50	122.50

Report to Board of Directors							
Agenda item:	**16**						
Date	6 August 2025						
Title	**FREEDOM TO SPEAK UP GUARDIAN REPORT**						
Author/Presenter	Emma Randle, Lead Freedom to Speak Up Guardian						
Executive Director	Lisa Stalley-Green (Director of Quality and Safety & Chief Nurse.	**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 assurance to the Board of Directors that the Freedom to Speak Up Guardians in partnership with the Trust are taking action to promote the following:

Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up

Speaking up policies and processes are effective and constantly improved

Senior leaders role model effective speaking up

All colleagues are encouraged to speak up

Individuals are supported when they speak up

Barriers to speaking up are identified and tackled

Information provided by speaking up is used to learn and improve

Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

This report reflects activity from Quarter 1 (April-June 2025)

Recommendations:

In previous reports we have highlighted some of the limitations of listening and engagement tools especially when trying to engage front line clinicians, and in terms of including new voices we aren't hearing from. Our latest Staff Survey results also illustrate the need for the Trust to consider new

initiatives and approaches to ensure that every voice matters and that staff feel safe to speak up about anything that concerns them. (Staff Survey results, 2024).

Led by our Chief Executive, the trust has accepted our recommendation for a new style of communication engagement and feedback initiative. The project has a working title of "All our Voices" with stakeholders currently working up proposals. We have a provisional launch date of September 2025. More information will be shared with the Board as the initiative progresses.

Enclosures
N/A

FREEDOM TO SPEAK UP GUARDIAN REPORT

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

Board Assurance Framework		
Strategic Risk	**Tick**	**Comments**
BAF02/QPES	✓	Potential failure to focus on the reduction and prevention of patient harm
BAF03/QPES	✓	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance
BAF06/QPES	✓	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing
BAF01/PC	✓	Potential failure to shape our future workforce.
BAF02/PC	✓	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience
BAF03/PC	✓	Inability to modernise our People Practice
BAF04/PC	✓	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation

1. INTRODUCTION AND BACKGROUND

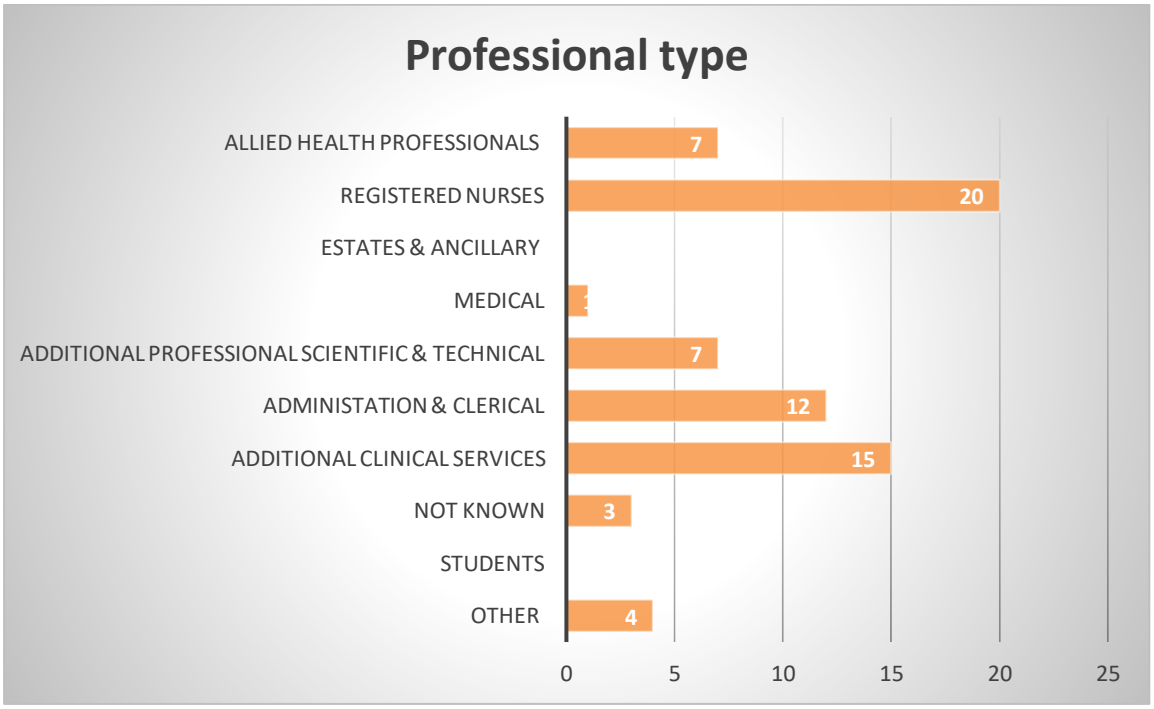
1.2. This report provides an update on activity from the Trust's Lead Freedom to Speak Up Guardian (FTSUG) following the previous Annual Board report in April 2025. This report covers **Quarter 1** (April-June 2025).

2. WHO IS SPEAKING UP TO THE SPEAK UP GUARDIANS?

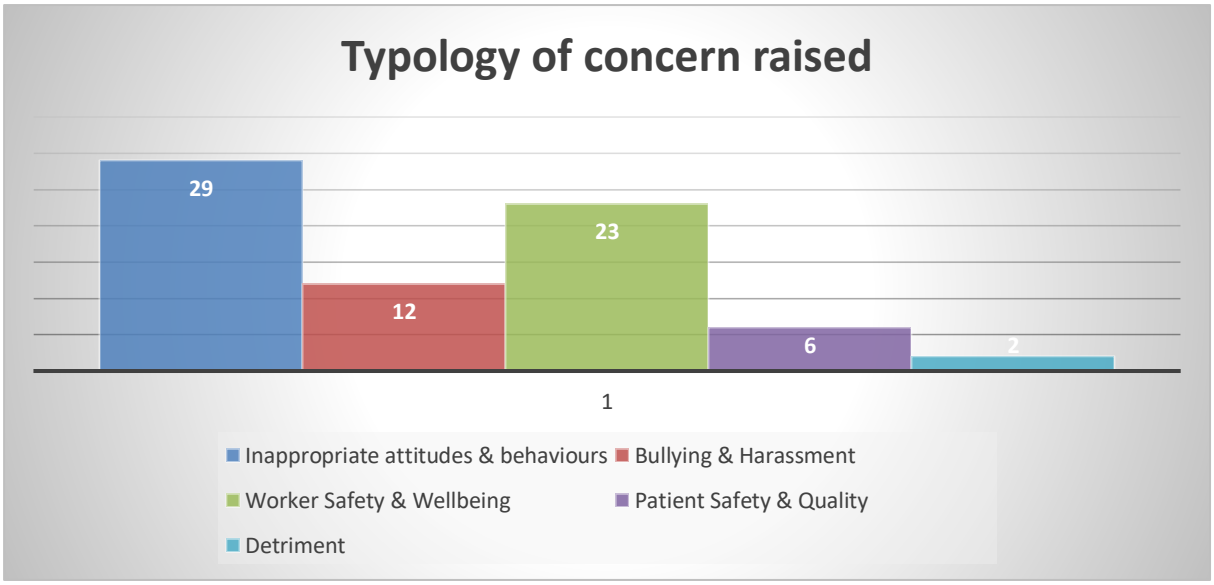
2.1 This quarter, the Freedom to Speak up Guardians and Champions received **72** speaking up concerns. (Quarter 4 was 94 contacts). We would expect to see a reduction in the use of the Guardian as staff are encouraged to resolve concerns at an earlier stage and with their local leaders.

2.2 Guardians and Champions are only one route of speaking up and other routes are embedded across the organisation.

2.3 Below is a breakdown of Guardian contact data contacts by professional group:



This quarter, the highest category of workforce representation was from Registered Nurses accounting for 29% of all contacts broadly in line with last quarter. For context this only equates to approximately 2% of our total registered nursing workforce. Second was additional clinical services (support to doctors and nurses, including HCAs) which accounted for just under a quarter (22%) of our contacts, and only approximately 3% in terms of the total additional clinical services workforce.



2.4 The above graph shows that concerns that have an element of inappropriate attitudes and behaviour make up the highest proportion to date, at 40%. The sub themes include concerns about incivility, rudeness, relational conflict, and behaviour not in line with our values. Just under one in three concerns fall into Worker safety and wellbeing. When colleagues tell us that they are feeling stressed and bullied or experience/ witness inappropriate behavior, we also record them in this category.

2.5 It is important to view relational conflict and inappropriate attitudes and behaviour as having a direct impact on patient safety and quality and not just a feature of culture alone. We can see this in the learning from inquiries such as the Francis Report (2013) and research evidence from publications like *The Price of Incivility,* (Porath & Pearson, 2013). This work highlights that even when you witness someone else being rude, there is a 20% decrease in performance and a 50% reduction in willingness to help others. Incivility affects more than just the recipient; it affects everyone in the team compromising patient safety and quality.

2.6 Going forward when inappropriate attitudes and bullying and harassment cases are raised with us, we will also record these in the “Patient Safety and Quality” category where relevant. We will continue to seek assurances that in addition to relational follow up actions, local leaders also give sufficient scrutiny and attention to the mitigation of risks to wider patient quality and safety.

3. TYPES AND THEMES OF ISSUES RAISED

3.1 Most of the concerns managed by the Guardians this quarter have been isolated and disparate in nature. However, some clear themes have emerged to date and these are:

- Complaints about the competence, conduct and compassion of team and line managers. Details include a lack of RMS and worker development and a lack of skills in managing team and interpersonal conflict and incivility
- Bank staff and managers adjusting to the new guidance in bank shift allocation
- Bank staff enquiries for restricted duties

3.2 We have also handled an anonymous letter from a colleague in Acute and Urgent Care (Barberry). We are aware that senior managers in this area may have received the same letter which was also sent to the CQC. A summary of the complaint covers the following areas:

- Unprofessional conduct, incivility amongst the team inappropriate use of personal devices
- Concerns previously raised have not been insufficiently resolved or are lacking a response,
- Complaints about the quality of leadership, favouritism and managers not following policy
- Irregular shift allocations and a lack of support for coroner's court appearances

3.3 Also included in the letter are patient safety and quality issues describing:

Incomplete hand overs, gaps in handovers, shifts not covered by suitably qualified staff (Call before Convey), Inappropriate waits for patients on PDU; Lack of diversity in doctors undertaking MHA assessment resulting in "predetermined outcomes", delays in street triage because of a lack of paramedics, Bed managers "purposefully hiding beds"

3.4 We have received a copy of the enhanced monitoring action plan from service managers to assure us that all concerns have been or are in the process of being followed up to include regular updates on progress to the Chief Nurse. We have suggested to managers that their action plan also enables staff to be sighted on all the concerns and fully engaged in their resolution, resultant learning and development. We are pleased that this important element has been included.

4. IMPROVING OUR SPEAK UP CULTURE AND ARRANGEMENTS

4.1 This quarter we have held surgeries, listening events and walk rounds at Reaside (night surgeries); The Juniper Centre (to include an evening surgery); HMP Birmingham to include a morning on the healthcare wing; and all wards at Ardenleigh.

4.2 We have hosted awareness raising sessions with some of the clinical teams at Newington /Maple Leaf centre and with the Pharmacy team.

4.3 We know we hold surgeries and listening events in some areas more than others. To address this and ensure parity, we have completed our trust wide gap analysis. From Quarter 2 we will be collating and monitoring our activity team by team, ward by ward. This information can also be readily shared with the Board, Senior leadership team and with the CQC when they ask us for site activity.

4.4 We continue attending inductions and this quarter we have taken part in the corporate and student / Master's student nurse's induction.

4.5 In response to their Staff Survey results, some teams have contacted us following their interactions with the Staff Experience and Engagement Lead asking us to present at their Away Days. This includes the Mental Health Act team and the Occupational Health team for Secure and Offender Health (based at the Tamarind).

4.6 We have shared our proposals with our Executive/Non-Executive Leads for how the Trust formally addresses concerns that relate to detriment from speaking up. The National Guardians Office has issued guidance for all Trusts Detriment-guidance.pdf and we will consult with all stakeholders in due course. This is one of the objectives from the Freedom to Speak Up Improvement plan.

4.7 All Guardians have now completed the People Management masterclass for Leading Investigations. We are currently working with one of our People Partners to include FTSU specific activity for trust investigators and commissioning managers, fully aligning our processes for disciplinaries and investigations (Dignity at Work and Resolution of Grievance). We have also agreed to work collaboratively on several development projects to strengthen our joint processes and to share learning and improvement with case work.

4.8 The goals listed below are held by the FTSU Guardian team. Milestone progress will be reported periodically. Colleagues supporting the People Promise strategy work "We have a voice that counts" have been fully appraised of our objectives as part of the Quality goals for 25/26 which are as follows:

Quality Goal	Senior Nursing Directorate Staff to have completed e-learning module	SLT presentation to socialise e-learning for all senior staff to cascade to their teams	Clinical leadership programme commencement to support conflict resolution within clinical leadership capability	Roll out of tool kit for leaders to support with appreciation of barriers to speaking up and mechanisms to overcome them

4.9 Guardians attended the Public Interest Disclosure Act (PIDA, 1998) webinar hosted by the National Guardians Office (NGO) supporting Guardians with the skills and knowledge to manage these enquiries.

5. SUPPORTING AN INCLUSIVE SPEAK UP CULTURE

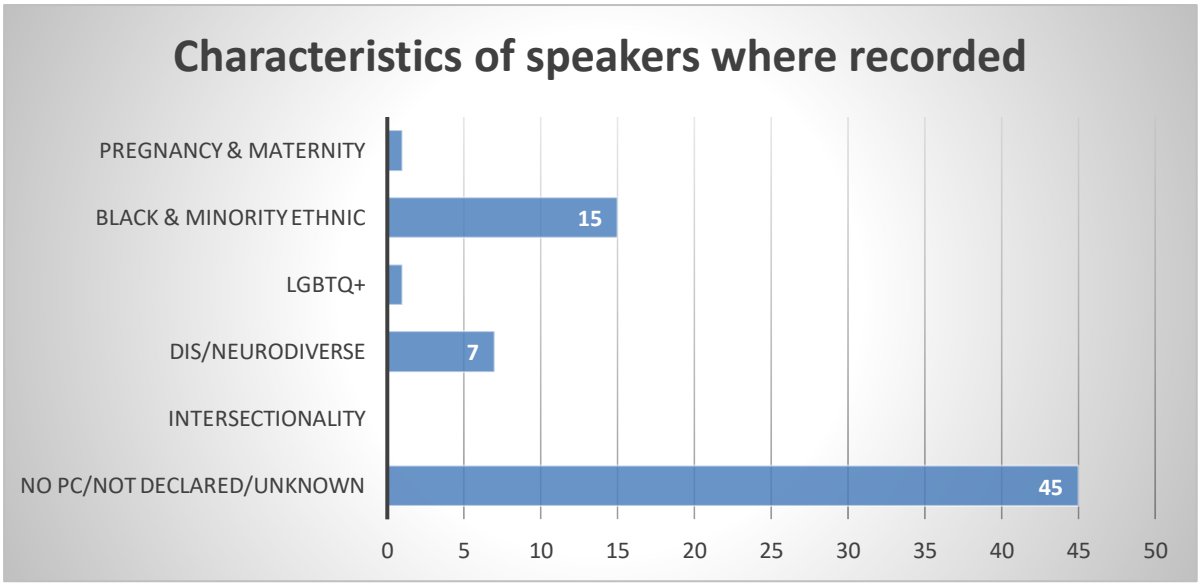
5.1 Kerry continues to offer the international nurses supervision space where required connecting with her colleague nurses, raising awareness of her role, and seeking to understand and remove any cultural barriers to raising concerns. Kerry's work in this space has been informed by Jeni Caguioa, Senior Clinical Manager and International recruitment and ethnic minorities nurse advisor from NHS England

5.2 We continue our out-of-hour surgery work targeting our clinical areas engaging our colleagues on nights and long days as well as bank, estates, and facilities staff who may find it harder to speak up and do not have regular access to Trust comms and a computer. a bid to reach colleagues that predominately work from home Lucy has been trialling pre-advertised virtual surgeries for TSS staff and the Learning and Development teams offering them a confidential listening space. Both had speakers attend.

5.3 Committed to supporting our deaf staff speak up Lucy has been awarded the Level 1 award in British Sign Language. She continues with her studies. Her vision is to host a deaf listening event with our deaf colleagues.

5.4 Guardians attended the "ADHD Lived experiences and challenges" webinar event hosted by Posturite, strengthening their commitment to be understanding and knowledgeable when supporting neurodivergent colleagues.

5.5 We continually monitor the protected characteristics [i] of our speakers, committed to ensuring our arrangements are inclusive. Challenges persist in recording, especially when we have telephone contact. This quarter, 22% of our speakers (that we recorded and knew about) identified as being Black and minority ethnic. Ten percent identified as having a disability or long -term health condition, with 1% LGBTQ+ and Pregnancy and Maternity. When recorded, no speakers had protected characteristics that intersected.



6. THE FREEDOM TO SPEAK UP CHAMPION NETWORK

6.1 We have recruited 31 FTSU Champions increasing the diversity of this network. We constantly evaluate where our Champions are located and the nature of their substantive posts. This enables us to identify where and what type of gaps there are enabling us to tailor recruitment.

6.2 In the Annual report we highlighted that we need to focus our recruitment in the Medical, the Acute, and Urgent Care directorates as only 5% and 9% of our Champions are situated in these areas. We ask our leaders again to promote their local champions and to use the

2024 Staff Survey data to identify gaps where champions could be recruited, strengthening their local speak-up listen up arrangements.

6.3 The Champion network has been operational for three years. We are therefore currently reviewing our recruitment, training and support processes, providing Champions the opportunity to step down should they wish. Part of this review will be to ask our Champions to undertake a yearly refresher training to equip them with additional knowledge and skills. The refresher will also provide assurance that they continue to uphold the Champion values and principles and are working within their role specification.

7. ORGANISATIONAL LEARNING & IMPROVEMENT– originating from FTSU enquires and feedback

7.1 Anonymous concerns were raised in the Urgent care team about rostering. The manager acted and followed up. The resultant learning led to improved roster controls by adding the hub manager into all rostering arrangements and oversight.

7.2 During our surgery work at the Juniper Centre it became apparent that some staff were unaware that sleeve guards could be used on the acute wards and that this was to be eclipsed if none were available. Sleeve guards are a discrete form of PPE that are used as an anti-microbial barrier as well as offering protection when working with challenging patients living with dementia. The Matron at the Juniper centre will be arranging a refresher on the importance of using sleeve guards across the site.

7.3 After an enquiry from a Resident Doctor about the trust's Sexual Safety policy and arrangements for reporting, we have asked the Programme Director for Foundation Training in Psychiatry to ensure that sexual safety and reporting is a regular agenda item on Residents induction programmes.

7.4 The post incident support framework for staff now includes details of the Guardians and FTSU Champions as additional sources of support for colleagues affected by trauma. We have also confirmed with the policy author that this resource can also be made available to the Guardians and or Champions should they need it.

7.5 Over the last five years the Guardian team have made a significant contribution to the cultural change work at Reaside, supporting the leadership team to develop and improve the speak up culture. We have hosted numerous listening events, surgeries, and drop ins. We were therefore delighted that the recent CQC inspection has led to improved ratings in Caring, Responsive and Well-led. Although the overall position remains as Requires

Improvement, we will continue to work with our leadership team to strengthen and embed improvements.

7.6 As part of the Culture of Care project we will be delivering a "Conversations that matter" masterclass for Band 6 and 7 leaders at Reaside, and Band 6 leaders at Ardenleigh. This will be a QI project which we intend to implement across other clinical sites with iterations trialled on other groups of staff identified by local leaders. We will also be involved in the roll out across our Acute wards in the next few months.

7.7 Instead of a shared feedback questionnaire each Guardian will be developing their own survey and sending it to the speakers they have supported when their cases are closed. We anticipate that this approach will encourage more of a conversational and personal approach to providing feedback. Equipped with this feedback Guardians can respond to speakers individually demonstrating their commitment to ongoing learning and continuous improvement.

8. RECCOMENDATIONS

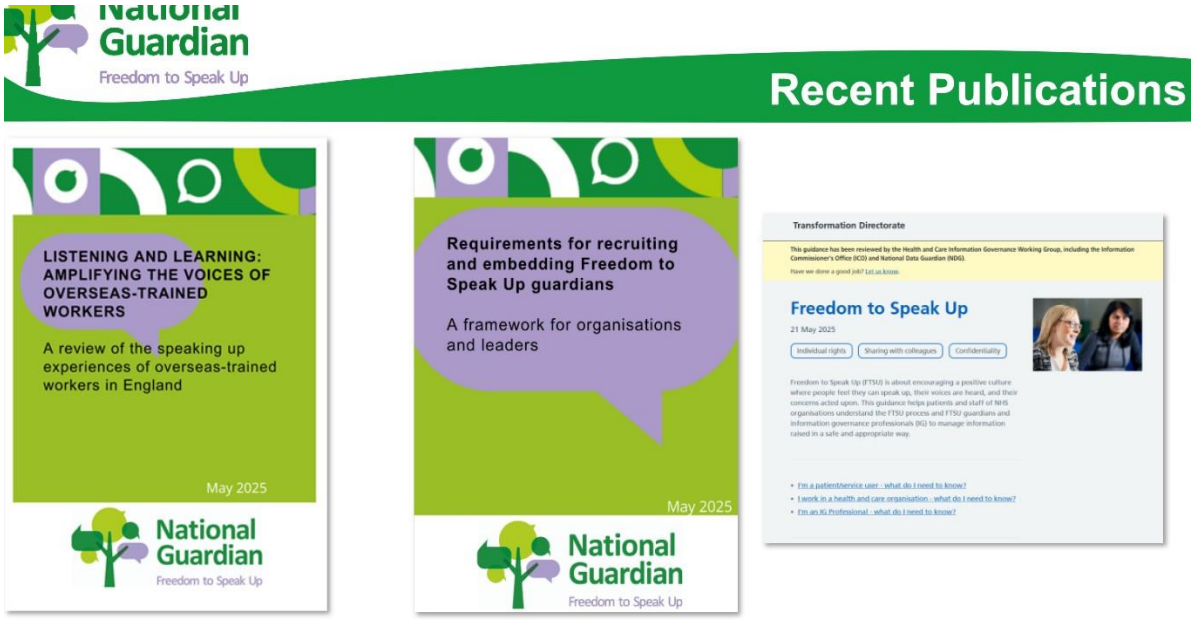
9.1 The results from the 2024 Staff Survey in the People Promise domain of "We each have a Voice that counts" tell us that although we have higher levels of autonomy and control compared to other trusts, when we look at the raising concerns component, we are barely making progress. Agreed in our shared purpose of exploring alternative communication, feedback and engagement models (to reach the staff we don't hear from), our senior leaders are working up our proposals as part of the "All our Voices" initiative. Under the leadership of our Chief Executive, Comms, EDI/OD and engagement leads we look forward to seeing how this project develops.

10. NATIONAL DEVELOPMENTS

10.1 The Dash Review and the NHS 10-year strategy, published earlier in the month, confirmed the role of the National Guardian will be abolished and "the functions of the National Guardian's Office should be aligned with other national staff voice functions and those in commissioner and provider organisations". We do not have any further details of when the functions will transfer from the National Guardian's Office to other organisations and will share additional information when we know more.

10.2 Despite national changes, our senior leaders have confirmed their support for the continuation of the Guardians and Champions highlighting the value and impact we have had, and continue to have on protecting patient safety, quality and staff experience.

10.3 Below are the publications from the National Guardians' Office (NGO) in the quarter reported, to include updated information governance that we have asked our IG team to display and share with colleagues:



[i] The protected characteristics we monitor are pregnancy & maternity, ethnicity, sexual orientation and Disability. (The Equality Act; 2010).

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**22 July 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 • Emergency Preparedness, Resilience and Response Annual Report • Taskforce for Climate-Related Financial Disclosure Report • Green Plan • Strategy Goals Year End 2024/25 and Q1 2025/26 Reports: Sustainability and Clinical Services
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 3 was a reported deficit of £2.5m. This was £3.5m adverse to plan. Whilst the Trust had a positive spot-month compared to Month 2, the Committee was alerted to the need to maintain trajectory to ensure year-end in line with plan; however, the Committee was not assured on the level of momentum and forward trajectory to confidently end the year on-plan. • The savings plans target for 2025/26 was £36m. Savings achieved during Q1 was £5.6m, which was £3.2m adverse to plan. • The Committee noted some positive improvements in some workforce and performance areas, however three key areas of concern remained: Clinically Ready for Discharge, non-contracted beds, and bank spend. • The Committee sought urgent assurance on the Trust's plan to remediate and realign plan, recognising the imminent publication of the National Oversight Framework.
Assure:	The Committee was assured by the draft Green Plan and noted the plans for approval required in line with NHSE requirements. Progress against Taskforce for Climate-Related Financial Disclosure recommendations was also noted. The progress on 2025/26 sustainability and clinical services strategy priorities was noted, with the refresh of the Trust strategy underway and staff

	engagement visits taking place. Non-Executive Directors were encouraged to participate in these visits to support the shaping of the strategy.	
Advise:	The National Oversight Framework 2025/26 had been published in June and would assess providers and determine segmentation from September. The Framework would focus on the following key priorities: Access to Services; Patient Safety; On track delivery of a balanced financial plan. A potential solution to the 24/7 neighbourhood pilot capital programme issue had been identified, with formal confirmation required. The Emergency Preparedness, Resilience and Response Annual Report was received for information, and the Committee was apprised of a potential solution to the single point of failure. The Committee the need for triangulation between Digital, Strategy and Quality Improvement teams and Chief Clinical Information Officers would be consulted to support the digital agenda.	
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources The Committee discussed and challenged the current risk score for SR5, due to the presented status of the Trust's financial position at Month 3 and progress against its most significant cost drivers.	
	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	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**19 June 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 • Information Governance Annual Report 2024/25 • Cyber Assurance Framework Escalation 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 2 was a reported deficit of £2.6m. This was £3.3m adverse to plan and was mainly driven by slippage on savings delivery. • The savings plans target for 2025/26 was £36m. The month 2 savings achieved was £3.4, which was £2.5m adverse to plan. Delivery of savings was crucial to ensure sustainability. • The Committee was alerted to a capital programme issue which would potentially result in a £3m financial pressure for the Trust; conversations were ongoing to review potential options. • Clinically Ready for Discharge remained a significant pressure.
Assure:	The Committee was assured by the good progress made in sickness absence and vacancy reductions.
Advise:	The Committee was advised that the inappropriate out of area placement trajectory had been achieved, and there would be a key focus on maintaining and reducing this position. The Committee noted that the Trust would not be compliant with the new Cyber Assurance Framework toolkit due to the decision not to implement clinical coding. A separate internal audit review had been commissioned to provide evidence of the Trust's rationale.
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources

	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

Report to Board of Directors						
Agenda item:	**18**					
Date	6 August 2025					
Title	Month 3 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 quarter 1 financial position.

Introduction

The 2025/26 consolidated Group quarter 1 position is a deficit of £2.5m which is £3.5m adverse to plan. The month 3 position is an improvement of £1.6m compared to month 2 mainly driven by non-recurrent benefits, with some actual improvement from May to June on temporary staffing, non-Trust beds and income.

Key Issues and Risks

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

- **Deficit position** – The quarter 1 position is a deficit of £2.5m compared to a planned surplus of £1m. Significant savings shortfall and financial pressure within acute and older adults inpatients. Managing and reducing the deficit position is critical for ensuring sustainability and a viable cash position. Delivery of savings is crucial.

- **Savings** – The 2025/26 savings target is £36m. The quarter 1 savings achieved is £5.6m, this is £3.2m adverse to plan, including £1.1m on non-Trust beds. Although there was a reduction in bed days in the first half of June, this has not been sustained, with continued increase in the second half of June/early July. 37% of savings plan unachieved to date - potential shortfall £10m.

- **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 November 2024

forecast). Additionally, local savings targets of £0.5m for agency and £1.7m for bank expenditure have been set. The quarter 1 spend of £8.4m is £0.6m above the NHSE ceiling plan and £1.2m adverse including local savings targets. The Executive Director of Nursing is leading the Bank Reduction Gold project to progress actions to meet required expenditure reduction.

- **NHSE Oversight framework** - The NHS Oversight Framework 2025/26, published on 26 June 2025, is a transitional 1-year framework which sets out how NHSE will assess providers alongside a range of agreed metrics. This will determine the segment score for each provider. It introduces a financial override rule such that all deficit organisations are capped at segment 3. The initial segmentation scores to be published in July will be based on plan and as BSMHFT has a planned surplus, the financial override rule will not apply. NHSE have indicated that segmentation scores to be published late August/early September will be based on quarter 1 actuals. It is at this point that we can expect our segmentation score to move to a 3.

Advise:

- **Financial position** - Discussions have taken place at Sustainability Board and Operational Management Team meetings to review the implications of the financial position. The Executive Team have reviewed a range of proposed actions including the requirement for savings mitigations plans and financial recovery plans to be presented at Sustainability Board on 31.7.25.

- **Pay Award** - As directed by NHSE, there is no impact of the pay award included in the year to date position.

- **Children and Young People's (CYP) services –** the CYP service transferred from Birmingham Women's and Children's Foundation Trust on 1.7.25. Therefore, the CYP position is not included within the quarter 1 BSMHFT position but will be included from month 4 onwards. CFO discussion ongoing to resolve underlying budgetary pressure.

- **Medium term plan** – NHSE have indicated that the development of medium-term plans will be required for 2026/27 onwards. It is anticipated that a planning framework will be issued in July 2025 to support the first phase of planning from July to September.

Capital position:

The quarter 1 2025/26 Group capital expenditure is £1m, this is £3m adverse to plan but slightly ahead of the revised forecast. The £16m capital plan was phased equally across the year.

Cash position:

The Group cash position at the end of month 3 was £84m, including £20m Trust cash balance.

Recommendation

The Board is asked to review the quarter 1 financial position and discuss the key alerts noted.

Enclosures
Month 3 2025/26 finance report

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

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**
SR5	✓	

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2025 to 30th June 2025

Quarter 1 Group financial position
£2.5m 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	176,517	170,578	(5,939)
Other Income	24,082	6,020	9,116	3,096
Total Income	**730,148**	**182,537**	**179,694**	**(2,843)**
Expenditure				
Pay	(319,512)	(79,878)	(79,517)	361
Other Non Pay Expenditure	(369,430)	(92,357)	(92,998)	(640)
Drugs	(6,058)	(1,514)	(2,066)	(552)
Clinical Supplies	(685)	(171)	(209)	(38)
PFI	(13,896)	(3,474)	(3,488)	(14)
EBITDA	**20,567**	**5,142**	**1,416**	**(3,725)**
Capital Financing				
Depreciation	(10,034)	(2,508)	(2,502)	6
PDC Dividend	(500)	(125)	(125)	(0)
Finance Lease	(6,939)	(3,724)	(3,735)	(11)
Loan Interest Payable	(882)	(220)	(227)	(7)
Loan Interest Receivable	3,376	844	1,037	193
Surplus / (Deficit) before taxation	**5,588**	**(592)**	**(4,136)**	**(3,544)**
Taxation	(380)	(95)	(98)	(3)
Surplus / (Deficit)	**5,208**	**(687)**	**(4,234)**	**(3,547)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	1	1	-
Adjust PFI revenue costs to UK GAAP basis	(1,013)	1,726	1,726	-
Adjusted financial performance Surplus / (Deficit)	**4,200**	**1,040**	**(2,506)**	**(3,547)**

Month 3 2025/26 Group Financial Position

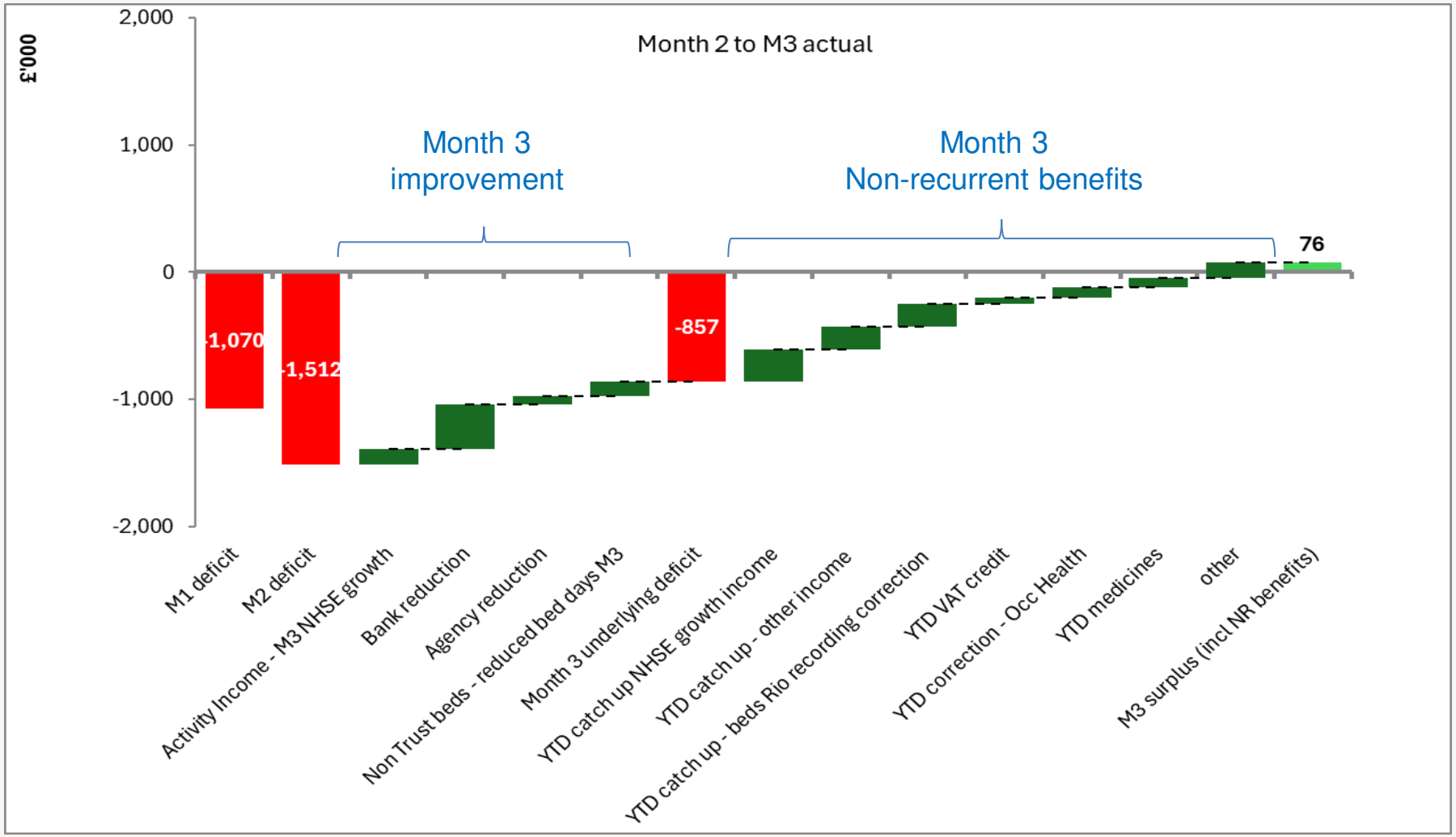
The 2025/26 consolidated Group quarter 1 position is a deficit of £2.5m (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 of £1.7m). The June position is an improvement of £1.6m compared to May, mainly driven by non-recurrent benefits (see page 3), with some actual improvement from May to June on temporary staffing, non-Trust beds and income.

The Group position is driven by a deficit of £2.5m in the Trust, £4k surplus for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £62k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

The 2025/26 final annual plan submitted to NHSE on 30.4.25 is a £4.2m surplus. The quarter 1 position is £3.5m adverse to plan. There is £3.2m slippage on savings year to date. 37% of the savings plan is unachieved (page 8). Non-Trust bed expenditure is £1.1m above plan year to date and is the largest element of savings slippage year to date (page 14). Although there has been a reduction in spend in June, temporary staffing expenditure year to date is £0.6m above the NHSE ceiling and £1.2m adverse including local savings targets. A significant pay pressure on acute and older adults inpatient wards is currently offset by other substantive underspends trustwide. (pages 9 to 12). As directed by NHSE, there is no impact of the pay award included in the year to date position.
Medication is £0.6m overspent year to date (page 16).

The draft quarter 1 position for Birmingham and Solihull Integrated Care System (BSOL ICS) is a deficit of £28m which is £16m adverse to plan (see page 4). In line with system agreement, the BSMHFT financial plan does not currently include Children and Young People's (CYP) services, this is included within the Birmingham Women's and Children's Foundation Trust plan, with adjustment to reflect the transfer to be made from 1 July 2025.

Month 2 to month 3 movement



Quarter 1 Draft System position

Total Performance	YTD Current Plan £000s	YTD Actual £000s	YTD Variance £000s	YTD Income / Allocation £000s	YTD Deficit as % of turnover
BSOL ICB	-1,887	-1,862	25	1,058,650	-0.18%
BSMHT	1,041	-2,506	-3,547	179,694	-1.39%
BCHC	103	-1,483	-1,586	97,070	-1.53%
BWC	0	-3,001	-3,001	191,532	-1.57%
ROH	-678	-216	462	35,327	-0.61%
UHB	-10,371	-18,807	-8,436	654,781	-2.87%
Total	-11,792	-27,876	-16,084	2,217,054	

Total Actual Surplus/(Deficit)	Trend M1 £000s	M2 £000s	M3 £000s	YTD £000s
BSOL ICB	-627	-555	-680	-1,862
BSMHT	-1,086	-1,496	77	-2,506
BCHC	-604	-585	-294	-1,483
BWC	-1,081	-698	-1,222	-3,001
ROH	-377	403	-242	-216
UHB	-11,221	-2,753	-4,833	-18,807
	-14,997	-5,685	-7,194	-27,876

Total Variance	Trend M1 £000s	M2 £000s	M3 £000s	YTD £000s
BSOL ICB	0	78	-53	25
BSMHT	-1,433	-1,843	-270	-3,547
BCHC	-496	-688	-402	-1,586
BWC	-1,081	-698	-1,222	-3,001
ROH	-96	629	-71	462
UHB	-7,268	654	-1,822	-8,436
Total	-10,375	-1,869	-3,840	-16,084

Quarter 1 Group position Segmental summary – YTD Actual

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	96,249	-	39,931	117,836	(83,438)	170,578
Other Income	8,980	7,428	-	-	(7,291)	9,116
Total Income	**105,229**	**7,428**	**39,931**	**117,836**	**(90,730)**	**179,694**
Expenditure						
Pay	(74,702)	(3,369)	(645)	(884)	83	(79,517)
Other Non Pay Expenditure	(24,057)	(2,008)	(39,531)	(117,296)	89,894	(92,998)
Drugs	(2,174)	(550)	-	-	658	(2,066)
Clinical Supplies	(209)	-	-	-	-	(209)
PFI	(3,488)	-	-	-	-	(3,488)
EBITDA	**598**	**1,501**	**(244)**	**(344)**	**(94)**	**1,416**
Capital Financing						
Depreciation	(1,635)	(817)	-	-	(50)	(2,502)
PDC Dividend	(125)	-	-	-	-	(125)
Finance Lease	(3,732)	(89)	-	-	86	(3,735)
Loan Interest Payable	(229)	(507)	-	-	509	(227)
Loan Interest Receivable	882	13	307	344	(509)	1,037
Surplus / (Deficit) before Taxation	**(4,241)**	**101**	**62**	**0**	**(58)**	**(4,136)**
Taxation	-	(98)	-	-	-	(98)
Surplus / (Deficit)	**(4,241)**	**4**	**62**	**0**	**(58)**	**(4,234)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	1	-	-	-	-	1
Adjust PFI revenue costs to UK GAAP basis	1,726					1,726
Adjusted financial performance Surplus / (Deficit)	**(2,514)**	**4**	**62**	**0**	**(58)**	**(2,506)**

Quarter 1 Group position Segmental summary – YTD variance to plan

Group Summary	Trust	SSL	Reach Out	BSOL PC	Consolidation	Group
	YTD Variance	YTD Variance	YTD Variance	YTD Variance	YTD Variance	YTD Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	(1,290)	-	(3,283)	(1,949)	584	(5,939)
Other Income	3,044	(196)	-	-	247	3,096
Total Income	**1,754**	**(196)**	**(3,283)**	**(1,949)**	**831**	**(2,843)**
Expenditure						
Pay	347	24	45	(54)	(0)	361
Other Non Pay Expenditure	(5,164)	171	3,231	1,984	(862)	(640)
Drugs	(561)	(22)	-	-	32	(552)
Clinical Supplies	(38)	-	-	-	-	(38)
PFI	(14)	-	-	-	-	(14)
EBITDA	**(3,676)**	**(23)**	**(7)**	**(19)**	**0**	**(3,725)**
Capital Financing						
Depreciation	(5)	11	-	-	0	6
PDC Dividend	(0)	-	-	-	-	(0)
Finance Lease	(11)	0	-	-	0	(11)
Loan Interest Payable	(9)	0	-	-	2	(7)
Loan Interest Receivable	156	13	7	19	(2)	193
Surplus / (Deficit) before Taxation	**(3,545)**	**1**	**0**	**0**	**0**	**(3,544)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(3)	-	-	-	(3)
Surplus / (Deficit)	**(3,545)**	**(2)**	**0**	**0**	**0**	**(3,547)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	-	-	-	-	-	-
Adjust PFI revenue costs to UK GAAP basis	-	-	-	-	-	-
Medical equipment grant	-	-	-	-	-	-
Add back all I&E impairments/(reversals)	-				-	-
Adjusted financial performance Surplus / (Deficit)	**(3,545)**	**(2)**	**0**	**0**	**0**	**(3,547)**

Trust Quarter 1 £3.5m overspend

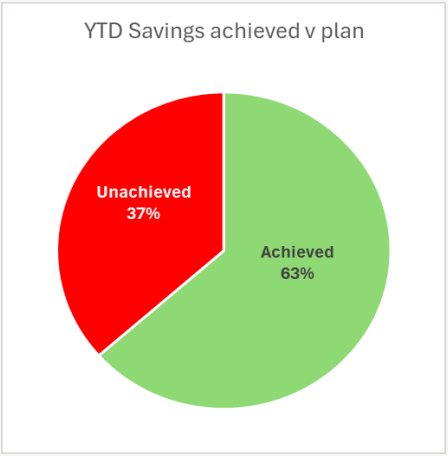
	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Projected spend	Variance
	£m	£m	£m	£m	£m	£m
Acute and Urgent Care Services	18.1	20.6	**(2.5)**	72.5	82.7	**(10.2)**
Healthcare Income	(97.0)	(95.4)	**(1.6)**	(387.9)	(381.9)	**(6.0)**
Specialties Services	12.7	13.9	**(1.2)**	50.8	55.3	**(4.5)**
Trustwide	0.4	0.6	**(0.2)**	1.7	1.6	**0.0**
ICCR	19.1	18.6	**0.6**	76.6	75.7	**0.8**
Secure Services & Offender Health	18.4	18.0	**0.4**	73.7	72.8	**0.9**
Corporate Services	28.8	27.9	**1.0**	107.4	105.2	**2.2**
Adjust PFI revenue costs to UK GAAP basis	(1.7)	(1.7)	**0.0**	1.0	1.0	**0.0**
(Surplus) / Deficit - Trust	**(1.0)**	**2.5**	**(3.5)**	**(4.2)**	**12.5**	**(16.7)**

The quarter 1 Group position is driven by the Trust overspend of £3.5m. Significant financial pressure in Acute & Urgent Care and Specialties driven by acute and older adults inpatients – non Trust beds overspend is £1m (page 14), with pay being £1.6m overspent in Acute & Urgent Care and £0.7m overspent in Specialties (page 9).

Efficiencies

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

	Plan YTD £000	Actual YTD £000	Variance YTD £000
Recurrent	7,467	4,814	(2,653)
Non Recurrent	1,384	805	(579)
Total Efficiencies	**8,851**	**5,619**	**(3,232)**



- The 2025/26 efficiency target is £36.4m. This comprises £30.9m recurrent and £5.5m non recurrent targets.
- The month 3 year to date savings achieved is £5.6m, this is £3.2m adverse to plan.
- Year to date performance indicates a potential £10m shortfall on delivery

Current actions

Savings shortfall discussed at Executive Team meeting on 16.7.25 with proposal for mitigation plans to be presented at Sustainability Board on 31.7.25.

	Savings						
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan £'000	Forecast £'000	Forecast Variance £'000	Comments - forecast variance
Acute & Urgent Care	2,259	883	(1,376)	9,039	5,067	(3,972)	£3.6m non Trust beds, £0.4m vacancy factor
Trustwide	3,608	2,265	(1,343)	15,429	10,608	(4,821)	£2.5m decommissioining, £1.7m PCincome, £0.7m Corporate benchmarking
ICCR	492	353	(139)	1,966	1,566	(400)	£0.4m ICRT overhead & margin
Specialties	319	45	(274)	1,282	1,048	(234)	slippage on 2% savings schemes
Corporate	314	188	(126)	1,258	581	(677)	slippage on 2% savings schemes
Secure & Offender Health	359	385	26	1,434	1,433	(1)	
Provider Collaboratives	1,500	1,500	-	6,000	6,000	-	
Total	**8,851**	**5,619**	**(3,232)**	**36,408**	**26,303**	**(10,105)**	

Trust Pay

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Service Area	Trust YTD Plan £'000	Trust YTD Actual £'000	Trust YTD pay variance £'000
Agency	822	996	(174)
Bank	6,866	7,153	(287)
Substantive	67,078	66,263	815
Total Pay variance	**74,766**	**74,412**	**354**

Service Area	Trust YTD Plan £'000	Trust YTD Actual £'000	Trust YTD variance £'000	Forecast variance £'000
ACUC	12,731	14,336	(1,605)	(6,723)
SPEC	12,867	13,595	(728)	(3,061)
CORPORATE	14,261	13,438	823	2,310
ICCR	17,264	16,296	968	2,280
SCOH	16,556	16,368	188	352
TRUSTWIDE	1,089	380	709	2,741
Total Pay variance	**74,766**	**74,412**	**354**	**(2,101)**

Pay position

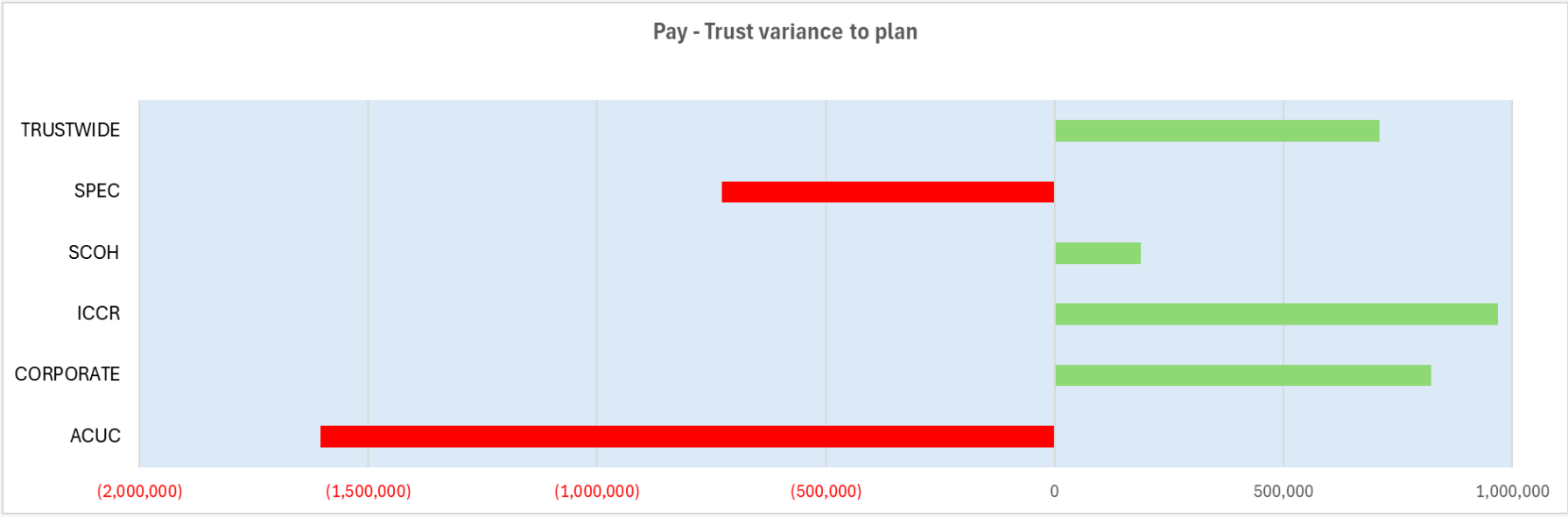
- The month 3 Trust pay position is an underspend of £354k.
- The Trust temporary staffing overspend of £0.5m is offset by substantive underspend of £0.8m.

Inpatient pay pressure

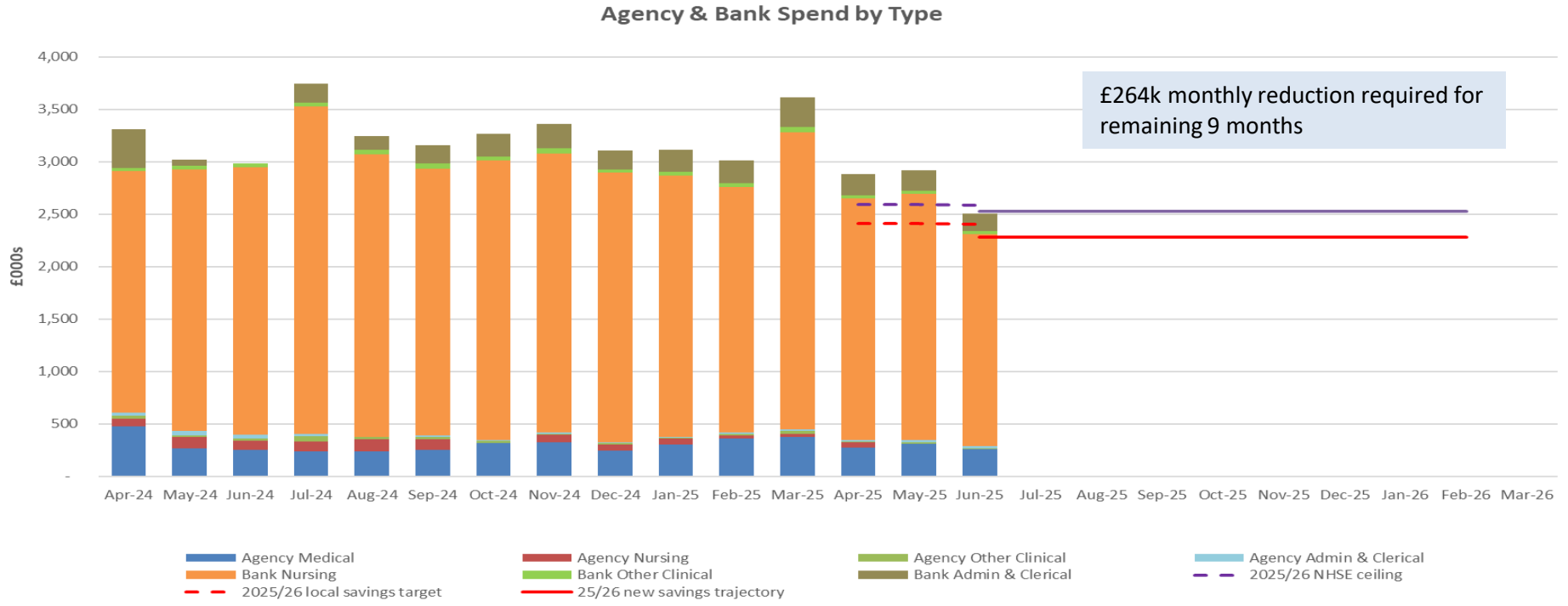
Significant forecast overspend on pay - Acute & Urgent Care and Specialities. MHOST funding to be concluded but there will still be a significant pressure across acute and older adult inpatient wards.

Current actions

- Acute & Urgent Care and Specialities financial recovery plans to be presented to Sustainability Board 31.7.25.
- Consideration is being given to 'banking' forecast pay underspends.



Temporary staffing expenditure

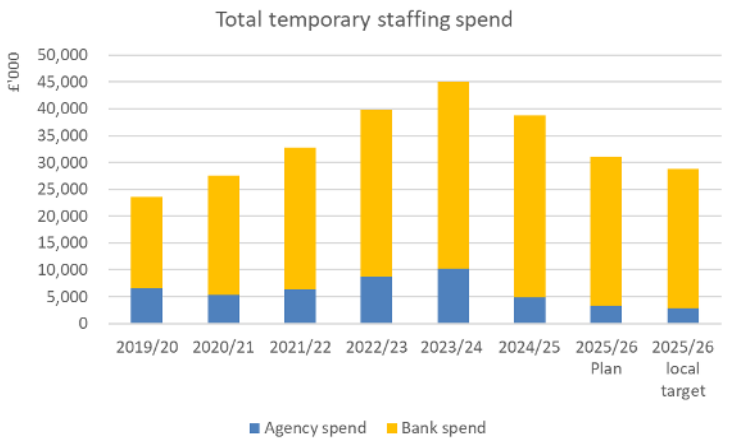


The 2025/26 temporary staffing plan of £31m has been set in line with the NHSE ceiling (reduction of 30% agency and 15% bank spend compared to November 2024 forecast). Additionally, local savings targets of £0.5m for agency and £1.7m for bank expenditure have been set.

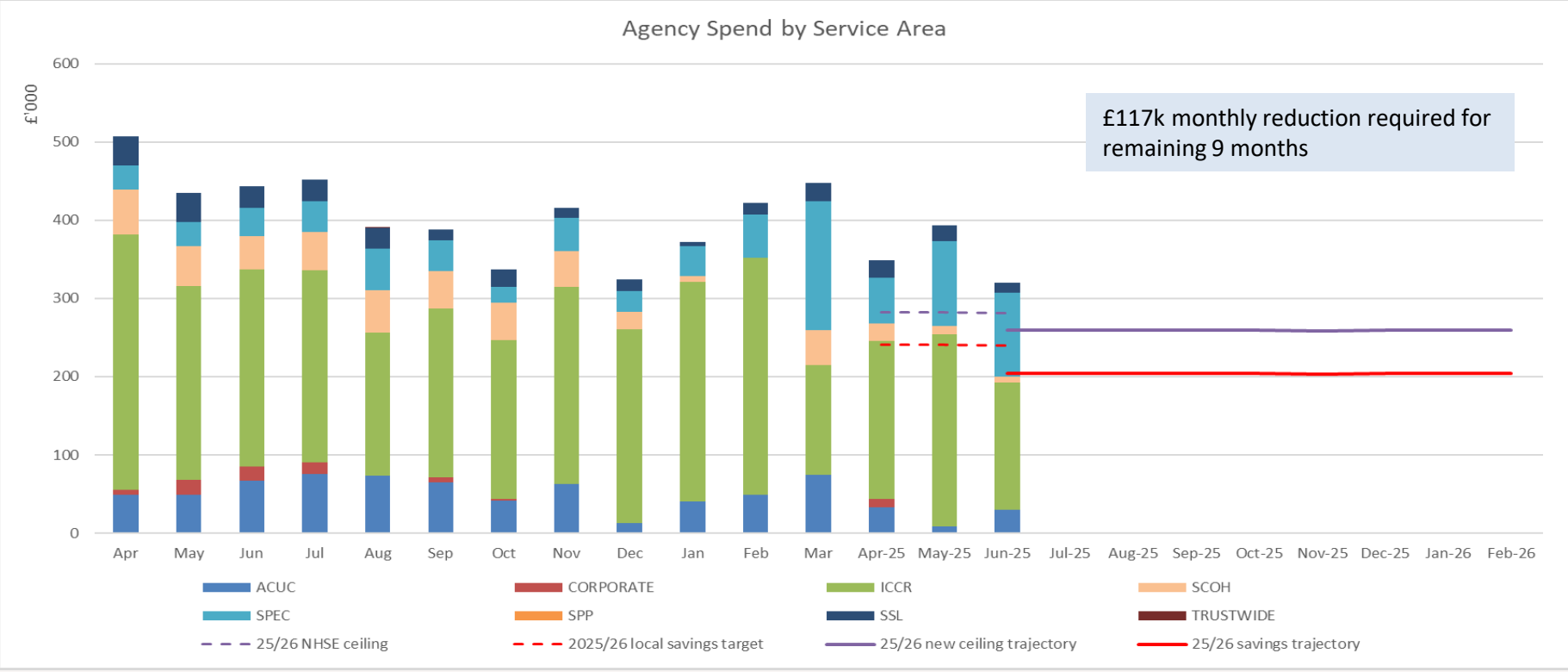
The Group quarter 1 spend of £8.4m is £0.6m above the NHSE ceiling plan and £1.2m adverse including local savings targets. Spend in June is £0.4m less than May. However, for total spend to be within the NHSE ceiling and meet local savings targets, monthly spend will need to reduce by a further £0.3m per month from July onwards.

Bank expenditure £7.3m (87%) – the majority of bank expenditure relates to nursing bank shifts - £6.7m

Agency expenditure £1.1m (13%) – the majority of agency expenditure relates to medical agency - £0.8m.



Agency expenditure



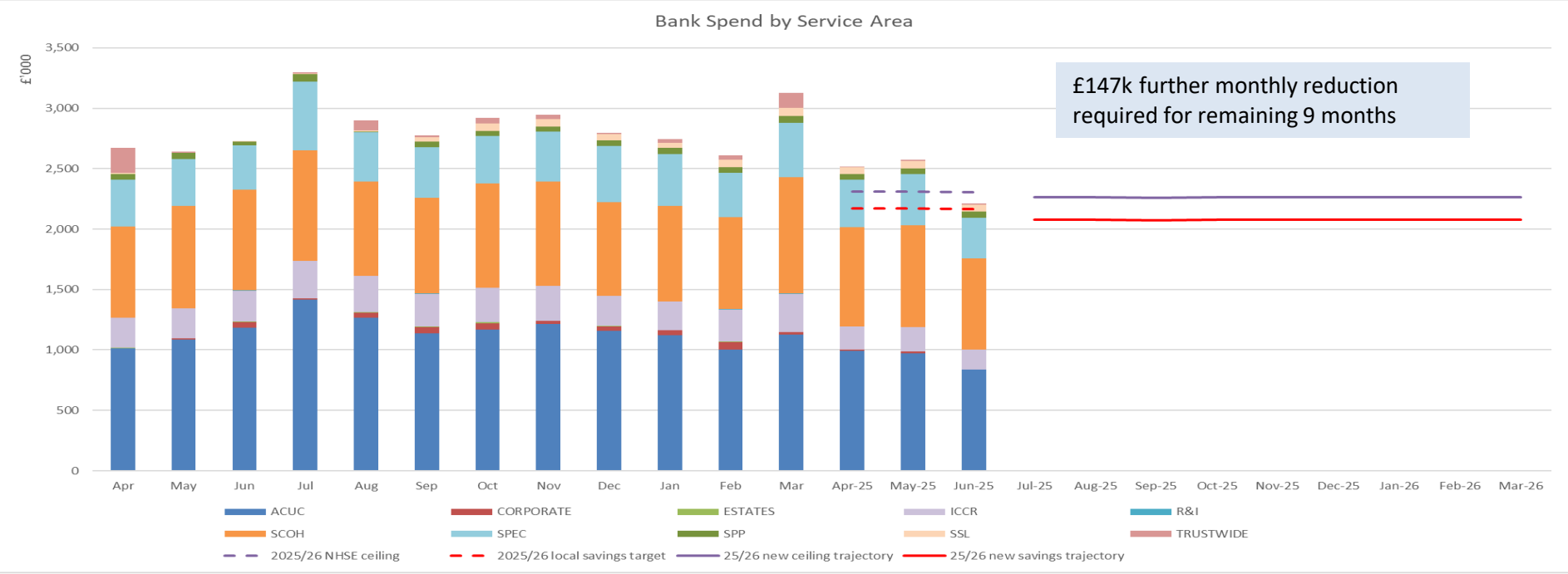
Agency expenditure

- The month 3 year to date agency expenditure is £1.1m which is £205k adverse to the NHSE ceiling (set as 30% reduction from November 2024 forecast) and £330k adverse including local savings targets.
- June agency expenditure is £62k lower than May, driven by ICCR medical agency reduction.
- For total spend to be within the NHSE ceiling and meet local savings targets, a further reduction of £117k per month from July onwards is required.

Current actions:

Significant amount of work lead by medical staffing team to reduce medical agency, with 7 vacant posts currently covered by agency staff due to be substantively covered from July/August. All consultant CMHT posts forecast to be filled by doctors on NHS contracts by the end of August.

Bank expenditure



Bank expenditure

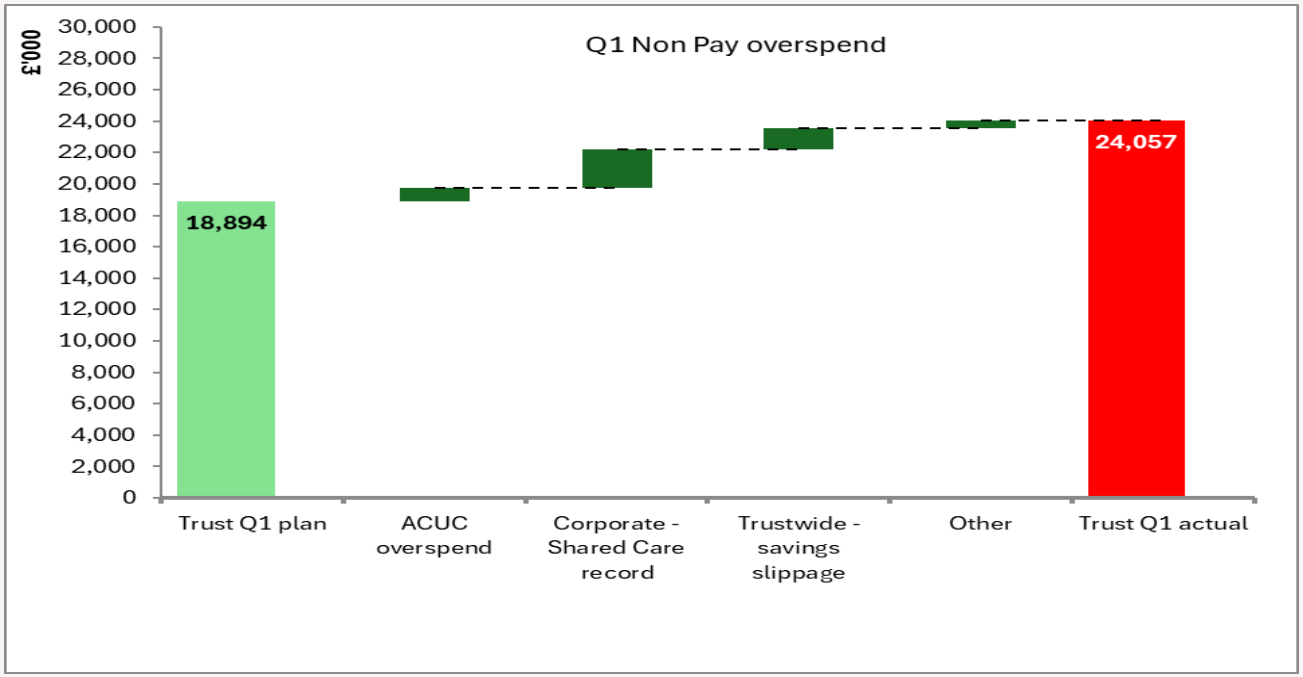
- The quarter 1 bank expenditure is £7.3m which is £397k adverse to the NHSE ceiling (set as 15% reduction from November 2024 forecast) and £822k adverse including local savings targets.
- Significant reduction in bank spend in June has taken the in-month spend below the NHSE ceiling for the first time this year (£86k below) but still £55k above local savings targets.
- June bank expenditure is £349k less than May. Monthly spend reductions: Acute & Urgent Care £135k, Secure & Offender Health £90k, Specialties £84k and ICCR £38k.
- For annual spend to be within the NHSE ceiling and meet local savings targets, a further reduction of £147k per month from July onwards is required.

Current Actions – The Executive Director of Nursing is leading the Bank Reduction Gold project – operational, workforce and finance colleagues meet fortnightly to progress actions to reduce expenditure. This includes increased bank sign off controls, roster policy compliance, annual leave booking practice and focus on top 20 spend areas.

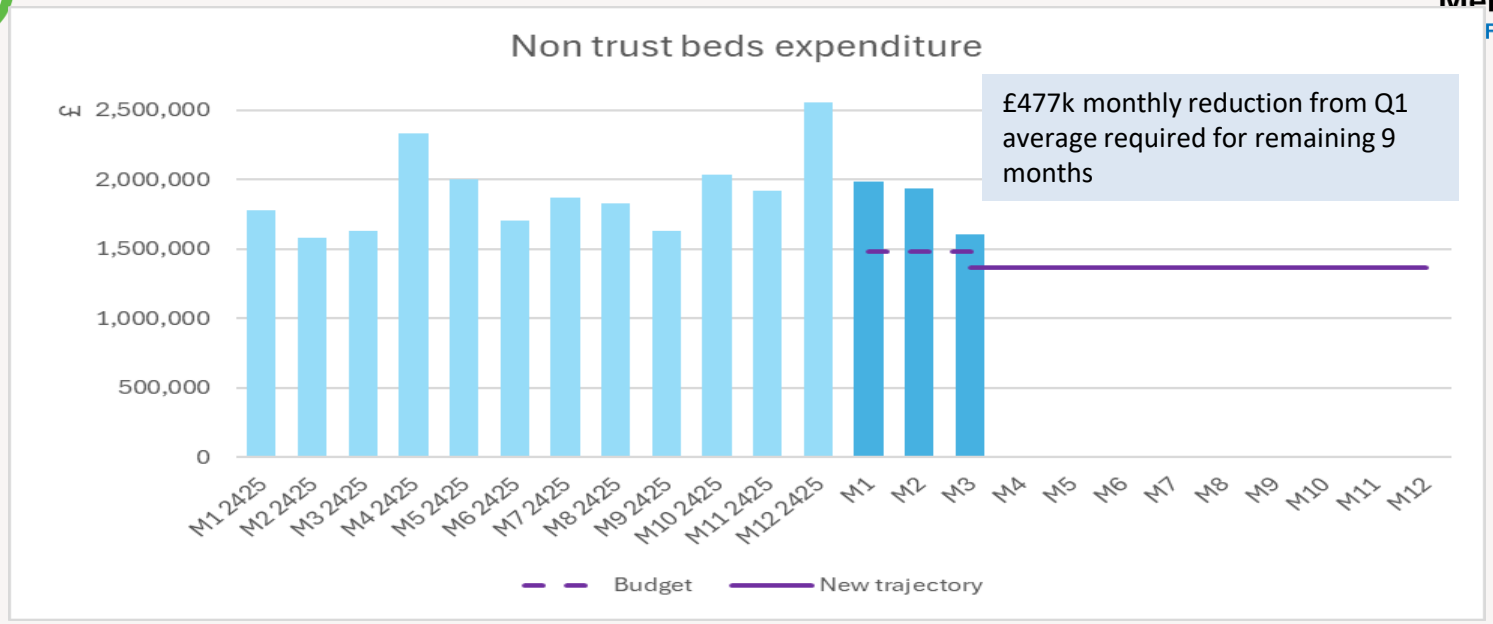
Trust Non Pay £5m overspend

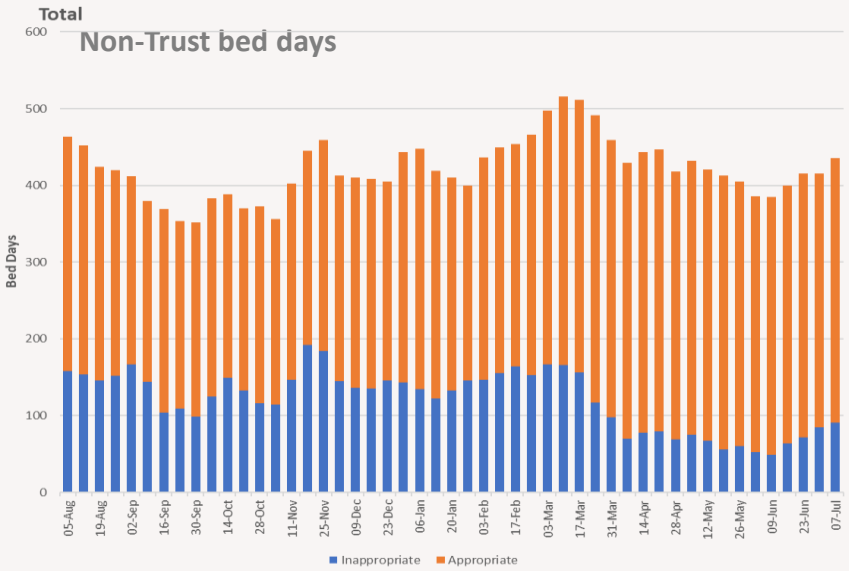
Service Area	Trust YTD Plan £	Trust YTD Actual £	Trust YTD variance £	
ACUC	5,270	6,141	(870)	£1m non Trust beds savings slippage
CORPORATE	10,489	12,903	(2,414)	£2.5m shared care record expenditure - offset by income
ICCR	1,600	1,909	(308)	£0.1m savings slippage
SCOH	2,040	2,014	26	
SPEC	495	689	(194)	£0.1m savings slippage
TRUSTWIDE	(1,001)	402	(1,403)	Savings slippage
Total Non Pay variance	**18,894**	**24,057**	**(5,163)**	

Current actions
Mitigation plans for all savings schemes with forecast shortfall to be presented to Sustainability Board on 31.7.25



Non-Trust Beds overspend





- The 2025/26 non-Trust bed budget is £17.8m.
- The quarter 1 spend was £5.5m which is an overspend of £1.1m. Without further action to reduce activity, forecast overspend is £4m.
- The June spend is £0.3m less than May, £0.2m of this relates to year to date correction of Rio recording, with £0.1m improvement relating to bed usage. Although there was a reduction in bed days in the first half of June, this has not been sustained, with continued increase in the second half of June/early July.
- In order for total annual spend to be within budget, monthly expenditure would have to reduce by £0.5m per month from the quarter 1 average for the remainder of the year.

Current Actions

A recovery action plan has been developed including bed management medical oversight and new admissions process. Progress reported to be presented to Sustainability Board on 31.7.25.

Trust Income

E3 Description	Sum of YTD Plan	Sum of YTD Actuals	Sum of YTD Plan Var	
ACTIVITY INCOME	(97,130,227)	(95,877,035)	(1,253,192)	See table below
EDUCATION & TRAINING INCOME	(4,112,934)	(4,063,036)	(49,898)	
OPERATING INCOME	(1,956,075)	(5,021,552)	3,065,477	£2.5m Shared care Record income in month 3, offset by expenditure
RESEARCH AND DEVELOPMENT INC	(275,387)	(267,290)	(8,097)	
Grand Total	**(103,474,623)**	**(105,228,913)**	**1,754,290**	

	YTD variance £	
BSOL CCG	(909,617)	£0.6m deferred income, £0.2m Talking Therapies under perfomance
NHSE - FORENSIC WOMENS	(311,662)	Slippage on Dawn House offset by underspend
NHSE - FCAMHS LOW SECURE	(297,646)	Contract reduced to 2 beds - forecast shortfall £1.2m full year, part offset by underspend
NHSE - BLOCK	-	NHSE Growth income shortfall -resolved in month 3
Other	(89,000)	PFI funding shortfall
Healthcare Income	**(1,607,925)**	
Other	354,733	
Activity Income	**(1,253,192)**	

Current Actions

- Review of deferred income.
- Talking Therapies – current forecast £0.4m shortfall. Service to present activity recovery plan to Sustainability Board on 31.7.25

Trust Medication £0.6m overspend

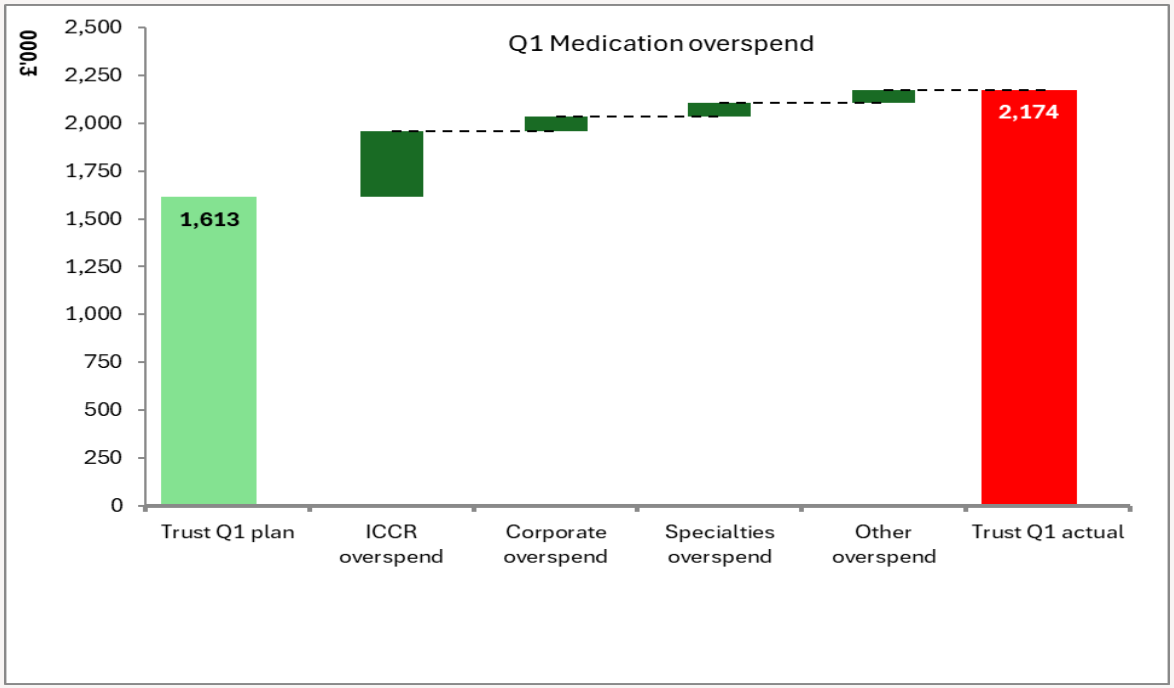
Birmingham and Solihull Mental Health NHS Foundation Trust

Service Area	Trust YTD Plan £	Trust YTD Actual £	Trust YTD variance £	Forecast variance £'000
ACUC	157	172	(15)	(64)
CORPORATE	0	76	(76)	(106)
ICCR	999	1,343	(343)	(1,305)
SCOH	245	286	(41)	(173)
SPEC	212	287	(76)	(267)
TRUSTWIDE	0	10	(10)	(43)
Total Drugs variance	**1,613**	**2,174**	**(561)**	**(1,958)**

The quarter 1 medication overspend is £0.6m, with a forecast overspend of £2m.

Current Actions

The majority of medication overspend to date is in ICCR. Overspend under review with Interim Chief Pharmacist including assessment of expenditure in relation to newly created teams.



Commissioning overview

Mental Health Provider Collaborative (MHPC)

- 2025/26 income plan is £479m.
- Month 3 position break even
- Month 3 cash balance £31m.
- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

Reach Out Provider Collaborative

- 2025/26 income plan is £173m.
- Month 3 position £62k surplus – in line with agreed contribution to Trust overheads.
- Month 3 cash balance £28m.
- Key risks:
- Clinical concerns around expected growth in out of area numbers and EPC costs.

Children and Young People's (CYP) services

Children and Young people's (CYP) services transferred from Birmingham Women's and Children's Foundation Trust (BWC FT) on 1.7.25. Therefore, the CYP position is not included within the quarter 1 BSMHFT position but will be included from month 4 onwards.

CYP quarter 1 position

£0.9m underspend year to date against expenditure budget, driven by:

- £1m beds underspend (72 beds occupied against a plan of 88 for Q1).
- £0.5m savings shortfall offset by non recurrent underspends on pay £0.2m and non pay £0.3m.
- £0.2m pay underspend (£1.3m vacancies offset by £0.9m agency and £0.25m bank spend)
- The current expenditure budget exceeds the income budget - bottom line budgetary pressure to be addressed.

CYP Budget position

CYP expenditure budget held by BWC FT is £80m (including direct, indirect and R&D) with income budget of £72m – conversation ongoing at CFO system level to address the budgetary pressure.

CYP Savings position

- £3.2m savings target - £2.3m identified plans (£1.7m recurrent and £0.6m non recurrent), £0.9m unidentified
- Current forecast is £2.3m recurrent shortfall against savings plans.

Quarter 1 financial position CYP

Period	Jun-25			
		Budget	Actual	Variance
Division	Expense Type	YTD	YTD	YTD
		£000's	£000's	£000's
FTB	Pay	8436	8539	-103
FTB	Non Pay	15127	14142	985
FTB	Income	-4190	-4190	-0
FTB	**Total**	19373	18491	882

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-Jun-25 £m's	Actual YTD 30-Jun-25 £m's	NHSI Plan Forecast 31-Mar-26 £m's
Non-Current Assets				
Property, plant and equipment	221.1	222.7	219.7	227.5
Prepayments PFI	1.2	1.2	1.8	1.2
Finance Lease Receivable	0.0	-	(0.0)	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	222.4	224.0	221.4	228.8
Current assets				
Inventories	0.6	0.6	0.3	0.6
Trade and Other Receivables	31.0	31.0	32.9	31.0
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	86.4	85.1	83.6	83.0
Total Curent Assets	117.9	116.7	116.8	114.6
Current liabilities				
Trade and other payables	(86.2)	(86.4)	(80.8)	(86.2)
Tax payable	(6.7)	(6.7)	(7.1)	(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)	(1.1)	(1.3)
Deferred income	(35.6)	(35.6)	(42.2)	(35.6)
Total Current Liabilities	(133.7)	(133.8)	(134.9)	(133.7)
Non-current liabilities				
Deferred Tax Liability	0.2	0.2	0.2	0.2
Loan and Borrowings	(20.8)	(19.7)	(19.7)	(18.6)
PFI lease	(79.4)	(81.2)	(81.2)	(78.9)
Finance Lease, non current	(4.8)	(4.6)	(4.9)	(4.1)
Provisions	(2.4)	(2.4)	(2.4)	(2.4)
Total non-current liabilities	(107.1)	(107.7)	(108.0)	(103.8)
Total assets employed	99.6	99.2	95.3	105.9
Financed by (taxpayers' equity)				
Public Dividend Capital	117.9	118.2	117.9	119.1
Revaluation reserve	49.1	49.1	49.1	49.1
Income and expenditure reserve	(67.5)	(68.2)	(71.7)	(62.3)
Total taxpayers' equity	99.6	99.2	95.3	105.9

SOFP Highlights

The Group cash position at the end of June 2025 is £83.6m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 20 to 21.

Current Assets & Current Liabilities

Ratios

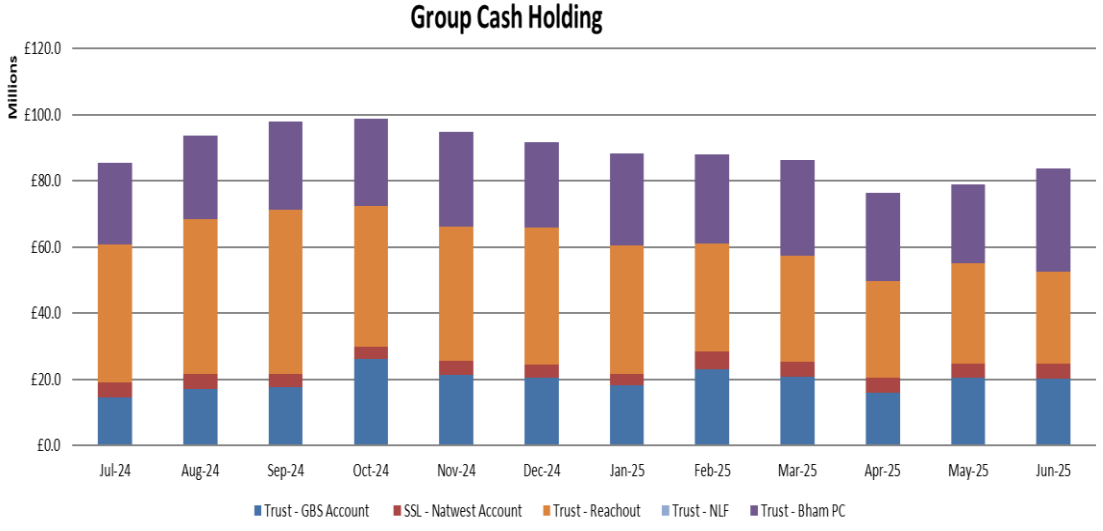
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

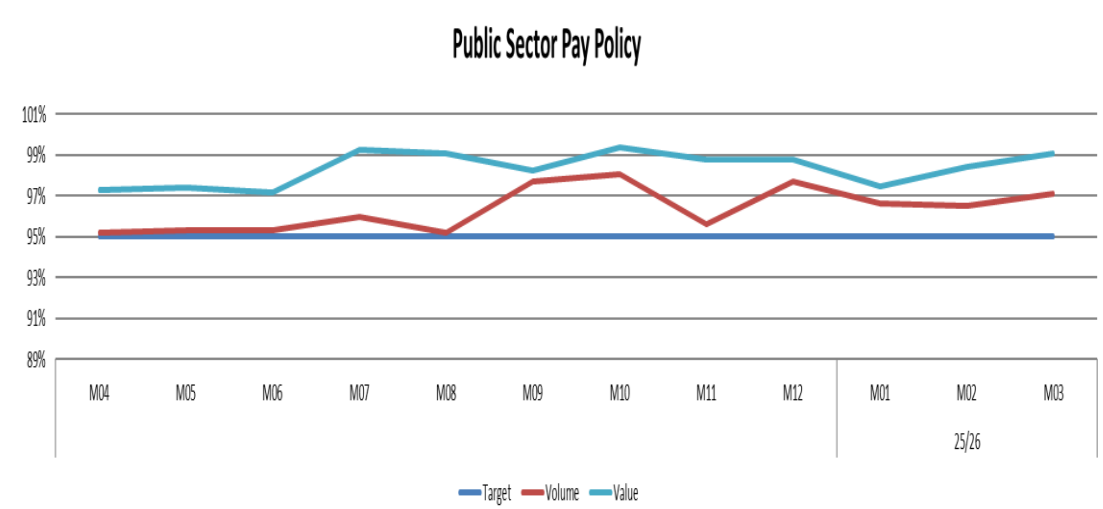
Current Ratio :	**£m's**
Current Assets	116.8
Current Liabilities	-134.9
Ratio	0.9

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of June 2025 is £83.6m. This comprises of Trust £20m, SSL £4.5m, Reach Out Provider Collaborative 28m and Mental Health Provider Collaborative £31m.

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

Better Payments

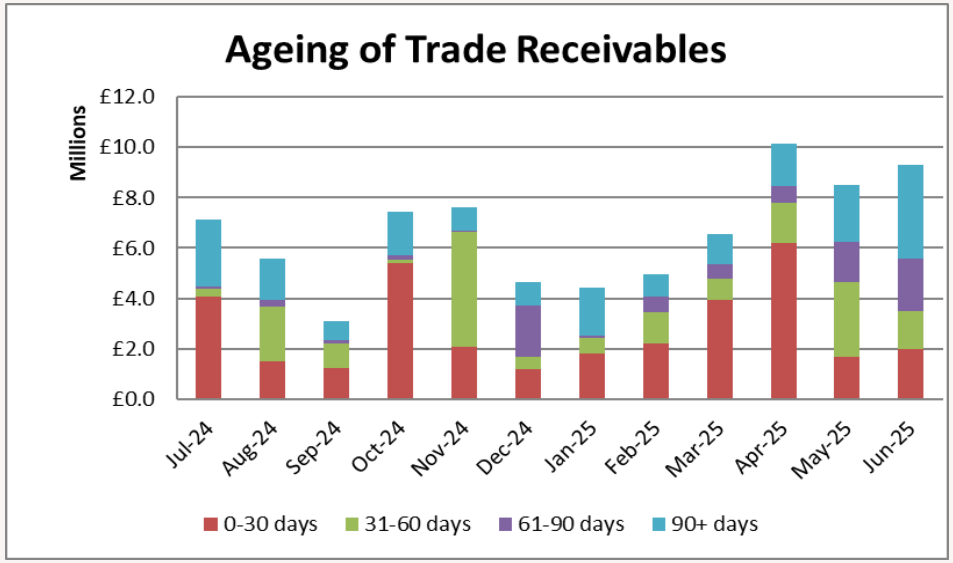
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

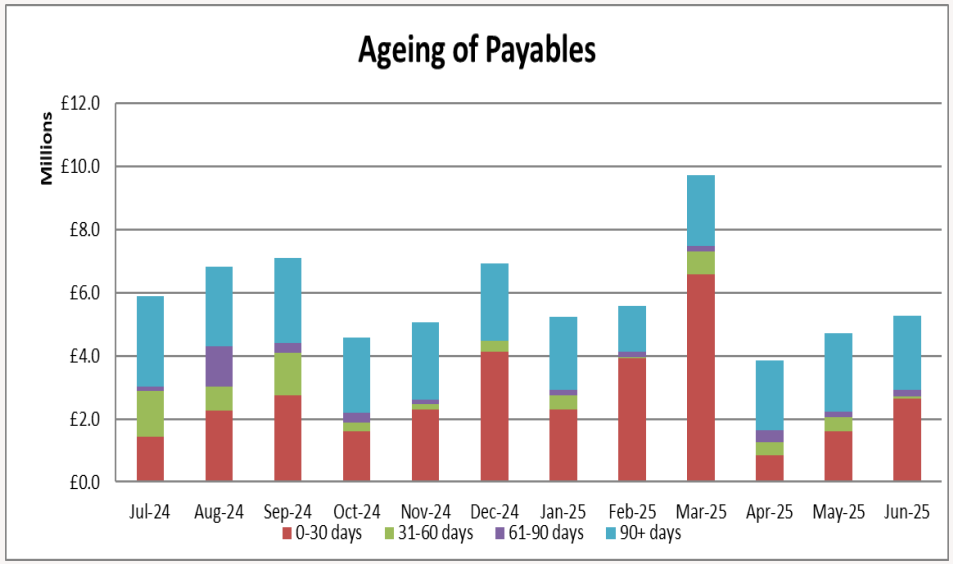
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	98%	✓	100%	✓
Non - NHS Creditors within 30 Days	97%	✓	99%	✓

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 Deputy Director of Finance or Executive Director of Finance have been pursued between organisations.

Trade Receivables :

- **0-30 days-** Overall Balance £2m–Increase in balance. Several debts have been settled, 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 £1.5m - Decrease in balance. *Paid June 25*: £4k, *Awaiting authorisation:* £762k. *In query: £747k* balances are currently being resolved. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £2.1m- Increase in balance mainly relating to UHB (escalated between both Trusts). *Awaiting authorisation*: £2m various balances including UHB, BWC, NHS C Board, Amey, WHSSC, Mercury Pharma. *In query*: £62k. Remaining balance mainly staff overpayments (on payment plans).

- **Over 90+ days-** Overall Balance £3.8m–significant increase in balance. *Awaiting authorisation:* BWC £841k, Greater Manchester WMT £1.7k, Birmingham Community HCT £9k, BSOL MHPC £539k, ReachOut £223k, University of Birmingham £95k, Comm Care HG PCN £3k, ATW £25k, Parexel Inc Ltd £17k, SDSmy HC £12k, Smartcare PCN £7k, Anthony Nolan £58k. *Paid:* UHB £943k *In query:* UHB £765k. Remaining balance mainly staff overpayments (on payment plans).

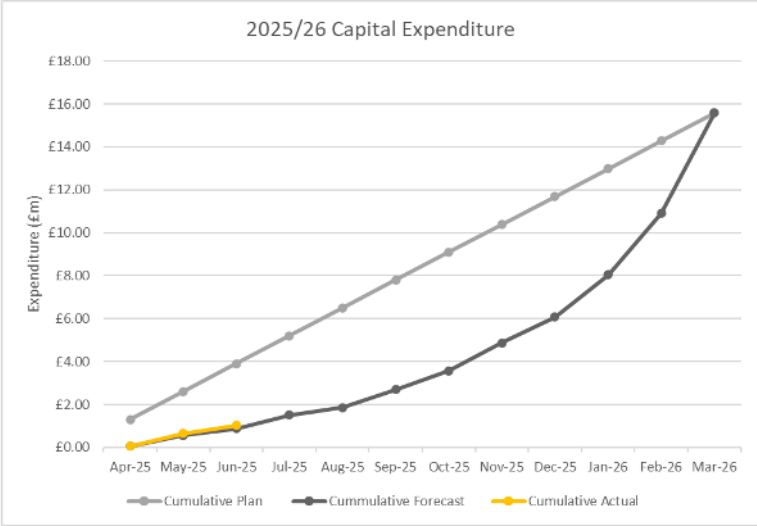
Trade Payables-Over 90 days:

NHS Suppliers £1.1m: NHS Property £123k-historic invoices with Estates and Facilities, UHB £874k in query (working directly with UHB to resolve accordingly).

Non-NHS Suppliers (52+) £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 July 2025.

Quarter 1 Capital expenditure

Capital schemes	Annual Plan	Annual Forecast	Adjustments	New annual forecast	YTD Forecast (phasing adjusted to reflect cashflow)	YTD Actual	Variance to Forecast
	£'m						£'m
Approved Schemes:							
Highcroft New Build	6.13	6.13		6.13	0.07	0.02	0.05
AUC/Others - Anti-Barricade Alarmed D	0.35	0.35	-0.35	0.00	0.00	0.00	0.00
Refurbishment for FIRST Team and Reco	1.02	1.02		1.02	0.00	0.00	0.00
ACUC Bathrooms	0.20	0.20		0.20	0.00	0.00	0.00
SSBM Works	2.07	2.07		2.07	0.04	0.14	-0.10
Medical Devices	0.10	0.10		0.10	0.00	0.00	0.00
Lease Vehicles	0.30	0.30	0.49	0.79	0.74	0.51	0.23
Recognition of IFRS 16 Leases	0.26	0.26		0.26	0.00	0.00	0.00
ICT	0.06	0.06	0.33	0.39	0.00	0.24	-0.24
Minor Works	3.98	3.98	-0.47	3.51	0.03	0.12	-0.09
CIR Estates Risk	1.12	1.12		1.12	0.00	0.00	0.00
Total	15.59	15.59	0.00	15.59	0.88	1.03	-0.15



Group Capital Expenditure

As per the table above, there has been £1.02m spend against an initial year to date plan of £4m. The revised capital forecast for month 3 was £0.88m, year to date spend is £150k ahead of forecast.

A revised plan has been developed to incorporate the 24/7 project within the current £15.59m capital budget. The revised plan comes with an overcommitment risk of £592k

The Capital cash forecast will be updated to reflect the revised plan to incorporate 24/7

2025/26 Capital Realignment

Capital Project	25/26 Original Plan £	25/26 Revised Plan £
Highcroft - New Build	6,126,710	6,126,710
Main House Refurbishment for FIRST Team	1,520,000	1,520,000
Main House Additional Grd/First Floor Rooms	670,000	0
AUC Bathrooms	200,000	200,000
SSBM	2,069,200	2,069,200
Trust Medical Device Replacement	100,000	100,000
IFRS16 Lease Cars	790,000	790,000
IFRS16 Property Leases	261,188	261,188
ICT	393,500	393,500
Major/Minor & Priority Risk (Additional)	2,427,385	1,000,000
CIR	1,122,000	1,122,000
24/7	0	2,600,000
	15,679,983	16,182,598
Overcommitment	89,273	591,888

The original plan assumes that the 24/7 project is funded by NHSE. The revised plan removes the additional works at Main House and removes all prioritised AD items to enable the Trust to fund the 24/7 project.

Commitment to the CIR Estate Risk schemes remains the same as this is funded by NHSE.

Summerhill Services Limited (SSL) Business Report

April 2025- June 2025

This report summarises the performance and activities of SSL from April 25 to June 25.

The first three months of this year remain very busy, with implementing the numerous capital projects across the Trust, and continuing to implement our new food and catering system for the trust called Symbiotics across additional sites.

SSL has been supporting the Trust with the recent CYP services. Currently, all CYP sites will remain with Birmingham Women's and Children's until April 2026, However, in the meantime SSL has implement an SLA to enable property management and monitor compliance and service. Our Pharmacy has also been impacted by the CYP transfer with an increase of up to 25% in dispensing volume and the introduction of a new drugs delivery service.

This year will see the largest capital spend in many years, with a number of key capital projects such as the new hospital at Highcroft, Main House redevelopment and the development of the Trusts' new 24/7 service.

SSL continues its focus on reducing additional pay costs including agency and overtime. SSL has successfully reduced these costs by over 60% over the past few months by utilising our new staff bank, thereby significantly reducing the cost per hour.

SSL is committed to the development and support our staff, and we have recently introduced our new training development programme which seeks to review all staff and the business training requirements, across all levels.

SSL continues to work with partners across the BSOL healthcare system to identify new opportunities, which can deliver improved performance and service quality, increase revenue, and provide financial benefits to the Trust and our healthcare partners. SSL continues to support the ICB and the BSol trusts to identify potential services where trusts can collaborate and enhance services across BSol. Nationally, SSL has worked with several trusts on capital projects ,delivering our patented PFI HealthCheck and more recently exploring opportunities with other Trusts in developing new wholly owned subsidiaries.

SSL Pharmacy services continue to perform well, and we are working on the implementation of our new pharmacy robot which will hopefully be fully operational in the next few months.

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Facilities Management

Domestic and Housekeeping Services

General:

- Paper products and chemicals are currently being reviewed with tender process underway – current anticipated savings of **£43k** per annum.
- New pest control policy is going through Trust procedure with a few minor amendments required prior to formal ratification.
- We are looking to review and update the Cleaning Policy over the next few months.

Training / Inductions:

- We have a new Training Manager - Bethany Bannigan will be joining SSL in November from Birmingham City Council where she was Operations Manager - Food lead.
- Our Allergen awareness training has been completed by all Hotel Service Managers.
- Our internal food specialist has initiated a Food Safety National working group which includes various other food safety specialists from other trusts around the UK, they will meet quarterly and SSL will be leading and chairing this forum.

Catering Services

- Master Catering Programme progressing well.
- The new food management system including tablet ordering on the wards has gone live @ Ardenleigh and Reaside – Tamarind is scheduled for October 2025.
- New 4 weekly menu and recipe book – A new 4 week menu cycle has been approved by the Dietician this has been implemented at Ardenleigh and Reaside.
- As part of the Go Live @ Ardenleigh the Cafeteria is also having a rebrand with some draft images developed below:

Dining Room wall
word - Food is everything
1100mm x 350mm

- Draft PAP (Primary Authority Partnership) has been formulated between SSL and Birmingham City council. This will allow a closer working relationship with the local EHO department and for us to gain assured advice – registration is currently underway.
- The EHO inspected kitchens all achieving a **5-star** rating.
- Compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS "Plastic Pledge".

- A detailed review of all retail prices across our five commercial kitchen is underway. In the interest of fairness and equality, we will prepare a proposal to the Trust on a single pricing policy across all sites.

Laundry and Linen Management

- New laundry provider Oxwash which commenced January 2025 is performing well.

Transport & Logistics

Fleet Update

- **Hydrogen Trial**
  The planned *hydrogen vehicle trial with Vauxhall, originally scheduled for August, has been cancelled. Vauxhall has decided to shelve its hydrogen programme due to limited market opportunities in Europe and little prospect for change in the near future
- **Replacement Fleet Programme**
  SSL continues with the fleet replacement program during 25/26. We currently have another 11 vehicles on order, which will arrive in the next few months.

NEPT / Portering

- **CYP Medicine Delivery**
  As part of the CYP transfer, SSL was created a new medicine delivery service for CYP. We are now in the third week of SSL operating the CYP pharmacy delivery via general route . Feedback has been very positive, our drivers have been praised for their timing and consistency, especially compared to their previous contractor, who were less predictable "surprise visit" approach. This reliability has been well received.

- **UBook**
  The trial has gone well, and we have demonstrated improvements, however we have identified some concerns which need to address before potentially progressing the project further. We are now looking at the resources required to extend this service across the Trust.

Warehouse

- **Resus Packs**
  We have been working with the Trust developing a proposal on Resus Packs. The proposal aims to centralise the ordering, storage, and distribution processes at the SSL HUB. All items will be sourced, picked and packed. They will signed off by the Trust clinical team before being dispatched. This initiative would improve operational monitoring, free up storage space in clinical areas, and streamline the exchange and delivery of resus bags.

Capital Projects

Capital Programme 25/26 progressing well, however, with the recent approved funding for 24/7 from NHSE, the program has now increased to **c£18m**. Which means we are working with the Trust to

identify which projects which had been moved until 26/27, could now be completed in this financial year.

We have a number of key projects including:

- **Highcroft New Hospital Development** – £25m approved Scheme has now been validated by Birmingham City Council. We now await their decision in the next few months.
- **Main House Redevelopment** – This redevelopment is progressing well. The project will deliver new office space for the expanding First Team.
- **24/7 Service** – we are still awaiting planning approval from Birmingham City Council.

SSL PFI/Contract Management

- **North Food Supplier**
  Due to financial concerns over BonCulina, we are looking to move to Apetito. However, this may result in increased costs, which we are currently working on with the Trust.

- **Food Production Project**
  SSL has instigated an internal project to review the potential option to provide all food through our own commercial kitchens. This project is still at a very early stage and may require significant capital investment. Once the options have been identified, we will work with Trust to decide the best option.

- **Parking Project**
  The first parking project (Trust and SSL) was held at Barberry recently. This group are reviewing the recent parking survey, potential options/ solutions and the health and safety concerns which have been raised.

- **Northcroft**
  SSL has submitted planning request to replace the cladding on Northcroft. Unfortunately, we are still awaiting planning approval from Birmingham City Council.

ICS Primary Care

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

- Significant progress has been made in the reporting period with the completion of Locality Clinical and separate Locality Estates Strategies.
- SSL is supporting ICS with a primary care capital program of c £2.6m this year.

Property Management

- **Public Sector Decarbonisation Fund**
  Unfortunately, it has been confirmed in the latest Government Spending review (confirmed also by NHSE) that this funding route will cease with immediate effect (post current scheme). This meaning that the £660K of Low Carbon Skills funding which has been spent by SSL on behalf of BSMHFT on Detailed Designs for some £10million of Capital heat decarbonisation schemes which now have no grant funding available.

- **Green Plan**
  The BSMHFT Green Plan has been redrafted and is now at final draft stage (work still being undertaken across the system re consistent approach to carbon data). As per revised NHSE timelines, we are planning the final version will be ready for the October 2025 FPP / Board

Outpatient Dispensing Services

- Summerhill Pharmacy dispenses 17,000 items on average per month accounting for 64% of medication items dispensed by the Trust pharmacy services.
- SSL Pharmacy as of 1st July-25 successfully transferred Forward Thinking Birmingham pharmacy services into SSL. This is forecasted to add an additional 5000 items per month, 2,500 item immediately and an additional 2,500 items in January 2026.
- SSL implemented an upgrade to its Prescription Tracker which tracks our pharmacy prescriptions
- SSL Pharmacy are launching a service with HMP Birmingham, providing cost effective supply of high-cost opioid substitution therapy. This will deliver both savings and improve clinical pharmacy capacity at HMP Birmingham
- SSL are supporting Birmingham Council with a novel medicines supply pilot for smoking cessation therapy.
- SSL Pharmacy is underway upgrading its compliance aid machine, this will have a self-checking function which will improve both safety and efficiency.
- SSL robot continues to deliver an accuracy of 99% on compliance aids (see appendices)

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance
Period Ending 24/25

SSL ended 24/25 £512k profit before tax and £1.025m profit after tax. The tax impact was due to the tax consultancy work which was requested by SSL Management and conducted by Deloitte's. This involved assessing SSL's previous years Capital Works and how, if at all, any Capital Allowances applied. This moved a potential tax liability for 24/25 of just over (£300k) to a credit of £500k so a turnaround of c£800k. Further work is expected on the Capital Works for 24/25 so further credits are expected in the period 25/26.

Period Ending M3 25/26

SSL is (£196K) (3%) behind budgeted revenue after the first 3 months of this financial year. This is mainly due to the lower than expected energy costs due to a combination of rate and usage. As in previous years, SSL is committed to a pay award for all SSL staff and will mirror the Trust pay award.

SSL is focussed on reducing additional pay costs including agency and overtime. We have maintained the low levels seen at the end of 24/25.

Revenue from External work is steady for our 3 main revenue streams, namely Primary Care, Trusts/ICS and PFI Consultancy.

- Primary Care – We continue support over 270 GPs across BSOL. The focus of work has now moved away from COVID and now more around monitoring Rent, Space Utilisation and Capital work. In terms of Capital, the team will now be managing circ £2.6m worth of work in the financial year 25/26.
- Trust/ICS – We continue to support the ICB with their Sustainability/Green plan
- PFI Consultancy – We have been commissioned by 2 organisations to complete PFI support work. There is an additional pipeline of projects for the 2nd half of the financial year which the team are working on. This project is being reviewed constantly to ensure we are managing any risk.

We have included (appendix B) is a table detailing our 5 yr Forecast and a cost benefits statement which shows how SSL delivers over £4m in financial benefits to the Trust annually.

Resourcing

- SSL has 2 Graduates in PFI and Capital and 7 Apprentices, spread across Analytics, Sustainability and Waste, and other operational and support areas. All participate in early years events, training. and projects to grow their skills and experience.
- SSL launched our own bank system in April 2025, which has seen a significant reduction in spend in overtime, greater control over rosters and resources through one-to-one training being provided by the HR Team to Supervisors and Managers.
- SSL continues to maintain its current staffing profile of 390 employees with vacant positions being filled through our refer a friend scheme, working with charities, recruitment fairs, and external advertisement.
- SSL has introduced a new Exit Interview Process with the focus being on understanding why colleagues are leaving SSL so that we can look at different schemes to improve retention.

Training and Development

- SSL also has an additional 16 permanent person undertaking professional development or apprentice qualifications across its organisation.
- SSL has also launched in June our First Line Manager/Supervisor Bootcamp which is a three-day course which all Supervisors/Line Managers will attend to ensure they have the appropriate people knowledge to manage their teams.
- SSL will also be launching it professional power skills training for first line managers, and its talent population to support professional growth.
- SSL's Board in June signed off a paper prepared by the Head of HR to work with Workpal who offer a performance management platform which will replace the Trusts "Better together Platform". Workpal will also work in conjunction with SSL to develop its Learning Management System offering to develop its training offering and ensure compliance of training records for Estates workers.

Reward and Recognition

- SSL has recently developed a Retention Bonus Payment for employees as appose to a Long Service Award to reward employees who complete 3,6,9-year service. SSL has also introduced a Retirement Voucher Scheme for employees who complete 15 years plus service.
- SSL has completed a strategic review of our company pension scheme, and the SSL board has agreed to move to a Salary Sacrifice Scheme with Ageon from September 2025. The new pension scheme offers staff additional financial benefits, increased flexibility and visibility with their pension. SSL has developed an effective communication plan to inform its workforce, and all staff have been written to informing them of the changes, with workshops to be delivered in August 2025.
- SSL has agreed a 3.6% pay increase in line with the NHS. This will be paid to staff in August 2025 along with back pay.
- SSL in June celebrated its 3rd People and Values Award whereby 100 members of SSL's 400 workforce came together to celebrate the Team's success. It was attended by Roisin Fallon-Williams and members of SSL Strategic Board.

Equality, Diversity & Inclusion

- SSL has recruited a range of new advocates and is undertaking training of new advocates in September 2025.
- SSL has completed its review of EDI statistics which will be presented to the EDI forum and actions decided upon.to take forward it's EDI Strategy.

Business Development, Opportunities and Plans

PFI Consultancy

- SSL continues to develop our PFI consultancy services which includes PFI Health check (Trademarked), PFI Handback and LIFT Co Consultancy.
- SSL continues to work with government departments and leading organisations including NHSE, DHSC and NISTA.

Wholly Owned Subsidiaries Consultancy

- Following the recent announcement from Jim Mackay regarding the positive benefits of Trusts having access or developing their own WOS. We have been contacted by a number of trusts to discuss how they can work with SSL or how we could help and support them.
- SSL is looking to develop a WOS Consultancy Service and model to help to support these requests.
- SSL is currently exploring options with a number of trusts regionally and nationally.

ICB / BSol

- SSL is working with the ICB and the BSol trusts to identify potential services where trusts can collaborate and enhance services across BSol.

Governance and Assurance

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

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix A – Financial Statement April 24 – Oct 24

SSL Financial Position	Annual budget	M3		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	16,175	4,044	3,969	(75)
Lease & Long License	3,476	869	776	(93)
Contract Management	2,486	621	575	(47)
Facilities Services	4,319	1,080	1,067	(13)
Grounds and Garden	408	102	65	(37)
PPE & Warehouse	323	81	86	6
Pharmacy	2,506	626	653	26
External Services - Head of Assets	511	128	197	70
External Services - STP	0	0	18	18
External Services - CCG Vaccine Progr	0	0	0	0
External Services - PFI	250	63	15	(48)
External Services - FM	40	10	6	(4)
Total income	30,494	7,624	7,428	(196)
Pay costs	(13,400)	(3,350)	(3,360)	(10)
Drug costs	(2,112)	(528)	(550)	(22)
Non pay costs	(8,762)	(2,190)	(2,046)	144
Internal Recharge	48	12	30	18
Total Expenditure	(24,226)	(6,057)	(5,927)	130
EBITDA	**6,268**	**1,567**	**1,501**	**(66)**
Depreciation	(3,314)	(828)	(817)	11
Interest Payable	(2,028)	(507)	(507)	0
Interest Receivable	0	0	13	13
Finance Lease	(356)	(89)	(89)	0
Profit / (Loss) before tax	**570**	**143**	**101**	**(41)**
Taxation	(380)	(95)	(98)	(3)
Profit / (Loss) after tax	**190**	**48**	**4**	**(44)**

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix B – 5 Yr Forecast and Benefits Statement

SSL I&E 5 Year Forecast	23/24 Actual £000's	24/25 Actual £000's	25/26 Forecast £000's	26/27 Forecast £000's	27/28 Forecast £000's	28/29 Forecast £000's	29/30 Forecast £000's
***Total Trading Income**	**29,417**	**29,084**	**30,494**	**30,957**	**31,429**	**31,910**	**32,399**
Pay Costs	(12,286)	(12,583)	(13,570)	(13,842)	(14,118)	(14,401)	(14,689)
Drug Costs	(2,645)	(2,138)	(2,112)	(2,329)	(2,329)	(2,329)	(2,329)
Non Pay Costs	(8,977)	(8,455)	(8,714)	(8,667)	(8,839)	(9,014)	(9,193)
Total Trading Expenditure	**(23,908)**	**(23,176)**	**(24,397)**	**(24,837)**	**(25,286)**	**(25,744)**	**(26,211)**
EBITDA	**5,509**	**5,908**	**6,098**	**6,120**	**6,143**	**6,166**	**6,189**
Depreciation	(3,105)	(2,908)	(3,314)	(3,035)	(2,866)	(2,849)	(2,848)
Interest Payable	(2,081)	(2,133)	(2,028)	(1,920)	(1,808)	(1,692)	(1,573)
Interest Receivable		27					
Finance Lease	(382)	(382)	(356)	(356)	(356)	(356)	(356)
Total Capital Financing	**(5,569)**	**(5,397)**	**(5,698)**	**(5,310)**	**(5,030)**	**(4,897)**	**(4,777)**
Profit / (Loss) before Tax	**(61)**	**512**	**400**	**810**	**1,113**	**1,268**	**1,412**
Benefit to the Trust							
Tax Efficiency	1,261	1,058	1,218	1,282	1,313	1,367	1,406
Managed Service Operational Benefits	1,332	1,119	1,131	1,142	1,153	1,165	1,177
Staff/Operational Savings	1,648	1,468	739	766	795	824	855
Total Benefit to the Trust (Not in P&L)	**4,241**	**3,645**	**3,088**	**3,190**	**3,260**	**3,356**	**3,438**
Total Benefit before Tax	**4,181**	**4,157**	**3,488**	**4,000**	**4,373**	**4,625**	**4,850**

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**6 August 2025**
Date(s) of Committee Meeting(s) reported	**30 July 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 • Internal Audit Reviews: Cyber Assessment Framework Clinical Coding; Cyber Assessment Framework Independent Assessment; Waiting Times Follow Up Report • Local Counter Fraud Specialist Progress Report • Declarations of Interest Checklist Report • External Audit Completion Report • Declarations of Interest and Fit and Proper Persons Compliance Report • Constitution, Standing Orders and Scheme of Delegation • Emergency Preparedness, Resilience and Response Policy
Alert:	The Committee wished to alert the Board of Directors that a positive compliance report had been received into Declarations of Interest and Fit and Proper Persons, and reminded Board members to update declarations of interest as changes occur.
Assure:	The Committee was assured on the following areas: • The Committee was assured by the positive audit completion report and would formally recommend approval of the Annual Report and Accounts 2024/25 to the Board of Directors. • The Committee noted the **Cyber Assessment Framework Clinical Coding** advisory review and the rationale behind the Trust's decision to not take part. • The Committee noted the positive internal audit independent assessment into the **Cyber Assessment Framework**, with a High confidence level provided across all five objectives, and High confidence level provided in the Trust's self-assessment.

	• Positive assurance was received on the action tracking report. Good progress had been made to respond and close recommendations in line with deadlines.	
Advise:	The Committee endorsed that changes to the Constitution, including the Standing Orders and Scheme of Delegation, noting that these had already been approved by the Council of Governors. The changes would be formally recommended to the Board of Directors. The Committee noted Good Progress made from the internal audit follow-up review into **Waiting Times**, with all 37 recommendations fully implemented and one additional action raised.	
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 Committee flagged the need to strengthen CYP and Cyber related risks within the BAF, and highlighted some lack of urgency described within the finance risks and the rationale for reducing the impact of the People risks. 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. Increased alignment between the Corporate Risk Register and Board Assurance Framework would be reviewed as part of the Board Strategy Session in August. The Committee noted that the Commissioning BAF would be discussed as part of the Board Strategy Session in August and continually reviewed and scrutinised through Commissioning Committee. Positive assurance was received on the SSL Risk Summary, but food safety and estates were highlighted for additional assurance in the next report.	
	New risks identified: no new risks identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Report to Board of Directors							
Agenda item:	**21**						
Date	6 August 2025						
Title	Changes to the Trust Constitution and Scheme of Reservation and Delegation						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

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

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

Alert		**Advise**		**Assure**	✓

1. Purpose:

The purpose of this report is to set out the changes that have been made to the Trust Scheme of Reservation and Delegation (SoRD) and Constitution, including to the composition and constituencies that make up the CoG. Updating the Trust Constitution provides an opportunity for the Trust to ensure it accurately reflects its current operations, legal obligations, strategic direction and aligns with best practice and any changes to the national policy landscape (e.g. the publications of the Health and Care Act 2022 and the Code of Governance for NHS Provider Trusts 2022).

2. Introduction:

The Trust Constitution sets out the objectives of the Trust, powers and functions of its Board of Directors and its Committees including the statutory duties and composition of the Council of Governors as well as its constituencies. Good Corporate Governance as encapsulated in the Trust Constitution while echoing *The Healthy NHS Board* ensures that the Trust is able to fulfil its overall purpose, achieve intended outcomes for service users and operate in an effective, efficient and ethical manner.

Updates to the following two key documents of the Trust` Governance Manual are hereby presented for approval (Please see appendixes 19.1 & 19.2 for details).

- Constitution
- Scheme of Reservation and Delegation (SoRD)

The following material changes have been made to the enclosed updated Trust Constitution: -

- Inclusion of the Trust`s responsibility to climate change as per the Climate Change Act 2008 & the Environmental Act 2021 – (see Pg 5 for details).
- Updates to the CoG`s role in endorsing Significant Transactions to align with the Trust`s Significant Transactions Policy and the Code of Governance for NHS Provider Trusts – (see Pg18 for details).
- Circumstances under which any amendments to the Trust Constitution will be deemed valid – (see Pg19 for details).
- Changes to the composition and constituencies arrangements of the CoG – (see Pg24-25 for details).
- Changes to the terms of office of the Lead and Deputy Lead Governors – (see Pg94 for details).

- The amendments to the enclosed Trust Constitution (see item 9.1.2 for details) are highlighted in orange.

For the changes to the Constitution to be valid, more than half of the members of the Board of Directors will need to vote to approve them. However, because the proposed changes to the CoG are quite substantial, there is an additional requirement as per the HSCA 2012 for these to be presented at the AGM for approval, recognising that these changes would become null and void if the AGM doesn't approve them.

Key changes to the Scheme of Reservation and Delegation (SoRD)

- Reference to a provision in the Code of Governance for NHS Provider Trusts (2023) on a formal schedule of matters specifically reserved to the Board (*See pg 4 for details*).
- Refreshing of the list of matters specifically reserved to the Board (*See pgs 5-6 for details*)
- Refreshing of the list of matters specifically reserved to the Commissioning Committee (See pg 6 for details).

3. Key issues and risks:

The main issues worth noting are:

- The need to widely populate the updated Constitution so that all staff, governors and NEDs are fully aware of the changes.
- The need to timely organise elections to fill all vacancies on the CoG.

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. NOTE the content of this report.
2. REVIEW, SCRUTINISE and RATIFY the amendments to the enclosed Trust Constitution and the Scheme of Reservation and Delegation.

Enclosures

Appendix 19.1: Changes to the Trust Constitution including the composition and constituencies of the CoG (See item 19.2 for details) – Reading Pack

Appendix 19.2: Changes to the Trust Scheme of Reservation and Delegation (See appendix 19.3 for details) – Reading Pack

Report to Board of Directors						
Agenda item:	**22**					
Date	22nd July 2025					
Title	Emergency Preparedness Resilience & Response (EPRR) Annual Report 2024/25					
Author/Presenter	Louise Flanagan – EPRR Officer David Tita – AD of Corporate Governance					
Executive Director	Vanessa Devlin	**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
This annual report provides an overview of the Trusts emergency preparedness and covers the activities the Trust has undertaken since the previous report (March 2025) to ensure the Trust's resilience in the event of a business continuity, critical or major incident, or other severe disruption occurring. It then concludes with the Trust`s EPRR priorities for the coming year.

Introduction
This report aims to provide the Board of Directors an update regarding activities undertaken since the previous report (March 2025) in relation to emergency preparedness and business continuity, and to ensure that the Trust meets its responsibility to provide an effective incident response, while maintaining the services it is commissioned to provide.

The overall responsibility for complying with the Civil Contingencies Act (2004) and EPRR Framework rests with the Chief Executive Officer who is responsible for ensuring, through appropriate delegation of responsibility, that we comply with our statutory responsibilities and that NHS Core Standards for EPRR are met.

Key Issues and Risks
Capacity within the EPRR provision remains 1.0 whole time equivalent member of staff and this is insufficient to sustain and improve the Trusts statutory responsibilities and to provide sufficient resilience in the absence of the EPRR Officer. This has led to issues with completion of components of the EPRR Workplan, primarily in relation to our exercising needs.

Lack of a working back up system for our critical ICT systems is a current risk. This work needs to be led by clinical services to ensure that a fit for purpose plan is developed.

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. **NOTE** the content of the enclosed EPRR Annual Report.
2. ***REVIEW, SCRUTINISE and APPROVE*** *the Trust EPRR Annual Report.*

Enclosures

Appendix 20.1 Emergency Preparedness Resilience & Response (EPRR) Annual Report August 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

Emergency Preparedness, Resilience & Response (EPRR) Annual Report

July 2025

Louise Flanagan, EPRR Officer

1. EXECUTIVE SUMMARY

Strengthening Emergency Preparedness, Resilience, and Response and Ensuring Organisational Resilience

Emergency Preparedness, Resilience, and Response remains a critical priority for our organisation, ensuring we maintain operational readiness and compliance with regulatory requirements. This report provides an update on our EPRR activities, highlighting progress, challenges, and required actions to enhance our preparedness.

Key Updates & Achievements

- **Core Standards Assessment:** Our 2024 self-assessment identified areas of compliance and highlighted key areas requiring improvement to meet national EPRR standards which the Emergency Preparedness, Resilience & Response Officer (EPRRO) has continued to work on during the year, ahead of the 2025 self-assessment process.
- **Training & Exercising:** This remains and area of concern in terms of our internal testing and exercising regime. However, we have recently initiated a program of table-top directorate exercises which will be run at regular intervals in locality team meetings. BSMHFT continue to participate in regional testing and exercising and a incident response team attended the recent Exercise Tangra, a regional pandemic/infectious disease exercise.

  An 'all staff' EPRR Awareness e-learning module was launched in May 2025, in line with feedback from the 2024 Core Standards process. This module is mandatory for all staff (with the exclusion of those who need to complete the module for on-call staff). The EPRRO is working with the Learning & Development Team to have these modules included on the traffic light system to ensure staff receive timely reminders of training requirements in relation to EPRR.

- **Document Reviews:** A review of all existing business continuity and emergency plans has been undertaken as per the EPRR work programme to ensure alignment with best practices and evolving risks. Updates have been made to ensure alignment with regionally/nationally updated guidance where appropriate.

Challenges & Risks

- **Resource Constraints:** Limited resources, particularly relating to personnel, remains a significant barrier to fully implementing EPRR activities. This is impacting our ability to meet evolving demands and maintain and improve levels of preparedness and compliance with statutory responsibilities.
- **Operational Readiness Gaps:** While progress has been made, gaps remain in certain response capabilities, requiring targeted action and investment.

Next Steps & Recommendations

- Additional resource requirements still requires exploration to address identified gaps and strengthen resilience.

- Enhance leadership engagement in EPRR initiatives to drive strategic alignment and prioritisation.
- Continue to refine training programs and conduct further exercises to validate preparedness levels.

2. INTRODUCTION

Under the NHS Constitution (as updated 2023), the NHS is there to help the public when they need it most; this is especially true during a significant incident or an emergency. Each NHS funded organisation must therefore ensure it has robust and well-tested arrangements in place to plan for, respond to and recover from these situations. The Civil Contingencies Act 2004 (CCA) outlines a single framework for civil protection in the United Kingdom. The Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. Whilst Mental Health Trusts are not specifically noted to be Category 1 responders, as defined by CCA, subsequently issued guidance such as the EPRR Framework and the NHS Standard Contract make it clear that as an NHS funded organisation we are obligated to plan and respond as though we were Category 1 responders. As such BSMHFT is subject to the full set of civil protection duties and are required to:

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

The NHS England Emergency Preparedness Framework (2022) provides strategic national guidance for all NHS funded organisations to help with meeting the requirements of these statutory obligations.

This report provides the Finance, Performance and Productivity Committee/Trust Board with an update regarding activities undertaken since the previous report (March 2025) in relation to emergency preparedness and business continuity, and to ensure that the Trust can meet its responsibility to provide an effective incident response, while maintaining the services the Trust is commissioned to provide.

2. GOVERNANCE ARRANGEMENTS

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

The Trusts designated Accountable Emergency Officer (AEO) is the Executive Director with delegated responsibility for ensuring resilience across the Trust and the delivery of safe and robust responses to all

kinds of emergency disruptions, supported by the Emergency Preparedness, Resilience & Response Officer (EPRRO). Our AEO is the Executive Director of Operations.

Operational management support is provided by the EPRRO. The AEO represents the Trust at regional forums including the Local Health Resilience Partnership (LHRP). The Trust has an internal Emergency Planning and Business Continuity Committee (BCEPC) which meets on a quarterly basis. An assurance position will be provided to the Finance, Performance & Productivity (FPP) Committee on a 6-monthly basis which is then reported to Public Board, as required by NHSE Core Standards for EPRR.

The EPRR function sits in the Corporate Governance portfolio under the management of the Associate Director of Corporate Governance.

3. RISK

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

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

Further detail on the risks highlighted in both the national and community risk registers can be found at the following links:
National Risk Register - 2025 edition
Preparing the West Midlands for Emergencies

Summary of EPRR Risks*

Risk ID	Title of Risk	Lead	Current risk score	Movement in risk score
1167	Risk of widespread fuel shortage, caused by a number of factors resulting in impact to service delivery	EPRR Officer	9	⟷
1174	Risk to staff and inpatient health and wellbeing caused by extreme weather related to heatwave	EPRR Officer	12	↑
1175	Risk of losing essential power/ heating/ communications/ ICT network and critical systems/ water caused by regional failure of utilities	EPRR Officer	12	⟷
1176	Risk that staff will be unable to attend work and premises will be rendered unusable due to the excess surface water or widespread flooding	EPRR Officer	9	↓
1177	Risk of staff not being able to attend their normal place of work caused by pollution or widespread toxic release of substance resulting in a CBRN Incident and/or the potential closure of Trust site.	EPRR Officer	8	⟷
1738	Risk that the Trust will not be able to maintain compliance with NHSE EPRR Core Standards and its statutory duties caused by a lack of capacity and resource within the EPRR portfolio	EPRR Officer	12	⟷
1828	Risk to staff and inpatient health caused by extreme cold weather and snow with low temperatures	EPRR Officer	8	↓
1830	Risk that there will be an outbreak of an influenza-type pandemic affecting the UK population resulting in large scale staff absence, increased pressure on the system wide health service and increased mortality	IPC Lead	10	⟷
1891	Risk of Flu outbreaks across the Trust due to very low flu vaccine uptake	IPC Lead	12	⟷

1892	Risk to staff and community patient health and wellbeing, this is caused by extreme cold weather and snow	EPRR Officer	8	↓
1893	Risk to staff and community patient health and wellbeing. This is caused by extreme weather related to heatwave	EPRR Officer	12	↑
1978	Risk that the EPMA BC system may not work as intended leading to the ability of clinicians to prescribe and dispense medications	Chief Pharmacist	8	↔
2034	Risk to patient safety and quality of care in the event of unplanned loss of access to critical information systems including RiO, EPMA, EMIS, Illy, Iaptus, Dialog+	EPRR Officer	12	↑
2055	Risk due to staff within the trust not having access to appropriate training on High Consequence Infectious Diseases (HCIDs) and clear national guidance for mental health & community settings	IPC Lead	16	new

*please refer to ICT report to FPP for details of ICT based risks

4. PLANNING AND PREPAREDNESS ACTIVITIES

Document Reviews

In accordance with NHSE Core Standards requirements, all EPRR related plans must be reviewed annually as a minimum, following any activation or after any significant organisational change. A number of documents have therefore been reviewed and updated since the previous report (March 2025) as part of the EPRR Workplan schedule:

- BSMHFT Adverse Weather Plan
- BSMHFT Emergency Communications Management Plan
- BSMHFT Incident Response Plan
- BSMHFT Initial Operational Response (IOR) to Incidents Suspected to Involve Hazardous Substances or CBRNE Materials

The annual cycle of auditing local business continuity plans, major incident plans, evacuation and shelter plans as well as the audit of major incident equipment boxes and initial operational response equipment boxes has been completed for 2025 and all updated plans are available on the dedicated section of Connect. At the time of writing the EPRRO is in the process of making further updates to all EPRR documents due to the launch of the new intranet, which means that all links in documents need to be refreshed.

Documents currently under review:

- BSMHFT Emergency Preparedness and Business Continuity Policy

Plans in development:

- Project to develop an ICT Outage BCP in progress with the support of the QI Team

Document Review Compliance:

Trustwide plans:

	LAST REVIEW	NEXT REVIEW
BSMHFT EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY POLICY V5.2	August 2024	August 2025
BSMHFT INCIDENT RESPONSE PLAN V7.9	June 2025	June 2026
BSMHFT ADVERSE WEATHER PLAN V1.7	June 2025	June 2026
BSMHFT FUEL DISRUPTION PLAN V1.7	March 2025	March 2026
BSMHFT IOR RESPONSE TO INCIDENTS SUSPECTED TO INVOLVE HAZARDOUS SUBSTANCES OR CBRNE MATERIALS PLAN V1.2	March 2025	March 2026
BSMHFT LOCKDOWN GUIDANCE (IN IRP) V1.0	June 2025	June 2026
BSMHFT MASS COUNTERMEASURE DISTRIBUTION PLAN V1.5	March 2025	March 2026
BSMHFT PANDEMIC FLU PLAN V2.0	October 2024	October 2025
BSMHFT EMERGENCY COMMUNICATIONS MANAGEMENT PLAN V1.1	May 2025	May 2026
BSMHFT INCIDENT RESPONSE PLAN FOR TRUSTWIDE STAFF REDEPLOYMENT V3.0	October 2024	October 2025
ICT/POWER/COMMS OUTAGE BCP - A&UC	July 2025	July 2026
ICT/POWER/COMMS OUTAGE BCP - SPECIALTIES	June 2025	July 2025
ICT/POWER/COMMS OUTAGE BCP - SCOH V1.1	June 2025	June 2026
ICT/POWER/COMMS OUTAGE BCP - ICCR V1.1	May 2025	May 2026
TOTAL	14	
TOTAL IN DATE	14	
% COMPLETION	100%	

All EPRR related documents can be found on the dedicated Business Continuity and Major Incident Planning - Business Continuity and Major Incident Planning section of Connect. This is also where you can find information and guidance relating to on-call, training and personal development portfolios.

Transfer of Children & Young People (CYP) Services

A number of CYP services transferred from Birmingham Women's & Children's NHS Foundation Trust (BWC) to BSMHFT on 01 July 2025. A support centre was stood up between 30 June and 04 July, to provide staff and services transferring with a single point of contact during the initial week of transfer. The support centre received around 170 queries logged, predominantly relating to issues concerning ESR and other systems linked to ESR data which had not been transferred as expected as well as manager access within the ESR system. The CYP directorate have continued to work on the outstanding actions locally.

In addition to this, work was also completed to ensure that all existing business continuity plans were reviewed and updated in order to be fit for purpose for BSMHFT. The annual review of the BSMHFT Incident Response Plan was also undertaken to ensure that the transfer of services was considered.

5. TRAINING AND EXERCISING

Training

EPRR Awareness for On-Call e-learning package has been reviewed and updated and is available as a module in the BSMHFT Learning Zone, allowing for better monitoring and reporting of compliance with the required training which is mandatory for all staff who undertake on call duties as part of the strategic, tactical and psychology on-call rota's. It will also make the module more easily accessible for staff.

An All Staff EPRR Awareness module has been developed and was launched in BSMHFT Learning Zone in May 2025. This module is considered mandatory for all staff to complete (with the exception of staff who are required to complete the On-Call module). The lack of an all-staff awareness module was identified as an area of non-compliance in the 2024 Core Standards confirm & challenge process so this represents positive progress in a key action. Staff have been given a 3 month period in which to complete this training and compliance will be reported on within the next EPRR report (due March 2026).

Personal Development Portfolios (PDP's), mandated by NHSE, for all staff who could be called upon to undertake roles within an Incident Management Team (as per our Incident Response Plan) were rolled out in the second half of 2024. PDP's have been developed in line with the Skills for Justice National Occupational Standards for Civil Contingencies and will help to identify gaps in training for key staff. Template PDP's are available via the EPRR training page on Connect and it is the responsibility of individual staff to complete and maintain PDP's. The EPRRO maintains a log of completed PDP's as per the requirements to provide evidence for Core Standards, current compliance is poor.

Principles of Health Command Training is a mandatory training for all staff who undertake duties on the strategic on call rota and also those who could be called upon to hold the role of Incident Director in or out of hours. The training is delivered by NHSE in line with the Skills for Justice National Occupational Standards for Civil Contingencies. There remains a lack of availability for this course which we continue to escalate as a system. The training is currently being updated by NHSE and we are awaiting the release of new dates which will be circulated to appropriate staff. This training is required to be completed every 3 years.

Decision Loggist Training - The Trust has successfully increased its number of trained decision loggists during 2024 with the support of the ICB EPRR Team with an additional 2 loggists coming on board as part of the CYP services transfer to BSMHFT. Each operational directorate should maintain a minimum of 2 trained loggists to support a Trust-wide response.

Exercising

Delivery of a 'live' exercise has been delayed due to the capacity of the EPRRO but this is in development for the latter part of 2025/26. A live play exercise will require support from senior leaders to form an incident response team.

Exercise Baby Toucan – Internal Communications Exercise run by the EPRRO every 6 months. Working from home arrangements of the staff who support our Executive Team continue to present some issues with urgent communication with our Executive Team in hours. The most recent in and out of hours tests were both unsuccessful and will be repeated.

Exercise Astral Convention – RAF/WMAS large scale exercise being held at the NEC on 13 September 2025. BSMHFT have not been asked to participate at the time of writing.

Current compliance with training and exercising requirements are monitored by the EPRRO and reported to BCEPC quarterly and form part of our evidence for Core Standards.

6. ASSURANCE AND OBLIGATIONS

NHSE Emergency Preparedness Resilience and Response Core Standards for EPRR

The 2025 annual assurance process instruction letter was received from NHSE on 03 July 2025 and we have been informed that there are no changes to the standards this year and additionally, there will be no deep dive section of the self-assessment for 2025.

The 2024 action plan continues to be worked through by the EPRRO, addressing areas of partial compliance, many of which have already been completed. Capacity of the EPRRO to complete all of the action has been a significant challenge. The deadline for the 2025 self-assessment submission is 29 August 2025.

EPRR Internal Audit

The last EPRR audit was carried out at the end of 2023 and was extended into the start of 2024 due to staff absence. Of the 15 management actions considered one remains unresolved:

- Identification of a designated deputy for the EPRRO (high priority recommendation)
-

7. RESOURCES/RESILIENCE

The EPRR function within the Trust continues to be provided by a single individual (EPRRO). As previously reported, this continues to represent a single point of failure for the organisation as this allows for no cover arrangements in the event of the absence, planned or unplanned, of that individual. NHSE Core Standard 5 requires the Trust Board to be "satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties" and this is currently an area of concern and makes delivery of the annual work program unsustainable. The EPRRO has previously provided a draft business case to the Associate Director for Corporate Governance for consideration of increased resource to the EPRR function which was not accepted.

8. PARTNERSHIP WORKING

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

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

System wide Task and Finish Groups have been set up for the following areas of priority:

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

9. NEW AREAS OF WORK

The Terrorism (Protection of Premises) Act 2025, also known as Martyn's Law, is a UK law which received Royal Assent on 03 April 2025. The Act delivers the Government's manifesto commitment to strengthen the security of public premises and events. The Government has indicated that there will be an implementation period of at least 24 months before the Act comes into force. This will allow the Security Industry Authority's (SIA) new function to be established, whilst ensuing those responsible for premises and events in scope have sufficient time to understand their new obligations. All healthcare buildings of a certain capacity (200 people on site at any one time for tier 1 and 800 people on site at any one time for tier 2) are in scope of the Act. We await the issuing of statutory guidance so that the Trust can undertake

work to ensure that we are fully complaint with the new requirements, although for most healthcare sites the already existing requirements of NHS Core Standards for EPRR will already be over and above that required by the Act.

9. PRIORITIES FOR 2025/6

- On-going delivery of statutory requirements under the CCA 2004, the Framework for EPRR and Core Standards and NHS Standard Contract requirements
- Completion of Core Standards Action Plan to improve and maintain Core Standards compliance position
- Development and implementation of an ICT Outage Business Continuity Plan
- Development and delivery of a live play internal exercise and annual business continuity exercises
- Increase capacity and resilience to the EPRR function
- Work to ensure compliance with Martyn's Law requirements

Conclusion

Our organisation continues to make progress in strengthening EPRR, but critical gaps remain, particularly in achieving compliance with exercising and testing our plans. Urgently addressing these gaps is essential to maintaining operational resilience and ensuring effective emergency response. Addressing these gaps requires strategic investment and a commitment to embedding EPRR best practices across our organisation. To move forward, leadership commitment and resource investment are critical. By prioritising these efforts, we can strengthen our preparedness, enhance compliance, and better protect our organisation and the communities we serve.

Report to Board of Directors							
Agenda item:	**23**						
Date	6 August 2025						
Title	Emergency Preparedness and Business Continuity Policy						
Author/Presenter	Louise Flanagan – EPRR Officer David Tita – AD Corporate Governance						
Executive Director	Vanessa Devlin	**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
It is a requirement of NHS Core Standards for EPRR that the Emergency Preparedness and Business Continuity Policy should be approved by the Board of Directors. This report provides an opportunity for the Board to review, scrutinise and approve the updated Trust's Emergency Preparedness and Business Continuity Policy while fulfilling its oversight function of overseeing and assuring itself that the Trust`s EPRR arrangements are robust and fit-for-purpose.

Introduction
The Emergency Preparedness and Business Continuity Policy is required to be reviewed every three years as a minimum and NHSE Core Standards requires the policy to be ratified at Trust Board level.

The overall responsibility for complying with the Civil Contingencies Act (2004) and EPRR Framework rests with the Chief Executive Officer who is responsible for ensuring, through appropriate delegation of responsibility, that we comply with our statutory responsibilities and that NHS Core Standards for EPRR are met.

Key changes to the updated Emergency Preparedness and Business Continuity Policy include:-

- Command post exercise added as an exercise requirement as it was missing *(See pg 5 for details).*
- Trustwide Staff Redeployment and comms plan added to list *(See pg 6 for details).*
- Section 3.9.9 clarifies governance already in place around lessons/actions tracking *(See pg 11 for details).*
- Paragraph on climate change and adaptation added as a recommendation from external consultation with NHSE *(See pg 12 for details).*
- Sections 3.11 & 3.12 added as a recommendation from external consultation with NHSE *(See pg 14 for details).*
- Tactical manager on call added to list as it was missing *(See pg 17 for details).*
- Deputy arrangements for AEO clarified *(See pg 18 for details).*
- Trustwide Staff Redeployment and comms plan added to list *(See pg 39 for details).*

- Appendix K on BSMHFT Net Zero/Green Plan *(See pg 43 for details).*

Further amendments in the updated *Emergency Preparedness and Business Continuity* Policy are highlighted in orange.

Key Issues and Risks
The main issue is the need to ensure that the updated Emergency Preparedness and Business Continuity Policy once approved is appropriately disseminated across the Trust.

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 APPROVE*** *the enclosed Trust Emergency Preparedness & Business Continuity Policy*

Enclosures

Appendix 21.1 Emergency Preparedness & Business Continuity Policy v5.3

Birmingham and Solihull Mental Health NHS Foundation Trust

EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY MANAGEMENT POLICY

Policy number and category	**CG 09**	**Corporate Governance**
Version number and date	**Version 5.3**	**May 2025**
Ratifying committee or executive director	**Trust Board**	
Date ratified	**TBC**	
Next anticipated review	**May 2028**	
Executive director	**Executive Director of Operations & Accountable Emergency Officer**	
Policy Lead	**Emergency Preparedness, Resilience & Response Officer**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT

This document sets out the strategic framework for the management of emergency planning and business continuity for Birmingham and Solihull Mental Health NHS Foundation Trust. This policy has been developed in line with the Trust Policy Development and Management Policy and will be subject to an annual review as a minimum, in line with the requirements of NHSE Core Standards for Emergency Preparedness, Resilience & Response and will be subject to a consultation process both internally and with external stakeholders.

This policy:

The purpose of this policy is to ensure that Birmingham & Solihull Mental Health NHS Foundation Trust (the Trust) will comply with the requirements of the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022, and its statutory duty to implement arrangements. This policy is mandatory and applies to all staff (temporary and permanent) within Birmingham and Solihull Mental Health NHS Foundation Trust involved in writing and/or implementing policies. This policy also applies to all activities undertaken by the Trust including at HMP Birmingham

POLICY REQUIREMENT (see Section 2)

Effective Emergency Preparedness and Business Continuity Management is the responsibility of all staff and every department. The Trust's approach is an holistic one which requires the involvement and engagement of all staff across the Trust.
Appointed Directorate/Service Area Emergency Preparedness and Business Continuity Leads should work in co-operation with Trust staff in the development and review of a Business Impact Analysis (BIA), Business Disruption Risk Assessment (BDRA) and other materials which underpin the Trust's Business Continuity Management System.
Monitoring and progress reporting should be managed through the appropriate strand of the Trust's established governance structure.

CONTENTS

1 INTRODUCTION

1.1 Rationale

Birmingham and Solihull Mental health NHS Foundation Trust is a large and complex organisation delivering a comprehensive mental healthcare service for the residents of Birmingham and Solihull and to communities across the West Midlands and beyond.

We operate out of more than 30 sites and serve a culturally diverse population of 1.3 million spread out over 172 square miles and have an annual income of £301m, a dedicated workforce of almost 4,000 staff and a range of local and regional partnerships, making this one of the most complex and specialist mental health foundation trusts in the country.

Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas. As such, it is subject to a wide range of risks with the potential to disrupt normal service delivery and requires a clear and comprehensive Business Continuity and Emergency Preparedness policy to ensure all possible mitigations have been considered and implemented to ensure we continue to provide services in line with our organisations purpose, vision and values.

Trust Purpose, Vision and Values:

Our vision
Our vision for what we want to achieve in the future is simple: improving mental health wellbeing.

Our values
Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners.

Compassionate
- Supporting recovery for all and maintaining hope for the future.
- Being kind to ourselves and others.
- Showing empathy for others and appreciating vulnerability in each of us.

Inclusive
- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Valuing all voices so we all feel we belong.

Committed
- Striving to deliver the best work and keeping service users at the heart.
- Taking responsibility for our work and doing what we say we will.
- Courage to question to help us learn, improve and grow together.

1.2 Scope (Where, When, Who)

1.2.1.1 This policy is mandatory and applies to all staff (temporary and permanent) within Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). For

those staff covered by a letter of authority / honorary contract or work experience this framework is also applicable whilst undertaking duties on behalf of BSMHFT or working on BSMHFT premises. As part of good employment practice, agency workers are also required to abide by BSMHFT policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking any work.

This policy also applies to all activities undertaken by the Trust including HMP Birmingham Healthcare services.

Partnership organisations (suppliers, contractors and providers) will be expected to demonstrate the existence of a robust system of business continuity management commensurate with the principles set out in this policy.

Summerhill Services Limited (SSL), a wholly owned subsidiary of BSMHFT, has in place its own business continuity plan and this is included at Appendix E.

1.3 **Principles**

The Trust recognises the importance of an effective Business Continuity Management system (Appendix B) and emergency preparedness and the role all staff have to play in their development, delivery, maintenance and review.

Although Mental Health providers are not listed as a 'Category 1' responders under the *Civil Contingencies Act (CCA) 2004*, subsequent guidance and legislation requires all NHS funded organisations to plan for and respond to incidents as Category 1 responders. Additionally, we hold responsibilities under the Regional Mass Casualty Plan to support other NHS Trusts in the provision of psychological support and psychological site management to a major incident, contribute to any required distribution of mass countermeasures and to work to create capacity within receiving hospitals. The focus for the Trust is therefore on developing and embedding appropriate emergency preparedness and business continuity arrangements to ensure it can effectively meet the challenges of incidents that can disrupt the continuity of its critical and essential services under the *NHS Emergency Preparedness, Resilience & Response Framework 2022*.

The model adopted accords with the best practice expectations placed upon all NHS organisations in the NHSE Business Continuity Management Toolkit (2023) and the associated requirements listed in the *NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR)* being:

a) Fully aligned with the methodology outlined in the International Organisation for Standardisation's ISO 22301:2019 *Security and resilience - Business continuity management systems – Requirements* and in particular the supporting ISO 22313:2020 *Security and resilience – Business continuity management systems – Guidance on the use of* ISO 22301 standard.
b) Reflective of the British Standards Institute's PAS 2015:2010 *Framework for health services resilience* developed for the NHS

2 POLICY

2.1 Effective Emergency Preparedness and Business Continuity Management is the responsibility of all staff and every department. The Trust's approach is an holistic one which requires the involvement and engagement of all staff and stakeholders in the development of plans and supporting materials, in their testing and exercising and review to maintain a process of continuous improvement in line with the Procedure in Section 3 below.

As required by the *NHS Emergency Preparedness, Resilience and Response Framework 2022* the Trust is subject to the full set of civil protection duties and must:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Create business continuity plans to ensure that they can continue to exercise critical functions in the event of an emergency.
- Make information available to the public about civil protection matters, and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance coordination and efficiency.

The above will be achieved by maintaining compliance with NHS Core Standards for Emergency Preparedness, Resilience & Response. The Trust's compliance is monitored via an annual process of self-assessment against the standards. Organisational compliance with Core Standards is monitored by the Birmingham & Solihull Integrated Care Board (ICB), NHS England and the Local Health Resilience Partnership (LHRP). The Trust's Accountable Emergency Officer (AEO) will be required to participate in an annual check & challenge process following submission of our self-assessment document and supporting evidence.

NHS Core Standards for Emergency Preparedness, Resilience & Response requires that the Trust must carry out emergency planning testing/exercising for the purposes of validating plans, developing staff competencies and to test well-established procedures. The Trust must undertake the following as a minimum:

- Implement a live exercise every three years;
- Implement Command Post exercise every three years;
- Implement a tabletop exercise annually;
- Implement quarterly Incident Control Centre (ICC) tests; and
- Implement six monthly communication exercises

Local Directorate/Service Area Emergency Preparedness and Business Continuity Leads will work collaboratively with the EPRR Officer to prepare business continuity testing/exercising scenarios relevant to their service area and ensure the required resources are available to facilitate the annual programme of testing/exercising. The EPRR Officer will work with other local agencies and third sector providers to establish a schedule of testing/exercising in line with risks identified by local and community risk registers.

The Trust EPRR Officer must maintain an annual workplan which sets out the timetable for the above statutory requirements, ensuring the Trust remains compliant with its obligations under

the CCA and providing assurance to Trust Board that the Trust has sufficiently robust and resilient plans to maintain continuity of essential services and respond effectively in the event of an incident.

2.2 This policy is supported by a suite of plans and processes to anticipate, assess, mitigate and respond appropriately and proportionately to risks which have the ability to impact service delivery. The Trust has the following plans to support the business continuity management and emergency response:

- BSMHFT Incident Response Plan
- BSMHFT Adverse Weather Plan
- BSMHFT Fuel Disruption Plan
- Service/site specific Business Continuity plans (including evacuation & shelter plans where appropriate)
- BSMHFT Pandemic Flu Plan
- BSMHFT Initial Operational Response to Incidents Suspected to Involve Hazardous Substances or CBRN Materials
- BSMHFT Mass Countermeasure Distribution Plan
- Directorate Power/Communications/ICT Outage Plans
- ICT Business Continuity Plans (accessed via ICT On-Call)
- BSMHFT Incident Response Plan for Trustwide Staff Redeployment
- BSMHFT Emergency Communications Plan

These are subject to continuous review through a number of groups and committees including the Trust Board and via a process of consultation both internally and with external stakeholders. This process will be reported to and monitored by the Business Continuity and Emergency Preparedness Committee (BCEPC). Incident debrief reports and exercise reports will be reported to BCEPC including lessons identified and recommendations. BCEPC will be responsible for monitoring progress on completion of required actions, including those identified via the testing and exercising of revised plans following updates.

All business continuity and EPRR related documents can be found in the Major Incident and Business Continuity tab, accessed from the landing page of our intranet. The electronic versions stored on the Major Incident and Business Continuity section of Connect will be considered the definitive versions.

3 PROCEDURE

This Policy utilises a process of cyclical Business Continuity programme management (Appendix B) and associated stages directly derived from ISO 22301 and specifically the accompanying ISO 22313 Guidance.

Plan

- Establish the business continuity programme/strategy/system
- Develop a business continuity policy
- Create a business impact assessment
- Develop policy and procedures
- Establish a documentation system
- Plan

Do

- Undertake Business Impact Analysis (BIA)
- Implementation of plans
- Develop a communications plan
- Create an exercise programme

Check

- Schedule management reviews
- Undertake internal audits
- Exercise

Act

- Debrief
- Implement corrective actions
- Continuous improvement measures

Figure 1 below demonstrates that PDCA is cyclical and should be repeated at least annually to ensure compliance, currency and quality. Thus, business continuity plans and associated elements developed as a result of this policy will be living documents that will change and grow as incidents happen, exercises are held and risks are reassessed.

Figure1: *Business continuity programme elements*: PDCA (Source: ISO 22313)

The Policy will be operationalised through the activation and utilisation of the BSMHFT Incident Response Plan, local area Business Continuity Plans and other supporting plans and processes.

3.1 Framework

This section describes the broad framework for ensuring the Trust has effective arrangements in place to enable it to:

3.1.1 Identify the potential areas of risk to the Trust's services in order to develop plans which prevent or minimise disruption. The plans are produced by the Emergency Planning Team in consultation with relevant experts. They are reviewed by the Business Continuity & Emergency Preparedness Committee to ensure quality and completeness and tested on a regular basis.

3.1.2 React effectively to a Major Incident outside of the Trust, providing appropriate medical services and support to emergency response partners;

3.1.3 React effectively to a Critical Incident within/directly affecting the Trust so that it can continue to provide essential services as is reasonably practicable;

3.1.4 Minimise disruption when unplanned events have the potential to significantly interrupt normal business; and

3.1.5 Manage impacts on capacity when demand outstrips available capacity and normal contingency plans are insufficient.

3.1.6 React effectively to a situation where there is a significant loss of staff e.g., due to industrial action or pandemic

3.1.7 Respond to a Business Continuity Incident, alerting appropriate personnel, allocating resources and priorities for action to recover essential services and prepare for return to normal working as quickly as possible.

3.1.8 Support effective communication during an emergency or service interruption.

3.1.9 Ensure the Trust can continue to exercise its functions in the event of an emergency.

3.1.10 Ensure all departments are involved in the preparation of the plans, so that there is an effective and consistent response to emergencies and/ or Business Continuity Incidents.

3.1.11 Ensure that all plans are tested and updated in line with national requirements.

3.1.12 Ensure that all Risks relating to Business Continuity and Emergency Preparedness are captured on the Trust's Risk Register and are reviewed regularly and managed in line with the Trust's Risk Management Policy (see section 3.9 below)

3.2 The Trust's Emergency planning has 2 work streams which are identified as follows:

3.2.1 Major/Critical Incident Planning

3.2.2 Business Continuity Planning

3.3 The Trust's Business Continuity Plans are separate from the Trust's Incident Response Plan, under which the Trust would deliver its emergency response to a business continuity incident which cannot be managed within local plans, and critical or major incidents, such as a

road traffic accident, terrorist attack or chemical incident. Therefore, the Business Continuity Plans and Incident Response Plan can be implemented independently of each other. All plans can be found by navigating to the Business Continuity & Major Incident tab on Connect.

3.4 However, a business continuity incident may occur simultaneously to a critical or major incident or an event, or situation, in the wider environment which requires activation of the BSMHFT Incident Response Plan, and may also cause an interruption to the Trust's services or functions.

3.5 In such circumstances, the business continuity plans may need to be implemented in addition to, and independently, of the BSMHFT Incident Response Plan. However, a co-ordinated response to the critical/major incident and the business continuity incident will be required, to ensure there is an effectiveness of the decision-making process and to avoid duplication of effort.

3.6 The Accountable Emergency Officer (AEO), through the Business Continuity and Emergency Preparedness Committee (BCEPC), will oversee the work carried out under each work stream to ensure that the plans and procedures in each are coordinated, and that work programmes are adhered to.

3.7 Major/Critical Incident Planning

3.7.1 The AEO will ensure that the BSMHFT Incident Response Plan (IRP) is prepared by the Emergency Preparedness Resilience & Response Officer. The IRP will be reviewed annually as a minimum and also following any activation. All reviewed/updated plans will be subject to a process of internal and external consultation and submitted to the BCEPC for sign off.

3.8 Business Continuity Planning

3.8.1 The Trust has developed plans to deal with Business Continuity Issues that would affect multiple services of the Trust as set out in the Business Continuity plans, such as staff shortages, interruption to ICT services and power failures.

3.8.2 The AEO will ensure that the plans listed at Section 2.2 above are prepared and submitted to the BCEPC for approval, as part of the suite of emergency plans

3.9 Governance

3.9.1 Based on the above roles & responsibilities the EPRR day to day governance reporting structure is as follows:

3.9.2 Assurance- The minimum requirements that NHS-funded organisations must meet are set out in NHS Core Standards for Emergency Preparedness, Resilience & Response. These standards are in accordance with the CCA 2004, the 2005 Regulations the NHS Act 2006, the Health and Care Act 2022 and the Cabinet Office National Resilience Standards. Annually BSMHFT will provide evidence of their compliance to their board, at a public board meeting.

Internal Governance

This policy will be subject to annual review as a minimum, in line with the requirements of NHS Core Standards for Emergency Preparedness, Resilience & Response. This will include a period of both internal and external consultation. The BSMHFT Policy Development & Management Group monitor the review of all BSMHFT policies and once approved by PDMG, this policy will be presented to the relevant ratifying committee (Finance, Performance and Productivity Committee) and for final ratification and sign at Trust Board.

To ensure effective monitoring and emergency planning within BSMHFT, all BSMHFT plans & procedures are subject to internal scrutiny and sign off via the Trust's Business Continuity & Emergency Preparedness Committee (BCEPC). This group meets quarterly and has membership as set out in the Terms of Reference, which is reviewed annually to ensure that the appropriate persons are present.

3.9.3 to ensure appropriate scrutiny of documentation for sign off, this is to ensure that BSMHFT fulfils its duties as a Category 1 responder in line with the requirements set out in the Civil Contingencies Act 2004 and the following documents:

- NHS Emergency Planning Framework
- Command and Control Framework for the NHS during significant incidents and emergencies
- NHS Core Standards for Emergency Preparedness, Resilience & response
- Business Continuity Management Framework

3.9.4 All BSMHFTs EPRR reports are also shared to the Trust's Finance Performance & Productivity Committee (Sub-Board Committee) as well as the Trust Board as and when appropriate but annually as a minimum, as well as publicly outlining readiness and preparedness activities within the Trusts annual reports to include an overview on:

- Training and exercises undertaken by the organisation
- Summary of any business continuity, critical incidents and major incidents experienced by the organisation
- Lessons identified and learning undertaken from incidents and exercises
- The organisation's compliance position in relation to the latest NHS England EPRR assurance process
- Work programme

3.9.5 See appendix G for internal EPRR governance chart

3.9.6 BSMHFT has an annual EPRR work programme, maintained and actioned by the EPRRO. The EPRR work programme is based around the NHS Core Standards for Emergency Preparedness, Resilience & Response requirements with any additional operational work processes, identified risk/s and best practice reviews added in conjunction with AEO work allocations. The work programme schedule is reviewed as a minimum annually.

3.9.7 BSMHFTs emergency plan/s will be reviewed annually as a minimum by EPRRO/BCEPC and will be subject to a process of both internal and external consultation as part of the review process.

3.9.8 As part of BSMHFTs emergency preparedness and planning, the Trust will participate in exercises both locally and across the Birmingham & Solihull Local Resilience Forum (LRF) with partners.

3.9.9 As part of the continuous PDCA cycle described above, a log of all identified lessons including an action tracker will be maintained by the EPRRO and reported via BCEPC internally and also via HEPOG and the NHSE Lessons Identified process

Live incidents which require the plan/s to be invoked will conclude with a debrief process and lead to review/improvements of the plans. This will be led for the Trust by the EPRRO.

Duty to assess Risk - All EPRR risks are considered in line with BSMHFT's risk management strategy via a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks. All risks relating to Business Continuity and Emergency Preparedness are captured on the Trust's Risk Register and are reviewed regularly and managed in line with the Trust's Risk Management Policy (appendix F). All Business Continuity and Emergency Preparedness risks are reviewed at the BCEPC meeting quarterly and annually at the Risk Management Group meeting. Additionally, bi-monthly risk management reports are circulated at a number of committees across the trust to assure relevant groups, including the board, that the current risk management in place is effective.

The Trust has a number of EPRR related risks on the internal Risk Register, which is

benchmarked against the Trust's internal business continuity risks, the local Community Risk Register (CRR), Local Health Resilience Partnership Risk Register and the National Risk Register (NRR). The Trust's Risk Management Policy sets out the internal Risk Management process, including guidance for risk scoring, and sets out the risk appetite as determined by the board which determines the level of action taken in regard to Business Continuity and Emergency Preparedness risks. The Risk Management policy and risk appetite are reviewed and updated on an annual basis.

Additionally, BSMHFT consider the impact of short and long term risks, including those caused by climate change and has developed a Carbon Net Zero/Green Plan which sets out our approach to adaptation planning. BSMHFT has a large, varying estate with climate change adaptation part of a wider ICB infrastructure strategy with a focus on removing poor building stock to improve quality of services and future proof assets. The Trust is working towards a BREEAM excellent as minimum standard on all new buildings or significant changes to existing estate.

External Governance

3.9.10 **Local Resilience Forum -** The Local Resilience Forum (LRF) is a strategic level multi-agency partnership made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. All organisations within Local Resilience Forum have a responsibility to co-operate with each other, sharing relevant information.

3.9.11 **Local Resilience Forum** are supported by other organisations, such as the Highways Agency and public utility companies. The LRF work with other partners in the military and voluntary sectors who plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident within their local communities. Within the LRF NHS England, and the BSoL ICB represent all health bodies

3.9.12 **Local Health Resilience Partnership (LHRP) -** The Local Health Resilience Partnership is another strategic level forum, however for health colleagues only. This forum aims to bring together all health responders so that they can co-ordinate, plan and carry out specific joint work which is linked to the LRF. The forum ensures that member organisations develop and maintain effective health planning arrangements for incidents.

3.9.13 The core membership of the LHRP includes all 7 Local Authority Directors of Public Health, UKHSA, NHS England EPRR Lead, Ambulance services EPRR leads, as well as the Accountable Emergency Officers for each NHS Provider Trust. DPG/ICB co-chair LHRP on a rotational basis. BSMHFT is represented by the COO/AEO, or the Executive Director of Quality and Safety/Chief Nurse or the Executive Director of Finance in the absence of the AEO. Only attendance by and Executive level director will count in terms of our compliance with the requirements of NHS Core Standards for Emergency Preparedness, Resilience & Response. Representatives for BSMHFT must be able to authorise plans and commit resources on behalf of the Trust, with support as required from the EPRRO.

3.9.14 **West Midlands & Warwickshire Health Emergency Planners Operational Group (HEPOG) – HEPOG** is a working group of the LHRP which is chaired jointly by the ICB EPRR Leads. Membership is from all local emergency planners across the Birmingham and Solihull, Coventry and Warwickshire and Black Country Integrated Care Systems within health. HEPOG co-ordinates locally identified risks and ensures effective tactical and operational planning/response arrangements across the local system.

3.10 Training

To support this policy, a training needs analysis will be conducted to identify and review the associated training required within the organisation. This will include, where required, awareness sessions for the Management Team, training for Directorate/Service Area Leads and other key individuals.

Existing training meets some of the business continuity and incident training requirements e.g. Fire Safety, Health & Safety, FFP3 training.

In addition to external mandatory training for all potential Incident Commanders (Principles of Health Command course) as indicated as part of the Trust's Incident Response Plan, the training schedule will include:

a. General EPRR/Business Continuity Awareness
b. Initial Operational Response training
c. On-call Standard Operating Procedure e-learning
d. On-call buddying system for new staff to Strategic and Tactical On call
e. On-call EPRR e-learning
f. Exercising/testing of plans
g. Any supplementary training where a need has been identified.

The EPRR Officer will ensure provision of training for relevant staff to enable them to carry out their duties and responsibilities relating to business continuity, critical and major incidents. A training record will be maintained by the EPRR Officer of all training completed/booked/outstanding and performance will be reported as part of the annual EPRR report to the Trust Board.

3.10.1 Personal Development Portfolios (PDP)

PDP's will be developed for all staff who have a role during an incident response. It is the responsibility of individual staff to complete and maintain their PDP. Completion Guidance for PDP's is included at Appendix I of this document.

3.10.2 Exercising/Testing

An exercise schedule will be maintained by:

a. The EPRR Officer for the BSMHFT Incident Response Plan.
b. Directorate/Service Area Leads for Directorate/Service Area Plans.

3.11 Retention Periods

EPRR related documentation needs to be preserved in accordance with the minimum retention periods, as set out in the table below:

Category	Examples	Minimum Retention Period	Final Action
Incidents (declared)	Decision logbook, on call logbook, incident related documents including plans and organisational structures. Paper and electronic records.	30 years.	Review, archive or destroy under confidential conditions.
Exercise	Paper and electronic records.	10 years.	Review, archive or destroy under confidential conditions.
On Call (routine – non-major incident)	Decision log, on call log, handover records. Paper and electronic records.	10 years	Review, archive or destroy under confidential conditions.
EPRR	Incident response plans, guidance, standard operating procedures, NHS core standards for assurance. Electronic records.	30 years	Review, archive or destroy under confidential conditions.
EPRR	Information sharing protocols, memorandums of understanding, service level agreements. Paper and electronic records.	10 years	Review, archive or destroy under confidential conditions.
EPRR	BCEPC minutes, papers, action logs. Risk registers. Electronic records.	30 years	Review, archive or destroy under confidential conditions.

3.12 Information Sharing

Under the CCA 2004, local responders have a duty to share information and this is seen as a crucial element of civil protection work underpinning all forms of co-operation. BSMHFT under the CCA 2004 and 2005 regulations for responders has a duty to share information with partner organisations in an emergency. Data sharing guidance 2019 is available on the Civil Contingencies Secretariat page of Resilience Direct in an emergency. This is a crucial element of civil protection work and underpins all form of co-operation. However, the Data Protection Act 2018, GDPR 2018 and the Common Law duty of confidence must be complied with at all times.

It is important to remember a consenting party is not always a necessary pre-condition to lawful data sharing. BSMHFT conforms with its information policy and procedures in line with its data protection responsibilities. Any information to be shared will be as far as reasonably practical, be pre agreed and cleared by the Caldicott Guardian and / or Senior Information Risk Owner (SIRO) or their deputies, including advice and guidance from the Data Protection Officer. In any case information sharing will adhere to the principles of having suitable protections put in place (passwords, encryption etc) any sharing of information should be limited to what needs to be shared only.

4 RESPONSIBILITIES

Post(s)	Responsibilities
All Staff	All staff must make themselves familiar with and comply with all relevant policies and procedures related to emergency preparedness and business continuity. Employees must make themselves aware of relevant emergency procedures e.g. evacuation and fire precaution procedures appertaining to their particular role/work location.
Service Directors, Clinical Directors and Corporate Directors	Responsible for overseeing a programme of emergency preparedness and business continuity management activities for their particular portfolio within the Trust in accordance with this Policy. This includes identifying designated Risk Management and Business Continuity Leads within their areas to whom they will delegate, ensuring the development of directorate/department/service business continuity plans (BCPs) business impact analyses (BIAs) and business disruption risk register, ensuring consideration is given to the Equality Act 2010 as part of the process. A nominated Non-Executive Director (NED) will have business continuity and emergency planning identified as one of the key objectives within their portfolio. Service Directors, Clinical Directors and Corporate Directors will monitor and review risks on the risk register relating to their portfolio, escalating any areas of concern to the BCEPC
Strategic On-call Manager/Incident Director	The Strategic On-call Manager for the Trust will be the first port of call in an emergency that is initiated outside of normal office hours and will be expected to initiate and lead the Trust's response and act as Incident Director. Guidance for on call staff is contained in the On-call Standard Operating Procedure (SOP), as well as the NHSE Midlands Alerting Process both of which can be found under the Business Continuity and Major Incident tab via the front page of the intranet. All staff who undertake duties as part of the In addition to the completion of internal training for On-Call Managers, it is mandatory for any member of staff who undertakes duties as part of the Strategic On-call Manager rota to complete the Principles of Health Command Training programme delivered by NHSE in line with the National Occupational Standards for the role. All staff who undertake duties as part of the Startegic On-Call rota must also complete and maintain a Personal Development Portfolio (PDP) in line with the National Occupational Standards. Template PDP's and completion guidance can be found under the Business Continuity and Major Incident tab via the front page of the intranet. Should the need to declare a Major Incident arise, the Strategic On-call Manager (or in-hours designate) will activate the BSMHFT Incident Response Plan (as per on call SOP and NHSE Alerting Guidance) and instruct the Switchboard to call in

	the personnel required to staff the Incident Coordination Centre (ICC). At any time the Strategic On-Call Manager may defer their responsibility as Incident Director to another Director.
Tactical On-Call Manager	The Tactical On Call Manager is responsible for providing assessment of any reported incident, providing advise and guidance to the notifying member of staff on how to manage the incident and mitigate service disruption. They must ensure that they have escalated the incident as appropriate and in line with the BSMHFT Escalation Guidance. They must act as dictated by the emerging situation. Guidance for on call staff is contained in the On-call Standard Operating Procedure (SOP), as well as the NHSE Midlands Alerting Process both of which can be found under the Business Continuity and Major Incident tab via the front page of the intranet. All staff who undertake duties as part of the Tactical On-Call rota must complete and maintain a Personal Development Portfolio (PDP) in line with the National Occupational Standards. Template PDP's and completion guidance can be found under the Business Continuity and Major Incident tab via the front page of the intranet. At any time the Tactical On-Call manager may defer their responsibility to another appropriate tactical manager.
Directorate/Service Area Risk and Business Continuity Management Leads	As part of the Trust's Emergency Preparedness and Business Continuity Policy, directorate/service area leads are responsible on behalf of their Director for ensuring that all services within their portfolio: • Develop and maintain business continuity plans at directorate level; • Identify critical services and resources across their directorate by means of business impact analysis; • Validate through regular training, testing and exercises directorate/service Area business continuity plans and procedures, including those for out of hours emergencies; Review and update Directorate/Service Area plans regularly in light of lessons identified from exercises or incidents, research or changes in staff/service description.
All Managers including Heads of Department	Each manager/head of Department is operationally responsible for ensuring compliance with this policy within their area of responsibility. This includes promoting awareness of the Trust's Emergency Preparedness and Business Continuity Policy, Corporate and Directorate/Service Area Business Continuity Plans and procedures as appropriate within their own teams.
Policy Lead EPRR Officer	The Emergency Preparedness, Resilience & Response Officer (EPRRO) is responsible for overseeing the day-to-day implementation of emergency planning and business continuity arrangements within the Trust, on behalf of the Accountable Emergency Officer (AEO). This includes leading on Emergency

	Preparedness & Business Continuity issues and reporting into the Trust wide governance structure. The EPRRO represents the Trust as a member of the West Midlands and Warwickshire Health Emergency Preparedness Officers Group (HEPOG). The EPRR Officer is responsible for the regular review of the risk register in relation to EPRR related risks and to highlight any changes to BCEPC for discussion and review. The EPRRO is responsible for the planning and monitoring of training and exercising in line with the requirements of NHS Core Standards for EPRR.
Executive Director	**Accountable Emergency Officer** The Accountable Emergency Officer (AEO) is the Executive Director responsible for the Trust's emergency preparedness, resilience and response (EPRR) functions in line with the requirements of the Civil Contingencies Act 2004, the Health and Social Care Act 2012 and NHS Core Standards for Emergency Preparedness, Resilience & Response. As such, the AEO represents the Trust as a member of the West Midlands Conurbation Local Health Resilience Partnership (LHRP). The AEO is the Executive Director of Operations and this role is delegated to the Executive Director of Quality and Safety/Chief Nurse or the Executive Director of Finance in the absence of the AEO. The AEO is accountable for ensuring that effective systems of risk management and business continuity are in place, including an annual work programme which is informed by a suite of internal and external sources including the West Midlands Conurbation Community Risk Register and which includes ongoing Trust wide training and exercising. The AEO is supported by the EPRR Officer. The AEO/Deputy COO on their behalf chairs the Business Continuity & Emergency Preparedness Committee.
Business Continuity and Emergency Preparedness Committee (BCEPC)	The Business Continuity and Emergency Preparedness Committee will act as the Trust's business disruption risk management steering group, tasked with establishing and maintaining robust risk management, emergency preparedness and business continuity systems within the Trust. Chaired by the AEO or Deputy COO on their behalf, membership of the Committee is drawn from the Risk & Business Continuity Leads from across the Trust. The Business Continuity and Emergency Preparedness Committee reports into the Trustwide Governance structure (see Appendix G of this policy). The BCEPC will review risks relating to EPRR and BC on a quarterly basis and scope for any new emerging risks.

Trust Board	The Board's main role is to set the strategic direction of the Trust and to monitor performance over the year. It is the ultimate decision-making body in the Trust, accountable for overall performance and ensures that statutory, financial and legal responsibilities are met. These responsibilities fall both to executive and non-executive directors. The Board acts as the guardian of public interest and is responsible for reviewing the effectiveness of internal controls – financial, organisational and clinical. The Board is required to satisfy itself that the management of the Trust is doing its "reasonable best" to manage the Trust's affairs efficiently and effectively through the implementation of internal controls to manage the risks to the delivery of the Trust's essential services. The Trust Board will be assured through receipt of an annual EPRR report.

5 DEVELOPMENT AND CONSULTATION PROCESS

This policy will be developed as part of a cyclical process of review, as described in Section 3 above. The EPRR Officer is responsible for maintaining a tracker of comments and recommendations that are received as part of the consultation process, including details of accepted/rejected actions and the outcome of consultations will be reported to BCEPC.

5.1 Consultation Summary

As part of the annual review process this policy will be subject to a process of both internal and external consultation in accordance with the Trust Policy Development and Management Policy (appendix H) and the requirements of NHS Core Standards for Emergency Preparedness, Resilience & Response. This process will be led by the EPRR Officer on behalf of the Accountable Emergency Officer (AEO).

Consultation summary		
Date policy issued for consultation		17/03/25
Number of versions produced for consultation		1
Committees or meetings where this policy was formally discussed		
Business Continuity & Emergency Preparedness Committee		12/03/25
Policy Development Management Committee		11/06/25
Clinical Governance Committee		01/07/25
Where else presented	**Summary of feedback**	**Actions / Response**
BSoL ICB	See consultation log	
NHSE Midlands Regional Team	See consultation log	
BSMHFT Audit Committee	Recommend to Board	List of key changes required
BSMHFT Public Board		

5.2 Version Control

VERSION NUMBER	TITLE	SUMMARY OF CHANGES	IN FORCE FROM
2	BUSINESS CONTINUITY MANAGEMENT POLICY		OCTOBER 2017
3	BUSINESS CONTINUITY MANAGEMENT POLICY		JULY 2021
4	BUSINESS CONTINUITY MANAGEMENT POLICY		NOVEMBER 2022
5	EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY MANAGEMENT POLICY	ANNUAL REVIEW – INCORPORATING CHANGES AS PART OF CORE STANDARDS 2022 RECOMMENDATIONS	OCTOBER 2023

5.1	EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY MANAGEMENT POLICY	UPDATED TO REFLECT RECOMMENDATIONS FROM INTERNAL AUDIT/ CONSULTATION PROCESS/PDMG	OCTOBER 2023
5.2	EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY MANAGEMENT POLICY	UPDATED TO REFLECT RECOMMENDATIONS FROM CORE STANDARDS 2023	July 2024
5.3	EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY MANAGEMENT POLICY	UPDATED TO REFLECT RECOMMENDATIONS FROM CORE STANDARDS 2024 AND CONSULTATION FEEDBACK	TBC

6 REFERENCE DOCUMENTS

- The Civil Contingencies Act (2004). Available at Civil Contingencies Act 2004 (legislation.gov.uk)
- International Organization for Standardization ISO 22301 and ISO 22313
- British Standards Institute Framework for Health Services Resilience PAS 2015:2010
- Business Continuity Institute - Business Continuity Management: Good Practice Guidelines (2018) available via

  https://www.thebci.org/product/good-practice-guidelines-2018-edition---download.html
- Health and Care Act 2022. Available at Health and Care Act 2022 (legislation.gov.uk)
- HM Government (2006), Emergency Preparedness: Guidance on Part 1 of the Civil Contingencies Act 2004 (revised March 2012). Emergency preparedness - GOV.UK (www.gov.uk)
- NHS Emergency Preparedness, Resilience & Response Framework 2022: https://www.england.nhs.uk/ourwork/eprr/
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8 GLOSSARY

BCP	Business Continuity Plan – a plan written by service lead which outlines alternative arrangements which could be put in place to maintain critical activities within that Directorate or service area in the event of disruption to or loss of a critical service.
BIA	Business Impact Analysis – this identifies the key services within the organisation and assesses how long the Trust can manage without these services as well as the resources that are required for each service to run effectively. Typical examples of resources that are required are people, premises, technology, information and suppliers and partners.
BCM	Business Continuity Management – Holistic management process.
CCA	Civil Contingencies Act 2004.
Critical Service	A critical service is one whose loss or disruption would cause serious interruption to care delivery, risks to the health and safety of patients, public or staff, an effect upon service capacity, reputational damage, financial damage or contravening a legal or statutory obligation.
Disaster Recovery	Disaster recovery is planning is a subset of business continuity planning which includes planning for resumption of applications, data, hardware, communications (such as networking) and other IT infrastructure – Disaster Recovery is usually an ICT responsibility.
EPRR	Emergency Preparedness, Resilience & Response
ISO 22301	International standard for business continuity management system.
Plan Owner	Who has overall responsibility for a particular Plan.
Risk management	Is the process of identifying, classifying and mitigating the risks to the organisation which may cause a business continuity incident.
RTO	Recovery Time Objective – timescale in which service must be resumed to ensure level of provision in line with criticality of service.
Service loss or disruption	A service disruption is defined as any incident which threatens personnel, buildings or the operational procedures of an organisation and which requires special measures to be taken to restore to normal functions.

9 AUDIT AND ASSURANCE

This policy statement contains largely static information, however its content will be reviewed annually as a minimum, by the Trust's Business Continuity and Emergency Preparedness Committee and will include a process of external consultation. The Business Continuity and Emergency Preparedness Committee will also monitor progress on policy implementation and report regularly to the Finance, Performance & Productivity Committee and Trust Board.

The business continuity plans developed as a result of this policy will contain more volatile information. Associated plans will be living documents that will change and grow as incidents happen, exercises are held and risks are re-assessed. As a minimum, all associated plans will be reviewed and updated on an annual basis. Compliance with this requirement will be monitored by the Business Continuity and Emergency Preparedness Committee quarterly and reported via the EPRR Annual and Interim Report to FPP/Board.

Incidents reported via the Eclipse incident reporting system will be monitored by the EPRR Officer and any incidents related to EPRR will be reported to the BCEPC quarterly.

The Internal/External audit contract is managed by the Finance Department and reports to the Audit Committee. EPRR is included in the planned cycle of audits which is reviewed annually. The current recommended audit cycle is between 3 – 5 years. Internal auditors review the organisational framework of governance, risk management and control with the Head of Internal Audit's annual opinion designed to assist the Accountable Officer and the Board in making the Annual Governance Statement on Internal Control.

The findings from these are presented as individual reports, including finding and recommendations. Recommendations/action are tracked, monitored and fed back at each meeting of the committee.

Monitoring of Implementation	Monitoring Lead	Reported to	Monitoring Process	Frequency	Assurance
Site/service specific BCP's are reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Trust Board	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	70% of plans are reviewed/updated with performance reported to Trust Board
Incident specific response plans are reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Trust Board	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	70% of plans are reviewed/updated with performance reported to Trust Board

Trust Incident Response Plan is reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC), Policy Development Management Committee Clinical Governance Committee	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	Evidence that plan has been reviewed/updated as per minimum standard
Plans are exercised in line with requirements of NHS Core Standards/EPRR Framework	Emergency Preparedness Resilience & Response Officer & Local Business Continuity Leads	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Board	National NHS Core Standards self-assessment audit reports	BCEPC takes place quarterly and performanc e reported to Board annually	Training records Post exercise debrief reports
EPRR Annual/Interim Report to Board	Emergency Preparedness Resilience & Response Officer	Finance, Planning and Performance Committee Public Board	Annual/Interim EPRR report containing summary of the above and additional context.	Bi-annual	Report is presented bi-annually as a minimum
NHS Core Standards for EPRR Self-Assessment submission & subsequent Confirm & Challenge Process	Emergency Preparedness Resilience & Response Officer/Accountable Emergency Officer	Birmingham & Solihull Integrated Care Board and NHS England Midlands	NHS Core Standards Action Plan	Annually	Recommendations actioned as appropriate and annual position of compliance is improved/maintained

10 APPENDICES

Appendix A – Equality Analysis Screening Form

Equality Analysis Screening Form

Title of Proposal	**Emergency Preparedness and Business Continuity Management Policy**		
Person Completing this proposal	Louise Flanagan	**Role or title**	EPRR Officer
Division	Corporate Governance Team	**Service Area**	Trustwide
Date Started	01/02/25	**Date completed**	06/03/25
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
The purpose of this policy is to be compliant with statutory requirements of an NHS funded organisation under the civil contingencies Act 2004 and the EPPR framework as required of all NHS funded providers and to have in place appropriate and effective policies and plans to manage a major, critical or business continuity incident or event, so as to minimise impact on service provision, safety and improve the sustainability of the Trust.			
Who will benefit from the proposal?			
This policy serves to benefit all staff, service users, carers and the local healthcare system and wider community by ensuring the Trust are prepared for, able to respond to and recover from a range of emergency or business continuity events or incidents.			
Do the proposals affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
This Policy seeks to positively impact service users, employees and the wider community by providing assurance that we have in place processes and plans to mitigate negative impacts from a potential major, critical, or business continuity incident and to support the Trust in a return to business as usual as quickly as possible following an incident with minimal disruption to service provision and risk to staff, service users and the wider community.			

Do the proposals significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***
The policy serves to positively affect service delivery by providing a framework for staff to follow in order to mitigate the effects of the impact on service provision and safety for staff, service users and the wider community
Does it involve a significant commitment of resources? ***How will these reduce inequality?***
No significant day to day commitment to resources required, however the activation of associated plans and any required resource will be determined by the nature of the incident
Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)
No

Impacts on different Personal Protected Characteristics – *Helpful Questions:*	
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box and include relevant data.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	X			Policy applies to all employees, FTC, secondments, bank staff and placements, irrespective of age or level/grade within the organisation. Our staff are reasonably evenly spread between 26-40 ages range 10.56% to 12.48% and ages 41 to 60 groups ranging from 13.13% to 14.38%. Therefore, there is a reasonable balanced profile with no one age group negatively impacted.
Including children and people over 65				

Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			Disability positive impact. Currently have network to support staff with disabilities. WDES Data is showing **4.7%** colleagues across our Trust have long-term condition or illness. Currently we have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. Therefore, it is anticipated that disability will not have an positive impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their disability
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			It is anticipated that gender will have a positive impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. The Trust has now set up a Women's Network who will be meeting on a monthly basis
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			It is anticipated that marriage or civil partnership will have a positive impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership

People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			It is anticipated that pregnancy and maternity will have an positive impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. We also have started the Women's Network where these matters can be discussed and shared there.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			It is anticipated that Race or Ethnicity will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			The Trust will provide necessary support and reasonable adjustment for an employee and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have a negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			We currently have LGBTQ Staff Network who meet regularly where information is shared. It is anticipated that sexual orientation will not

				have a negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			It is anticipated that Transgender or Gender Reassignment will not have a negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	X			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010. This policy applies to **all**, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.
If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
NONE IDENTIFIED
How will any impact or planned actions be monitored and reviewed?
USING FORMAL DEBRIEF PROCESS
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix B: Business Continuity Programme Management Stages

Stage 1: Understanding your Business

A BCM strategy relies on clarity about the organisation's mission and defining the essential processes within that mission.

The organisation provides a comprehensive mental healthcare service for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond. We operate out of more than 30 sites and serve a culturally diverse population of 1.3 million spread out over 172 square miles and have an annual income of £301m, a dedicated workforce of almost 4,000 staff and a range of local and regional partnerships, making this one of the most complex and specialist mental health foundation trusts in the country.

Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

Trust Purpose, Vision and Values:

Our vision
Our vision for what we want to achieve in the future is simple: improving mental health wellbeing.

Our values
Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners.

Compassionate
- Supporting recovery for all and maintaining hope for the future.
- Being kind to ourselves and others.
- Showing empathy for others and appreciating vulnerability in each of us.

Inclusive
- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Valuing all voices so we all feel we belong.

Committed
- Striving to deliver the best work and keeping service users at the heart.
- Taking responsibility for our work and doing what we say we will.
- Courage to question to help us learn, improve and grow together.

Our priorities
Our priorities set out what we will do to deliver our vision and live our values. They support us to stay focussed on what is important to us and make sure we are using our resources to do the right things. We have four strategic priorities:

Clinical services
Transforming how we work to provide the best care in the right way in the right place at

the right time, with joined up care across health and social care.

People

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

Quality

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

Sustainability

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

Against this organisational context and as part of this stage, Directorate/Service Area Risk and Business Continuity Management Leads will be asked to identify the critical, essential and routine processes in their services, as well as to consider the resources which support and contribute to the normal operation of the organisation.

Consideration must also be given to any statutory obligations or legal requirements placed on the Trust.

The Trust has developed a prioritisation methodology to assist Directorate/Service Area Leads in defining critical, essential and routine processes. This forms part of a business continuity toolkit aimed at those Leads (see Appendix C attached).

Where appropriate, the Trust also needs to review existing contracts, develop service level agreements and/or memoranda of understanding which will help in monitoring the business continuity arrangements of relevant external service providers/contractors.

Business Impact Analysis (BIA)

Having identified critical, essential and routine processes, the impact upon the organisation's goals and targets if these were disrupted or lost will be determined through a Business Impact Analysis (BIA).

ISO 22313 defines a BIA as the “process of analysing operational functions and the effect that a disruption might have upon them”. The BIA will identify, quantify and qualify the impacts and their effects of a loss, interruption or disruption and will measure the impact of disruptions to its processes on the organisation. It will provide information that underpins later decisions about business continuity strategies.

The BIA process will:

a. Define the activity and its supporting processes;
b. Map the distinct stages of each activity and process;
c. Determine the impacts of a disruption;
d. Define the recovery time objectives (where ISO 22313 defines Recovery Time Objective (RTO) as the period of time following an incident within which a product or service must be resumed, activity must be resumed, or resources must be recovered);
e. Determine the minimum resources needed to meet those objectives.

Through the BIA the Trust will:

a. Obtain an understanding of its activities and processes, the priority of these and the timeframes for resumption following an interruption;
b. Quantify the maximum tolerable period of disruption (MTPD) for each process – the timeframe during which a recovery must become effective before an outage compromises the ability of the Trust to achieve its business objectives in light of contractual, regulatory and statutory requirements (ISO22313 defines the Maximum Tolerable Period of Disruption (MTPD) as the time it would take for adverse impacts, which might arise as a result of not providing a product/service or performing an activity, to become unacceptable. The Recovery Time Objective (RTO) has to be less than the maximum tolerable period of disruption)
c. Obtain the resource information from which an appropriate recovery strategy can be determined and recommended;
d. Quantify the resources required over time to maintain the key processes at an acceptable level and within the maximum tolerable period of disruption, information which will enable facilities, ICT and other supporting resources to develop their own continuity.

The Business Impact Analysis toolkit developed is included at Appendix C of this Policy.

Risk Assessment

The risk analysis methodology provided in the Emergency Preparedness guidance (published in support of the Civil Contingencies Act) and that being employed corporately by the Trust do not differ significantly. Therefore, to ensure delivery of a Trust-wide risk assessment element of this policy which can be successfully embedded within the Trust's broader risk monitoring and management it has been decided to follow a risk analysis methodology consistent with the preferred approach already in use across the Trust.

Details of the methodology to be used are included at Appendix C as part of the Business Continuity toolkit.

Each service area will ensure that the risks identified are included within the relevant risk register for the Trust using the methodology and information sources described above and at Appendix C of this document. Appropriate elements of that risk register will be translated to the Trust Incident Response Plan. If, as a consequence of the development of Directorate/Service Area Business Continuity Plans, additional risks are identified, these will be added to the Trust's corporate risk register and appropriate details will be included in the Trust Incident Response Plan.

In following this approach and in assessing the generic, operational risks faced by the Trust the following sources of information will be referred to:

- Existing Trust Risk Registers;
- The Community Risk Register for the West Midlands Conurbation (drawn up by the Local Resilience Forum);
- The Incident History for the Birmingham and Solihull Mental Health NHS Foundation Trust ;

- The Incident History for the West Midlands Conurbation Local Health Resilience Partnership;
- Regional Incident History.

Based on the outcomes of the risk assessment, the Trust's EPRR Officer will explore the options that exist to minimise the level of risk faced by the organisation. Strategies will be devised for all risks identified from very high to low scores, based on the following framework:

***Mitigation*:** identifying strategies, activities, modifications or controls aimed at reducing the risk
***Acceptance*:** ensuring the risk is owned at the appropriate level (normally director level) within the organisation.
***Transferring*:** changing the process, ceasing the practice, outsourcing the service or transferring the risk (if financial by means of insurance)
***Eliminating*:** if possible, removing the cause, avoiding the risk or introduce preventative measures
***Recovery*:** developing and testing recovery plans to deal with any threats and hazards identified. For significant risks (rated High or Extreme) this will involve developing specific contingency plans, if appropriate, as part of the corporate business continuity plan. Other risks (rated Medium or Low) will be managed at directorate level as part of the directorate business continuity plan.

Stage 2: Selecting Business Continuity Options

The following paragraphs contain details of the key issues affecting service resilience which will be addressed as part of the BCM strategy for the Trust.

Key Staff: Addressing 'Key Person Syndrome'

To improve the resilience of services and supporting resources it is important that steps are taken to cope with the absence of key staff. Measures will include documenting key tasks, roles and responsibilities; capturing contact names and numbers and producing standard operating procedures.

Key individuals will be encouraged to take personal responsibility for nominating and training a deputy. This requirement will be reflected in an employee's annual objectives and will be subject to appraisal.

Suppliers

The Trust relies upon the products and services of other organisations to be able to deliver key aspects of its services. Suppliers include "outsourcers" and intermediaries who deliver services on the organisation's behalf. These suppliers or partners may be commercial, public or voluntary organisations.

NHS Trusts and NHS Foundation Trusts must be able to demonstrate a robust internal system for the management of risk to the delivery of their services. They must demonstrate active compliance with any risk or quality regime introduced by the Care Quality Commission. The Trust is a member of the Birmingham and Solihull (BSoL) Procurement Collaborative and as such all contracts are subject to provision of suitable business continuity plans as set out in

Section 6 of the NHS Terms and Conditions for the Provision of Services Contract (appendix J). This process ensures that there is a standard approach to service level agreements (SLAs) and contracts for external contractors and suppliers, with the inclusion of details on quality standards. External suppliers will be required to have in place appropriate and proportionate risk management and business continuity management policies and procedures. An integral part of the Trust contract monitoring process will be to ensure that appropriate documentation is in place to provide reassurance to the Trust in contracting with others.

What makes a Supplier key?

If the product or service supplied is unique and essential to the organisation's service capability or if there is a long term "outsource" agreement that makes it difficult to make alternative sourcing arrangements, then the supplier will be judged as key and a provider of a critical service.

Protecting against Supplier Failure

It is important to maintain close contact with suppliers and partner agencies and to understand what business continuity arrangements they have in place.
Simply asking if they have a plan is insufficient as the plan may be out of date or untested.

The following is a list of questions which will be asked of key suppliers:

- Have you identified the processes you need to ensure delivery of the products / services we need for our critical processes?
- Have you identified the resources that support these processes?
- Have you developed Business Continuity Plans to maintain the processes if you have a disruption?
- Have you exercised these plans?
- What lessons have you learnt from the exercises?
- What steps have you taken to integrate the lessons learnt into your Business Continuity Plans?
- What other customers do you have for the key products/services you supply and what assurances can you give that we will receive preference of supply at the time of disruption?

Answers to these questions should be supported by evidence from the supplier. This process is managed by the BSoL Procurement Collaborative and monitored as part of the annual assurance process.

Procurement and purchasing departments have essential roles to play in encouraging key suppliers to develop Business Continuity Plans. New contracts will, where relevant, contain appropriate business continuity clauses. When existing contracts are due for renewal the opportunity will be taken to discuss the need to include business continuity arrangements. Where appropriate performance measures will be added, or reference made to the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and the ISO BCM Standard.

The Trust's EPRRO will work with Directorate Risk and Business Continuity Management Leads and other Trust personnel to facilitate appropriate and proportionate enhancements in the resilience

of supply chains

Critical, Essential and Routine Processes

A separate exercise, modelled on the BCM requirements placed upon the Trust in the NHS Core Standards for Emergency Preparedness, Resilience & Response needs to be undertaken to determine appropriate criteria to be applied to suppliers and contractors to provide assurance to the Trust that business continuity arrangements which are proportionate are in place with suppliers and contractors. The extent to which the Trust applies these criteria and the need for any additional criteria, including variations, will be based upon:

- Criticality of the service
- The level of risk that has been determined
- The extent to which the service type and/or its contractor/supplier is unique and specialist in nature.

An internal assessment will take place to see if they meet the requirements (e.g. can they recover within required timeframes) and if the risks identified are acceptable levels.

If requirements are not met, then a review with the supplier and appropriate internal/external risk assessments would take place to review whether the service can still be provided by that supplier and deemed 'acceptable risks', or if another provider/supplier needs to be sought due to the risks outweighing the service they can provide.

The Trust has developed a prioritisation methodology to assist Directorate/Service Area Leads in defining processes as critical, essential or routine. This forms part of the Business Continuity Toolkit aimed at those Leads and is also at Appendix 3 and 4 of the Trust's Incident Response Plan.

Resources

In addition to critical, essential and routine processes it is important to consider the supporting resources which contribute to the normal operation of the organisation.

In informing the Trust's plans the following resources will be considered. These will be considered during the risk analysis and in the reduction steps taken and form part of the business continuity toolkit provided to Directorates/Service Area Leads.

- **Utilities:** coal, oil, gas, electricity, water, steam, sewerage, medical gases, compressed air.
- **ICT**: IT and telecommunications including third party suppliers, network and internet service providers
- **Logistics:** including third party suppliers.
  - In: supplies, transport.
  - Out: transport, waste.
- **Finance:** payroll, contracts.
- **Workforce:** skills, numbers, communications and resource mobilisation, standard operating procedures.
- **Premises:** buildings and infrastructure. Considerations to include new build (secure by design); old build (design constraints and risks);

alternative premises for use by single department or concurrent use by multiple departments (larger premises required).

The following, which support the smooth running of the Trust's business may also be considered under the 'resources' heading:

- Facilities Management
- Reception
- Security
- Car Parking

Alternative Premises

In the event that Trust premises are unavailable or inaccessible for an extended period alternative accommodation will be sought to house all essential processes. As part of the data gathering exercise Directorate/Service Area Leads will be asked to identify essential processes in their departments. In completing their Business Continuity Plans they will be asked to define a minimum office amenities requirement (desks, phones, PCs, etc.) necessary for them to maintain a process.

These requirements will be collated and with the support of the Trust's Estates Manager (SSL), and alternative accommodation sought from within the Trust's estate.

Following the formal declaration of an incident, should additional accommodation be required the Trust will request support from partner agencies including Integrated Care Boards (ICBs), the NHS England Midlands Regional Team, adjacent Mental Health Trusts and Acute Trusts, West Midlands Ambulance Service, Birmingham City Council and Solihull Metropolitan Borough Council via the mutual aid process detailed below.

Mutual Aid

Some Incidents may require organisations to request mutual aid from other organisations, this can include NHS funded providers of care and other organisations i.e. Police, Fire, or Civil Service.
Mutual Aid can be requested in two specific ways:

1. Request to the ICB for mutual aid support - this will be when we have exhausted our internal business continuity arrangements, declared a critical or major incident and can no longer safely provide critical services or activities. The request must explicitly detail the mutual aid requirements, why we are making the request and how long it will be likely to be required. There should also be an indication of how this will be funded (ie. if ICB support for funding is required).

   If the nature of the incident and request still meets the threshold for a Level 2 incident under the EPRR Framework and can be authorised and handled by the ICB. The Mutual Aid Request template contained within the BSMHFT Incident Response Plan must be completed and forwarded to the ICB Strategic Commander (2nd on call).

2. Request for support outside of the ICB area, this will meet the threshold for a Level 3-4 Incident under the EPRR Framework and therefore will require NHS England Midlands or National support, again the mutual aid request template is to be completed and submitted to the relevant NHS England team with appropriate sign off from the ICB Strategic Commander.

   In addition, there is a Birmingham and Solihull and Black Country Mutual Aid Agreement which can be enacted to support the deployment and distribution of mutual aid within the ICB response.

The process for requesting mutual aid is detailed in the BSMHFT Incident Response Plan at sections 5.6, 7.7 and 7.8.

Military Aid to Civil Authorities (MACA)

In addition to mutual aid arrangements, the military may be able to augment a system response where capacity is exceeded or there is a lack of specific capability.

Military assistance will only be provided if:

- There is a definite need to act and tasks to be completed are clear
- All other options are discounted, considered insufficient or unsuitable
- Required capability to complete the task is lacking and it is unreasonable or prohibitively expensive to develop
- The need to act is urgent and the NHS lacks readily available resources.

Requests for assistance will be made through NHSE Midlands Region On-Call using the request form.

Requests for MACA will attract media attention. The Ministry of Defence along with Department of Health will determine messages and will cascade these via Regional NHSE teams to ICB responders.

This approach takes account of NHS England's suite of Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Management (BCM) guidance, the statutory responsibilities of NHS organizations as category 1 and category 2 responders (as described in

the Civil Contingencies Act 2004) and the make-up of the locality.

Stage 3: Developing and Implementing a Business Continuity & Emergency Response

In addition to a broad policy statement it is important to have in place suitable business continuity and emergency plans. These will be operational plans containing the arrangements required to address generic and specific threats faced by the Trust. To supplement the BSMHFT Incident Response Plan, each Directorate/Service Area has developed its own business continuity plans.

The production of Directorate/Service Area plans will ensure that key stakeholders take responsibility for owning the BCM process and developing the arrangements required to respond to and recovery from an incident.

These business continuity plans build on pre-existing documents and good practice. The Birmingham and Solihull Mental Health NHS Foundation Trust already has a range of supporting policies, plans and documentation in place to deal with a variety of incidents and emergency situations. A full list of these documents is available in the BSMHFT Incident Response Plan and on the dedicated Business Continuity section of Connect.

Business Continuity Plans for each Directorate/Service Area will be completed, reviewed and approved by the relevant Directorate/Service Area Lead.

Stage 4: Exercising and Testing

The Trust will undertake a planned series of exercising and testing to ensure the Trust is able to respond efficiently and effectively, using a variety of processes such as tabletop and live play exercises. In accordance with the NHS EPRR Framework, all NHS funded organisations are required to undertake the following as a minimum:

- a live exercise every three years;
- a tabletop exercise annually;
- quarterly Incident Control Centre (ICC) tests; and
- six monthly communication exercises

The Trust has a series of Business Continuity Plans and an annual programme of testing will be undertaken by Directorate Business Continuity Leads with the support of the EPRR Officer:

- BSMHFT Incident Response Plan
- BSMHFT Adverse Weather Plan
- BSMHFT Fuel Disruption Plan
- Service/site specific Business Continuity plans (including evacuation & shelter plans where appropriate)
- BSMHFT Pandemic Flu Plan
- BSMHFT Initial Operational Response to Incidents Suspected to Involve Hazardous Substances or CBRN Materials
- BSMHFT Mass Countermeasure Distribution Plan
- Directorate Power/Communications/ICT Outage Plans
- ICT Business Continuity Plans (accessed via ICT On-Call)
- BSMHFT Incident Response Plan for Trustwide Staff Redeployment
- BSMHFT Emergency Communications Management Plan

The Trust will conduct incident or exercise debriefs and update plans and associated documentation based on lessons identified from both incidents and exercises. Debrief reports will be presented to the BCEPC who will be responsible for the monitoring of progress on identified actions and a summary included in the EPRR report to Trust Board. Risk registers will be reviewed and updated to allow for any change in circumstances and as new information becomes available.

As part of the ongoing business continuity cycle the Trust will re-evaluate its arrangements, identify the most vulnerable processes, improve resilience and thereby reduce the level of risk faced by the Trust.

As a minimum, business continuity plans will be reviewed annually, and also following any activation of a plan or major organisational change. The annual review will include a process of internal and external consultation. The EPRR Officer will maintain a consultation tracker and updates will be provided to BCEPC. This policy will also be reviewed following any exercise to take into account any lessons identified and recommended actions and following the NHS Core Standards for Emergency Preparedness, Resilience & Response self-assessment feedback process. EPRR is included in the Trust audit schedule and this policy, and all associated plans, procedures and guidance are reviewed by the Trust auditors and progress on recommendations included in their audit report will be reported via the BCEPC and also the Trust Audit Committee.

Incident reporting

Incident reporting is fundamental to the identification of risk and sound business continuity management and all staff are actively encouraged to use the Trust's existing incident reporting mechanism.

The Trust's Incident Reporting System (Eclipse) will act as the primary reporting mechanism for the reporting of all incidents, including those required by external assessment and enforcement agencies. EPRR related incidents will be monitored by the EPRR Officer and reported to BCEPC quarterly

Financial Implications

Financial implications may emerge as the policy is reviewed and updated and associated business continuity plans are developed. Any implications will be escalated through the Trustwide governance structures.

Audit & Assurance

This policy statement contains largely static information, however its content will be reviewed annually as a minimum, by the Trust's Business Continuity and Emergency Preparedness Committee and will include a process of external consultation. The Business Continuity and Emergency Preparedness Committee will also monitor progress on policy implementation and report regularly to the Finance, Performance & Productivity Committee and Trust Board.

The business continuity plans developed as a result of this policy will contain more volatile

information. Associated plans will be living documents that will change and grow as incidents happen, exercises are held and risks are re- assessed. As a minimum, all associated plans will be reviewed and updated on an annual basis. Compliance with this requirement will be monitored by the Business Continuity and Emergency Preparedness Committee.

Incidents reported via the Eclipse incident reporting system will be monitored by the EPRR Officer and any incidents related to EPRR will be reported to the BCEPC quarterly.

Monitoring of Implementation	Monitoring Lead	Reported to	Monitoring Process	Frequency	Assurance
Site/service specific BCP's are reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Trust Board	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	70% of plans are reviewed/updated with performance reported to Trust Board
Incident specific response plans are reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Trust Board	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	70% of plans are reviewed/updated with performance reported to Trust Board
Trust Incident Response Plan is reviewed and updated	Emergency Preparedness Resilience & Response Officer	Business Continuity & Emergency Preparedness Committee (BCEPC), Policy Development Management Committee Clinical Governance Committee	National NHS Core Standards self-assessment Audit reports	Annually as a minimum	Evidence that plan has been reviewed/updated as per minimum standard
Plans are exercised in line with requirements of NHS Core Standards/EPRR Framework	Emergency Preparedness Resilience & Response Officer & Local Business Continuity Leads	Business Continuity & Emergency Preparedness Committee (BCEPC) and included in EPRR Annual report to Board	National NHS Core Standards self-assessment audit reports	BCEPC takes place quarterly and performance reported to Board annually	Training records Post exercise debrief reports
EPRR Annual/Interim Report to Board	Emergency Preparedness Resilience & Response Officer	Finance, Planning and Performance Committee Public Board	Annual/Interim EPRR report containing summary of the above and additional context.	Bi-annually	Report is presented bi-annually as a minimum

NHS Core Standards for EPRR Self-Assessment submission & subsequent Confirm & Challenge Process	Emergency Preparedness Resilience & Response Officer/Accountable Emergency Officer	Birmingham & Solihull Integrated Care Board and NHS England Midlands	NHS Core Standards Action Plan	Annually	Recommendations actioned as appropriate and annual position of compliance is improved/maintained

Training

See Section 3.10 above

Appendix C: Business Continuity Management Toolkit

Templates for Business Impact Analysis and Business Disruption Risk Assessment are available on the dedicated section of Connect:
1. Business Continuity & Major Incident Plans (sharepoint.com)

Appendix D: West Midlands Conurbation Community Risk Register
The latest version can be accessed via the following hyperlink:
West Midlands Community Risk Register March 2024.pdf (west-midlands.police.uk)

Appendix E: Summerhill Services Limited (SSL) Business Continuity Plan
SSL Business Continuity Plan - Reviewed at March 2025.pdf

Appendix F: BSMHFT Risk Management Policy

Policies - Risk Management Policy.pdf - All Documents

Appendix G: Internal Governance Chart

Appendix H: Policy Development and Management Policy
Policies - Trust Policy Development and Management Policy.pdf - All Documents (sharepoint.com)

Appendix I: Personal Development Plan Development Guidance

Business Continuity and Major Incident Planning - Business Continuity and Major Incident Planning (sharepoint.com)

Appendix J: NHS Terms and Conditions for the Provision of Services

Z:\EPRR Documentation\PLANS PROCEDURES AND POLICIES\nhs-terms-and-conditions-for-the-provision-of-services-contract-version (6) (002).docx

Appendix K: BSMHFT Net Zero/Green Plan

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