

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST				
Board of Directors Public Meeting				
09.00, Wednesday 1 October 2025				
Uffculme Centre				
AGENDA				
Ref	Item	Purpose	Report type	Time
Staff 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 6 August 2025	Approval	Enc	09.35
5	Matters arising from meeting held on 6 August 2025	Assurance	Enc	
6	Chair's Report <i>Phil Gayle, Chair</i>	Assurance	Enc	09.40
7	Chief Executive and Director of Operations Report <i>Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations</i>	Assurance	Enc	09.45
8	Board Assurance Framework <i>David Tita, Associate Director of Corporate Governance</i>	Approval	Enc	10.00
9	Integrated Performance Report <i>Dave Tomlinson, Executive Director of Finance</i>	Assurance	Enc	10.05
Quality and Clinical Services				
10	Quality, Patient Experience and Safety Committee Report <i>Linda Cullen, Non-Executive Director</i>	Assurance	Enc	10.15
11	Quality and Safety Report <i>Lisa Stalley-Green, Chief Nurse</i>	Assurance	Enc	10.25
12	Assertive and Intensive Action Plan <i>Lisa Stalley-Green, Chief Nurse</i>	Approval	Enc	10.35
People				
13	People Committee Report <i>Sue Bedward, Non-Executive Director</i>	Assurance	Enc	10.45
Sustainability				
14	Finance, Performance and Productivity Committee Report <i>Bal Claire, Non-Executive Director</i>	Assurance	Enc	10.55
	• Delegation of Approval of Green Plan <i>Phil Gayle, Chair</i>	Decision	Verbal	
15	Finance Report <i>Dave Tomlinson, Executive Director of Finance</i>	Assurance	Enc	11.05
16	Audit Committee Report <i>Winston Weir, Non-Executive Director</i>	Assurance	Enc	11.15
Governance				
17	NHSE Provider Capability Assessment Update Report <i>David Tita, Associate Director of Corporate Governance</i>	Assurance	Enc	11.25
18	Risk Appetite Framework <i>David Tita, Associate Director of Corporate Governance</i>	Approval	Enc	11.35
19	Risk Management Policy <i>David Tita, Associate Director of Corporate Governance</i>	Approval	Enc	11.45
20	Audit Committee Terms of Reference <i>David Tita, Associate Director of Corporate Governance</i>	Approval	Enc	11.50
21	Board Effectiveness Annual Self-Assessment <i>David Tita, Associate Director of Corporate Governance</i>	Approval	Enc	11.55
Reflections				
22	Living the Trust Values <i>Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships</i>		Verbal	12.00
23	Board Assurance Framework reflections		Verbal	12.05
24	Any other business		Verbal	12.10
25	Questions from Governors and members of the public			

Close by 12.30

Date and Time of Next Meeting: Wednesday 3 December 2025, 09.00-12.30

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 6 August 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
	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	Shane Bray	SBr	Managing Director SSL (item 20 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Alex Copello	AC	Associate Director Research and Development (item 14 only)
	Emma Patterson	EP	Head of Research and Development (item 14 only)
	Emma Randle	ER	Freedom to Speak Up Guardian (item 17 only)
	Hari Shanmugaratnam	HS	Guardian of Safe Working Hours (item 16 only)
	David Tita	DTi	Associate Director of Corporate Governance
	Jenny Watson	JW	Deputy Director of Commissioning and Transformation (deputising for PN)
Observers	One governor and two members of staff/the public observed the meeting in person.		
Ref	Item		
1	Expert by Experience Talk A relative of a patient on Rosemary Ward attended to share the story of their mother who had moderate dementia, with a suspected underlying mental health condition. A number of concerns were set out regarding the quality of care received, and the involvement of relatives in care planning was raised as a significant and key issue. The Board heard about a specific incident regarding a lack of shared decision-making and the role of people with lasting power of attorney. The Board reflected on the need to appropriately involve families in decisions around care for their relatives to ensure better patient experience, care and outcomes. The Board thanked that expert by experience for attending Board and sharing their experience.		
2	Chair's Welcome and Introduction PG welcomed everyone to the meeting.		
3	Apologies for absence Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships		
4	Declarations of interest No new interests were declared.		
5	Minutes of meeting held on 4 June 2025		



	The minutes were approved as a true and accurate record.
6	Matters arising from meeting held on 4 June 2025 All actions were updated.
7	Chair's Report The Board received the report, and PG noted the following key points: - PG had recently visited Solar, where he had listened to staff ideas and suggested applying to the Caring Minds Charity for support. There were a number of initiatives to reduce waiting lists at the service. - PG had also visited Maple Leaf and spoke to staff about challenges and how many services were offered. - The Board noted that at all of the visits PG had made, staff wanted to highlight and celebrate the work they were doing.
8	CEO and Director of Operations Report The Board received the report for information. RFW and VD highlighted the following key points: - RFW thanked everyone who covered gaps during the recent industrial action. - RFW also thanked everyone involved in the safe transfer of Children and Young People's (CYP) services into the Trust. - The Trust continued to review the impact and implications of the NHS 10-Year Plan. - The CEO of NHS Providers had visited the 24/7 Neighbourhood centre. - New cluster arrangements for Integrated Care Boards were expected to be announced shortly. - There were key pieces of work for the leadership teams to work on in relation to CYP, focusing on pathways and integration, and governance and finance processes. - Assertive Outreach and Community Mental Health teams were working closely together to review patients. - Work had started on estate improvements at Reaside and Hillis Lodge. - VD highlighted the Winter Plan and the work that had been done on the submission. The Board was required to approve Assurance Statements in relation to the Winter Plan. SB commented that she had recently visited Ardenleigh and had been impressed by the artwork and how supportive staff were of the Culture of Care programme. WW commented on the national recognition of the 24/7 Neighbourhood Centre and if there were any plans for other areas of the Trust. RFW commented that the Trust would be considering how this could be rolled out further, considering national guidance. WW was pleased to read about the homeless service, and commented that he would like to know more about this and how the Trust was collaborating with other agencies. PG felt this was a positive report, recognising the challenges that remained.
9	Board Assurance Framework The Board received the BAF for information and assurance. DTi noted that the Board strategy session for August would focus on the BAF risks in depth. There was recognition that additional scrutiny on financial plans would affect some risk scores. The 10-Year Plan and the refreshed Trust strategy would also need to be incorporated in future iterations. BC and WW commented on the lack of high-scoring People risks on the Corporate Risk Register. WW also noted that the BAF and the Corporate Risk Register were consistent and reflective of each other, which was positive and supported triangulation. However, it was felt that cyber risks needed to be highlighted more and reflected as a key issue.

10	Integrated Performance Report The Board received the report for information. Key points were highlighted as follows: • The Integrated Performance Report would be reviewed to ensure it was reflective of the new National Oversight Framework. • The key concern around non-contracted beds remained and contributed to significant financial pressure. There had been some real improvements and progress made, and this sustained improvement would make significant reductions if the target was reached. • The Board noted that there were more substantive staff in post than there had ever been, and it was important to recognise the amount of recruitment that had taken place over the year. • DT advised that metrics on children and young people's services were being reviewed, particularly in relation to access. PG was encouraged by the improvements made in key People areas, particularly bank and agency spend, and turnover rates. LSG commented that there was room to improve, and person-centred care planning and Dialogue Plus would support further robust staffing levels. BC queried whether the deep dive into patient harm and increased assaults had taken place. LSG advised that all increases in assaults were subject to review, and noted they mostly related to acute wards and the early stages of patient admission. LC advised that psychological and physical harm was reviewed at June's Quality, Patient Experience and Safety Committee meeting; there were some improvements that could be made in post-incident reviews and sharing learning across the organisation. An update on this would be received in January.
11	Quality, Patient Experience and Safety Committee Report The Board received reports from meetings held in June and July. LC highlighted the following key points: • The Committee had undertaken a positive visit to Reaside to follow up on the Culture of Care programme. LC felt it was helpful and positive, and there was a tangible change to the energy and feel of the site. • The Committee had met and welcomed the Trust's new Chief Pharmacist. • The increase in formal complaints had been highlighted as an alert. • The incident on Larimar ward had been discussed and there was a focused discussion on investigation progress. • The Committee received the Freedom to Speak Up Guardian Report and the "More Voices" initiative. • LC confirmed that the Committee was planning to visit CYP sites. BC echoed the improvements at Reaside. BC asked about the increase in formal complaints and the reasons behind this. SB noted that some assurance had been given on increased management of the process, which included swifter triage of complaints. LSG noted that the Trust was implementing a pre-consultation meeting to discuss expectations, process and likely outcomes with service users and their families to mitigate any potential complaints. LSG noted that this had been utilised in Coventry and Warwickshire with positive results.
12	Quality and Safety Report The Board received reports from meetings held in June and July. LSG highlighted the following key points: • There had been some positive feedback around acute wards following recent CQC inspections, particularly George ward. • Larimar had been raised as an issue, with variation in completion of care plans and risk assessments. • There were noted improvements made through the Bronze, Silver, Gold escalation process. • LSG thanked colleagues who had initiated and completed the door alarm programme.



	WW asked how the Board was assured that nursing staff could improve bank use to support the financial plan. LSG described the significant amount of work that was underway to manage rotas and improve quality using the resources available. RFW commented on the increased support to service areas to ensure changes were sustainable.
13	Quality Account 2024/25 The Board of Directors formally received the Quality Account for assurance.
14	Research and Development Annual Report 2024/25 The Board received the annual report for information, noting the following key points: • The department had grown and developed partnerships to strengthen collaboration with the University of Birmingham. • Research and development had received £1m income in grants and trial activities. • The Trust had been a participant of grant awards worth a total of £16m. • The team had supported 100 different research teams across the organisation, particularly in relation to research governance. • The team had published 85 articles in international journals. • There had been a focus on demonstrating the impact that research and development had during the year, including research into addiction, mood disorders and perinatal that had local impact and informed national guidelines. • The team had also supported art psychotherapy initiatives, and nursing. • The transfer of children and young people's services would be reflected in next year's report. JW asked if there was alignment of research priorities with the Trust strategy. EP commented that the team worked to underpin and support the overall improvement of patient care. RFW noted that research and development supported the direction of travel of the organisation once it had been determined. There were additional opportunities available with CYP transferring into the Trust. AC noted that the team also needed to consider how the work of research and development was highlighted and disseminated across the organisation.
15	People Committee Report The Board received reports for meetings held in June and July. SB highlighted the following key points: • Stress, anxiety and depression remained a significant reason for sickness absence and the Committee held a focused session on the root cause for this at the June meeting. • The Committee had considered appraisal recording and the use of the ESR system. • The Committee was assured by the transfer of 530 CYP staff into the Trust, noting good feedback that had been received around the support available. • Significant progress on WRES/WDES and health inequalities work had been noted. There would be continued work to address racism and discrimination from members of the public. • The Committee had noted staff concerns and anxiety around job security in relation to financial challenges and the potential impact of this. • The Committee had also noted the increased workload relating to recruitment processes due to the use of AI bots. RFW asked whether there were any further deep dives planned into secure and offender health sickness absence rates, as this was the highest volume for 2024/25. SB confirmed that the Transforming our Future Workforce subgroup continued to review this and consider ward acuity.
16	Guardian of Safe Working Hours Quarterly Report and Annual Report 2024/25 The Board received the annual report for information. HS reported on the most recent reporting period, confirming that no immediate safety concerns were raised. There had been a steady increase year on year for flexible working requests. BC queried whether there was an

	age profile for these requests. HS confirmed that there was not currently any data available, but that this could be considered for the next report. LC also asked for consideration around whether career portfolios were being developed.
17	Freedom to Speak Up Guardian Quarterly Report The Board received the report for information and assurance. ER highlighted the following three key areas: • Changes to recording of relational conflict. • Changes to the National Guardians Office and the impact this would have on the Trust. • The implementation of a “More Voices” initiative to ensure more staff across the organisation were heard. RFW confirmed that there would be regular reporting on the new ways of working for BSMHFT. PG noted that attitudes and behaviours remained the key area, and the Board discussed whether there could be differentiation between disadvantageous and demeaning treatment in terms of how staff were treated, and detrimental effects in terms of patient safety. ER would consider this for future reporting. RFW commended Lucy Thomas, another Freedom to Speak Up Guardian for the Trust, who was learning sign language in order to engage with more members of staff. Members of the Board queried whether there could be a separation of data to make it clear those who do not have a protected characteristic, and those who do not declare. ER would consider this for future reporting. ER commented on the national changes and the rationale behind the decision, but advised that the current model would continue until further guidance was released.
18	Finance, Performance and Productivity Committee Report The Board received reports for meetings held in June and July. BC highlighted the following key points: • Challenges around the financial position remained. The Committee continued to review, monitor and scrutinise the plan to reach the year-end target. • The Committee had recognised the publication of the National Oversight Framework and the need for the Trust to realign plan in order to achieve its targets. • The Committee had endorsed the current draft of the Green Plan and discussed how this would influence the Trust strategy refresh. • Capital funding for the 24/7 Neighbourhood site was progressing. • There had been a discussion around the triangulation of digital, quality improvement and the strategy to ensure sustainable plans for the future. • The Committee continued to seek assurance on the three key challenges; Clinically Ready for Discharge, non-contracted beds, and bank spend, which were significantly impacting the Trust’s ability to achieve its year-end trajectory.
19	Finance Report The Board received the report for information, noting that the reported position was a deficit of £2.5m; although there was an improved position noted, this was mainly driven by non-recurrent benefits. Some real improvement had been reported on temporary staffing, non-contracted beds and income. RFW commented on the Trust’s current position according to the National Oversight Framework, which was resulting in an increased level of scrutiny.
20	SSL Business Review Report The Board received the report for assurance. SBr advised that the first quarter of the year had been very busy, with a number of capital programmes undertaken across the estate. This included Highcroft and the 24/7 Neighbourhood centre. SBr noted the impact of Children and Young People’s (CYP) services transferring to BSMHFT; it was confirmed that associated estate



	would transfer in April 2026 but that there was a service level agreement in place for SSL to manage the quality of the buildings. The CYP transfer had also impacted on pharmacy, with an increase in use of community pharmacy of 20-25%. A new pharmacy delivery service had also been implemented which offered a 24hr, timed delivery service. A new training and development programme was being introduced to identify individual and business needs. This included the implementation of Workpal, a performance development tool. SSL was committed to implementing pay awards for Agenda for Change staff and would commit to providing this across the SSL workforce. SSL continued to support the ICB and other partners within the region and was undertaking some consultancy work with other trusts looking to developing wholly owned subsidiaries. SB asked about the increase in pharmaceutical dispensary use, noting that drug spend had remained the same. SBr confirmed that drug spend had been impacted and reduced due to change from a branded to a generic drug. The increase had taken place in July and would be reflected in future reports. The current reported forecast did not include CYP data, but future reports would detail this. SB asked how the 'refer a friend' scheme ensured equity. SBr commented that the post would continue to be advertised externally, and usual fair and open recruitment processes followed. SBr commented on SSL's contacts with local colleges and universities and local authorities for involvement in recruitment programmes. VD noted that the Quality, Patient Experience and Safety Committee had recently visited Reaside and had fed back about the rollout of the food management system. SBr confirmed that the technical elements were being reviewed, and SSL was in the process of rolling this out further across the organisation. SBr confirmed that the food project for northern sites had been initiated to provide fresh food in that area. RFW commented on the hydrogen trial, noting that it had not taken place. SBr shared disappointment that it had not gone ahead but SSL was considering another option. RFW also asked about the parking project and when it was likely that the Trust would consider options. SBr noted that there was further work to do with colleagues before options could be developed. PG asked about the pharmacy dispense robot. SBr confirmed that a patch was being developed and would be complete within the next 4-6 weeks. The existing robot continued to function well and would remain in place until the new robot was ready. The Board thanked SBr for attending.
21	Audit Committee Report The Board received the report from July's meeting. WW highlighted the following key points: • The audit completion report had been received, with no issues raised. • The Committee had received internal audit reviews into the Cyber Assurance Framework and was satisfied with the outcome into both the clinical coding review and independent assessment. • The follow-up review into Waiting Times noted that good progress was being made. • The Committee endorsed the amendments to the Constitution, Standing Orders and Scheme of Delegation and recommended approval to the Board. • A robust discussion had taken place into how the Board Assurance Framework and Corporate Risk Register triangulated. The Committee had noted that people-related risks were featured within organisational risk registers but were currently not highly scoring enough to be reflected on the Corporate Risk Register. • WW reminded the Board to update declarations of interest as they arose, following a Declaration of Interest and Fit and Proper Persons compliance report received.
22	Constitution, inc Standing Orders and Scheme of Delegation



	The Board of Directors formally approved the Constitution, including changes to the Standing Orders and Scheme of Delegation.
23	Emergency Preparedness, Resilience and Response Annual Report 2024/25 The Board of Directors received the report for information only.
24	EPRR and Business Continuity Policy The Board of Directors formally approved the policy.
25	Living the Trust Values NM verbally reflected on a recent complaint resolution meeting that he had participated in and highlighted the compassionate, committed and inclusive values shown during the meeting. However, NM also noted that the complaint had arisen due to a lack values demonstrated by staff involved, which highlighted the importance of living by them. NM noted that he had visited a number of sites over the last few months, including attending safety huddles and learning from death reviews, and commended staff for the clear values shown.
26	Board Assurance Framework reflections There were no further reflections.
27	Any other business None.
28	Questions from Governors and members of the public - A question was asked about AI bots and the issues being caused in recruitment processes, noting that this was being seen across all sectors. SB confirmed that the Trust was reviewing how to be proactive about this, particularly in relation to cyber security. - The 10-Year Plan had mentioned the future of Council of Governors, and potentially no longer requiring NHS foundation trusts to have them. The Board noted that additional guidance surrounding this, including timescales and whether it applied to all foundation trusts was not yet understood.
Close	

Actions/Decisions			
Item	Action	Lead/ Due Date	Update
Constitution, inc Standing Orders and Scheme of Delegation	The Board of Directors formally approved the Constitution, including changes to the Standing Orders and Scheme of Delegation.		
EPRR and Business Continuity Policy	The Board of Directors formally approved the policy.		

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 10 September 2025, 12.00,
Uffculme Centre

Members	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	Peter Axon	PA	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
	Monica Shafaq	MS	Non-Executive Director
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Kat Cleverley	KC	Company Secretary (minutes)
	David Tita	DTi	Associate Director of Corporate Governance
	Tariro Nyarumbu	TN	Associate Director Acute and Urgent Care

Ref	Item
1	Winter Plan and Board Assurance Statements The Board received the Winter Plan and Board Assurance Statements for consideration. TN described the plan in detail, focusing on the following key elements and indicators: • System Urgent Care Dashboard • Data Trends and AUC Demand and Capacity Modelling • Flu Vaccination KLOE, Implementation Plan and Winter Action Plan • Flu Vaccination 2024/25 Learning • BSMHFT IPC KLOE submission and IPC 2025/26 Winter Plan • Workforce Winter Planning Template • Psychiatric Liaison Team: Response and Escalation Process The Board was satisfied that all key consideration had been met and formally approved the Board Assurance Statements.
2	Any other business None.

Close

Actions/Decisions

Item	Action	Lead/ Due Date	Update
Winter Plan	The Board formally approved the Board Assurance Statements.		



compassionate



inclusive



committed

Report to the Board of Directors						
Agenda item:	6					
Date	1 October 2025					
Title	Chair's Report					
Author/Presenter	Phil Gayle, Trust Chair					
Executive Director	Phil Gayle, Trust Chair	Approved	Y	✓	N	
Purpose of Report		Tick all that apply ✓				
To provide assurance	✓	To obtain approval				
Regulatory requirement		To highlight an emerging risk or issue				
To canvas opinion		For information	✓			
To provide advice		To highlight patient or staff experience	✓			
Summary of Report						
Alert		Advise		Assure		
The report is presented to Board of Directors in public to highlight key areas of involvement during the month and to report on key local and system wide issues.						
Recommendation						
Chair's report for information and accountability, an overview of key events and areas of focus						
Enclosures						
N/A						

BOARD OF DIRECTORS CHAIR'S REPORT

1. Introduction

I am pleased to provide the Board with a summary of my activities as Chair since our last meeting.

The Trust continues to make encouraging progress, particularly in driving culture change and embedding the Culture of Care across our inpatient wards. This work is already having a positive impact on staff morale and wellbeing, though we recognise there is still more to do. Our Executive Team, operational managers, and all our dedicated staff working tirelessly across our community services and inpatient settings.

This progress is taking place within a challenging national context, where NHS organisations are being asked to exercise greater financial discipline. We are mindful of the pressures this places on our workforce, and we remain committed to supporting staff while maintaining high standards of care. Our efforts are aligned with the ambitions of the NHS 10-Year Plan and the NHS Oversight Framework, ensuring that our strategic direction supports long-term sustainability, quality improvement, and better outcomes for service users. I am proud of the resilience and professionalism shown across the Trust as we continue to navigate these demands together.

This year's Annual General Meeting was held on 23rd September, and it was a valuable opportunity to bring together staff, governors, service users, and members of the public to reflect on our achievements and look ahead. The event was centred around the launch of our new Trust Strategy, which sparked thoughtful discussion and genuine enthusiasm about our future direction. Attendees engaged with key themes, market place stalls, and the warm energy in the room reflected a shared commitment to delivering high-quality mental health care and making a meaningful difference across our communities. The AGM was a great success and there was a lot of activity and enthusiasm in the room which was a pleasure to see.

2. Governance Matters

Our committees continue to provide oversight and assurance on matters of quality and safety, patient experience, of finance productivity performance, of people and culture, as well as audit and internal controls continue.

I was pleased to be able to Chair the Council of Governors in person meeting earlier this month, which was a particularly productive and engaging session. Although the attendance was low for various reasons, Governors brought thoughtful perspectives to the table. This fostered rich conversations and constructive debate around key strategic priorities for the Trust. There was a strong sense of collaboration and shared purpose, with open dialogue helping to shape meaningful insights into service

delivery and patient experience. It was encouraging to see such active participation and commitment to our collective role in supporting the Trust's vision and accountability.

I am also pleased to be able to announce that our newest Non-Executive Director, Peter Axon, joined us in September, and is settling in well. Peter brings a wealth of experience having most recently been Chief Executive of Staffordshire and Stoke-on-Trent ICB and has spent 30 years in the NHS, over half of which has been at Board level. Welcome, Peter.

Service visits

Visits to our Trust services are ongoing, with both Non-Executive Directors (NEDs) and Governors actively participating over the coming months. These visits are a vital part of our role as NEDs, providing us with the opportunity to engage directly with staff, patients, and service users. Listening to their experiences—both the positive aspects and areas where improvements are needed—helps us better understand the impact of our services and informs our oversight and decision-making. These interactions are essential in ensuring that the voices of those delivering and receiving care remain at the heart of our work.

Listening to staff

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.

Osborne House - I had the opportunity to visit Orsborne House and speak with several staff from the different teams who shared with me their challenges as a service with increasing referrals but equally, how they love working for the Trust and particularly their team. I thoroughly enjoyed my time at the service.

Pull up a Chair – I'm really pleased that we're re-starting our Pull Up a Chair sessions across Trust sites. These informal conversations offer a valuable opportunity for staff to share their thoughts, ideas, and experiences directly with me as Chair. It's a chance to listen, learn, and connect—creating space for honest dialogue and helping ensure that frontline voices continue to shape our direction and priorities. I'm looking forward to hearing from colleagues across the Trust.

3. Partner and System Development / Stakeholders

I continue to actively participate in a range of strategic meetings to ensure strong engagement and relationship-building with partners and stakeholders across the region.

I maintain regular attendance at the monthly BSOL Chairs Meeting, which covers a wide-ranging agenda and provides valuable opportunities for collaboration and shared learning.

In recent months as in my role as Chair, I've remain actively involved in a range of stakeholder meetings and system-wide forums, contributing to collaborative discussions that support the development of integrated mental health services. These engagements have provided valuable opportunities to strengthen partnerships, share insights, and align priorities across the wider health and care system. It's been encouraging to see a shared commitment to innovation, inclusion, and improving outcomes for the communities we serve.

4. *Stakeholder Engagement*

I maintain regular monthly meetings with Dale Bywater, Regional Director of NHS Midlands, and Shane Bray from SSL, which remain informative and valuable in shaping our strategic direction.

I also meet bi-monthly with Rebecca Farmer, Director of System Coordination and Oversight at NHS England, to discuss priority areas for the Trust and ensure alignment with national objectives.

5. *PEOPLE / QUALITY*

I continue to Chair the Board Strategy sessions, which provide a vital platform for collaborative discussion, strategic alignment, and driving continuous improvement across the Trust. These sessions are instrumental in shaping our direction and ensuring high-quality mental health services. I also hold regular one-to-one meetings with Roisin, our Chief Executive, and both Executive and Non-Executive Directors to maintain strong leadership cohesion.

My monthly meetings with the Freedom to Speak Up Guardians remain a key priority, offering valuable insights into staff experiences and concerns. These conversations often touch on workplace culture, wellbeing, workload pressures, and inclusion—areas that are central to our commitment to creating a safe, respectful, and supportive environment for all.

Despite recent national reductions in support for 'Freedom to Speak Up' initiatives across the NHS, we remain firmly committed at BSMHFT to fostering a culture of openness, learning, and continuous improvement. Championing innovation, refining our processes, and delivering compassionate, high-quality mental health care remain at the heart of everything we do. We continue to value the voices of staff, service users, and partners, ensuring that transparency and integrity guide our work across the system.

PHIL GAYLE
CHAIR

Report to Board of Directors							
Agenda item:	7						
Date	1 October 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

People and Learning and Development Update

The Trust's vacancy rate for August stood at 11.83%, continuing a steady downward trend since the start of the financial year. The transfer of Children and Young People's Services saw 528.96 WTE colleagues join Team BSMHFT in July; this created no impact on the vacancy rate, indicating effective workforce planning.

Staff turnover remains stable, with 418.09 WTE leaving the Trust over the past 12 months. The August turnover rate was 9.17%. Efforts are underway to improve the leaver's survey response rate so that we can better understand drivers of attrition and inform retention strategies.

Reducing reliance on bank and agency staffing remains a key operational focus. While agency usage increased due to the creation of the Children and Young People (CYP) division, early signs of reduction were observed between July and August.

Seasonal increases in bank usage during July and August were less pronounced this year, reflecting proactive management. The focus is now on improving the quality and safety of colleagues only employed with us via the bank, through enhanced training and supervision.

The Trust-wide sickness absence rate for August was 5.0%, down from 5.2% in July. Short-term sickness is now below our KPI at 1.1%, and the Trust has achieved its 1% reduction goal, ranking second lowest across the system.

In response to NHS England's plan to improve working conditions for resident doctors, the Trust has completed a self-assessment and developed an action plan in collaboration with resident doctor representatives. This will be embedded within our ESR data quality improvement programme.

Our Fundamental Training compliance is 93.6%, which is down slightly following the transfer of CYP services. Targeted support is being provided to teams whose Fundamental Training compliance is below 75% and the number of underperforming teams has reduced from 7 to 5, with ongoing monitoring and recovery plans in place.

Attendance at face-to-face management modules remains low, with eighty-nine staff attending both sessions as of mid-August. A Q3 improvement plan includes a communications campaign, flexible delivery models, and webinar pilots to enhance accessibility and compliance.

Overall appraisal compliance is 82.7%, showing gradual improvement. Acute and Urgent Care Services achieved a 10% increase between April and July. The Values-Based Appraisal (VBA) project has concluded, with training now underway and updated resources available via the Trust's Connect platform.

Other Strategic Workforce Developments

Anticipated national guidance will require three-year operational workforce plans. A cross-functional working group has been established to ensure alignment with finance and informatics.

The masterclass series continues to expand, covering discipline management, investigating officer skills, and health and wellbeing. Feedback mechanisms are in place to tailor future sessions.

The Optima Health platform is now live via CONNECT Hub, offering 24/7 access to counselling and specialist services, self-guided wellbeing resources, interactive resilience tools, and clear guidance for staff and managers. This complements the Occupational Health referral system and promotes proactive wellbeing engagement.

A new self-service HR platform has been launched, providing practical guidance and templates, centralised access to approved HR tools, and collaborative authoring for real-time operational needs. This supports consistent service delivery and empowers staff with accurate information.

The Sexual Safety Policy and Disciplinary Policy were formally ratified by the Transforming our Culture and Staff Experience Sub Committee (TCSE). The Sexual Safety Policy aligns with the Worker Protection Act 2023, outlining zero tolerance, reporting mechanisms, and support pathways. The Disciplinary Policy embeds restorative and learning culture principles, with improved usability via flowcharts.

Approximately 33% of resident doctors participated in industrial action (25–29 July). A backup Rota was implemented to cover 102 on-call duties. 45% of consultants voted in favour of further action in a recent BMA ballot. A further ballot is open until 6 October for Foundation Year 1 doctors.

All people-related risks are undergoing systematic review and update, with a clear distinction now being made between issues and risks. Long-standing risks are being reassessed to determine any changes in status, impact, or likelihood. A streamlined process for risk identification and prioritisation is being developed, supported by regular review sessions and expert input to embed continuous oversight and assurance.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

ICCR continues to progress key service area improvements, with focused activity underway in response to the findings from the national inquiry following the Nottingham case, a comprehensive action plan focussing on our Assertive and Intensive Service users has been compiled and will be tabled at key meetings through internal and external governance structures. 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 (CMHTs).

Neighbourhood and Community Mental Health Teams (NMHTs and CMHTs)

- **Neighbourhood Teams:** Dialectical Behaviour Therapy (DBT) skills group pilot is currently being evaluated, with a view to further roll out. Collaborative working continues with the Mental Health support into the Integrated Neighbourhood Teams (INTs).
- **CMHTs:** Teams have seen an increase in referrals, along with staff sickness in this period, which has created additional pressures; this continues to be monitored closely via performance meetings. The review of more complex caseloads has supported teams in identifying recordings gaps in cases and allowed for dedicated pieces of work to take place to improve recording. In the East, the 24/7 works continue, with the majority of the caseload now having been moved over along with specific roles to support.

Assertive Outreach Teams (AOTs)

Joint working with acute care and bed management has improved patient flow. AOT managers are supporting with twice daily bed management conference calls, coordinating our own admissions and escalating cases through support with another discharge manager.

Homeless Mental Health Services

Working effectively with partner agencies, adapting to service changes/withdrawals, and exploring access to Home Treatment where appropriate. The team remains open to collaboration with other citywide services supporting rough sleepers and vulnerable people.

Solihull Integrated Addiction Service (SIAS)

SIAS has developed and launched its own CBT orientated structured and unstructured group work program. Offering interventions to service users who are working towards recovery and those service users who are developing contemplation for change.

COMPASS Dual Diagnosis Team

In further developing training resources in support of developing and upskilling all clinical staff around Dual Diagnosis, COMPASS have utilised the skills of an Expert by Experience in creating a training video as part of training package development.

Steps to Recovery

Introduction of Patient Reported Experience Measures (PREMs) has provided valuable insights for service development. Approval of the Recovery Business Case has enabled the formation of a team to support step-down from out-of-area placements and promote community discharge – this in early stages of mobilisation. Patient Council has developed the EBE participation experience in the service and continues to grow.

Specialist Psychotherapies Service (SPS)

SPS has developed a primary care referral pathway pilot to look at improving access to psychotherapy the pilot will commence in the West Neighbourhood Mental Health Team and West Birmingham Healthy Minds. Additionally, the team are developing a supervision group for ICCR colleagues seeking supervision within a Psychodynamic framework.

Primary Care, Dementia Services & Specialties

The Deaf Service has completed a development planning day with our digital transformation team and Quality Improvement lead. Several projects will be initiated moving forward from this work to improve our care delivery and service user experience. Our Deaf Awareness training package has now been completed, and we are seeking agreement for it to become mandatory training for all staff involved in the deaf service.

The mother and baby team have successfully completed Culture of Care with NHS England and have several projects they will be working on. One of these will be baby diaries for moms so memories of baby can be captured through photos and diary notes and not lost due to mothers being unwell. The recently developed Mother and Baby Unit (MBU) Outreach Service is a pioneering service covering 7 days a week, 8am to 9pm, to provide expert perinatal mental health support for women requiring an admission or are at risk of being admitted and are under an urgent care team. The small team of Clinical Nurse Specialists are currently working closely with Home Treatment Teams (HTTs), Psychiatric Liaison Teams (PLTs), Trust General Adult wards, Psychiatric Intensive Care Units (PICUs) and the Community Perinatal Service to bridge the gap between non-specialised acute and urgent care services and community perinatal provision.

Following a competitive bidding process, the Dementia and Frailty team has 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, Social, Faith and Enterprise (VCSFE) partners, the Alzheimer's Society now holds 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 recruitment process of an Advanced Clinical Practitioner (ACP) and Trainee ACP has commenced along with the core steering group. The Community Dementia and Frailty teams have also 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. This has now progressed to recruitment of the positions. We are working collaboratively with IMROC and the peer support education team to recruit peer support workers across the community services.

Birmingham Healthy Minds Service continues to focus on improving rates for reliable recovery and reliable improvement and there are action plans in place to do so. In July 2025, the key performance indicator (KPI) for reliable improvement (68%) was achieved and data indicates that this is also on track to be achieved in August 2025. A Senior Psychological Practitioner within the service has been awarded the British Association for Behavioural Cognitive Psychotherapies (BABCP) Engagement and Involvement Award for 2025 for her work as an older adult champion providing Psychological Wellbeing Practitioner (PWP) support and psychoeducational sessions for older people in collaboration with Age UK. The award ceremony will be held in September 2025 in Glasgow.

Email feedback from a service user to one of the PWPs in the West team: *Thank you, L. The way you helped me means more than words can express. Your words felt like magic they truly touched my heart and brought me back to myself. I feel normal again because of you. You're not just a wonderful therapist; you're a beautiful soul. Thank you, from the bottom of my heart.*

The Bipolar Service has had a busy few months. In May, for the first time ever, we ran four Mood on Track programmes concurrently both online and face to face, with the support of additional investment. We have also been able to increase our range of cognitive behavioural therapy and family interventions alongside Mood on Track. Our waiting times have reduced with people usually being offered the next programme or the one after.

Children and Young People's Division (CYP)

Access and Performance

The division continues to make progress against the national CYP access target for data reported in August 2026 (June's data), remaining two months ahead of trajectory. Core CMHT Hubs sustained zero 52-week breaches in July, with only 30 service users waiting over 18 weeks, and referral to treatment (RTT) performance improved to 83%. Early Help services maintained strong performance, with Referral Management Centre backlogs reducing and consultation models strengthening access capture.

Workforce

Recruitment and conversion from agency to bank remain positive across urgent care and early help pathways, with crisis home treatment teams and the place of safety and the psychiatric decisions unit now largely staffed substantively. However, gaps remain in medical cover, psychology roles in early intervention teams, and consultant posts in urgent care. High caseloads in early intervention and our ADHD pathways continue to strain capacity. Daily management huddles, multi-disciplinary team (MDT) process improvements, and supervision are embedding well to support staff resilience.

Early Help and Prevention

Our STICK service continues to provide rapid access, with significant improvements in wait times and access capture. Referrals remain high (1,882 in July vs 1,528 in July 2023), reflecting sustained demand. DNA rates rose over the summer period, particularly in Primary Welcome, and are under review for data quality concerns. Plans to mobilise additional Mental Health Support Teams in South Birmingham remain on track for the coming months.

Urgent Care

Bed management performance is strong, with no out-of-area children and adolescent mental health services (CAMHS) or PICU admissions in July — a sustained improvement now in its third month. This has been complemented by continued lower bed usage and a significant reduction in spot purchase bed utilisation. Specialist Eating Disorder Services (SEDS) managed to avoid admissions through intensive community support, though community risk management remains high.

Focus for the forthcoming months will include

- Further strengthening urgent care pathways through improved call handling and strengthening medical cover.
- Mobilisation of additional Mental Health Support Teams in South Birmingham.
- Progression of divisional governance alignment within Trust systems.
- Continued elimination of spot purchase/unfunded bed use, with a focus on sustained elimination of out-of-area placements.
- Targeted focus on ADHD pathways, including exploration of new models to address long waits – in collaboration with the Integrated Care Board (ICB) and community trust teams
- Mobilisation of new bed framework capacity

Secure and Offender Health (SCOH)

Space in the community service building continues to be a restricting factor for both FIRST and Pharmacy and agile working remains in place. Renovation has started on Main House and the space designated for FIRST use has been mapped out within the building plans. It is proposed that the building will be shared with ICCR colleagues and joint working between the multiple services will take place. Further recruitment plans remain in place to bring the service up to its full establishment, including introducing new roles that support service users to pursue vocational pathways. The service is engaging with stakeholders to collaboratively develop plans for a locality-based, functionalised service model.

Tamarind: the service is generally well staffed with posts recruited into. Newly qualified nurses on waiting list if vacancy becomes available. Meetings are taking place with our Experts by Experience (EBEs) to discuss what a good night shift should look like. Positive feedback has been received from the culture of care work that started in July, with dates set for future meetings.

Staffing across the Men's service and Ardenleigh site is improving with continuous recruitment. Daily management huddles remain in place with weekly rota meetings to help forward planning. Safer staffing meetings are taking place to monitor the risks across the Trust.

Reaside: the bathroom upgrade work has commenced however due to issues with the original plans which are being worked through, and we anticipate a delay with the original scheduled date. We are pleased that the replacement of alarm system is almost complete.

The Culture of Care, clean up week was a real success, and we continue to explore and implement lots of new change ideas to improve the service. We have increased our EBE provision across the site, and they are now embedded in our recruitment processes and will be key members of our core meetings going forward. Good compliance with appraisals above target for all wards and no RMN vacancies.

The Health & Justice Vulnerability Service: we continue to recruit with positive outcomes, to our vacancies as they remain high within the qualified workforce. As of 1 September 2025, we are offering face-to-face provision in two of three custody blocks within the Birmingham and Solihull (BSOL) footprint (Bournville and Perry Barr); the business case for Bournville remains with NHSE. Following the success of our recruitment day on 14 May 2025, we are planning another in November for qualified staff only.

Acute and Urgent Care

Workforce

Supervision compliance continues to improve across the division. Clinical Supervision figures have shown noticeable progress, while Regular Management Supervision (RMS) is steadily increasing. Weekly updates are tracking staff bookings and identifying gaps with rationale. Targeted support is being provided to underperforming teams.

Leadership capacity has been strengthened with the appointment of Heads of Nursing each to support Acute Inpatients and Urgent Emergency Care respectively. We have increased matron numbers and reduced the number of areas they are responsible for to ensure they have the capacity to support to areas under their responsibility. We are delighted to announce a series of internal promotions that reflect the talent and dedication within our directorate. These appointments reflect our commitment to strengthening clinical leadership and ensuring our services are guided by experienced, compassionate professionals. We look forward to the contributions each of these leaders will make in shaping the future of care delivery across the Trust.

Winter Planning

The division has played a central role in shaping and operationalising our 2025/26 Winter Plan, which has gone through a series of testing gateways with our ICB and NHSE colleagues. Our approach is rooted in proactive planning, integrated working, and risk mitigation to ensure service continuity and patient safety during seasonal pressures. Our key priorities include:

- Mobilisation of the 10-bed Recovery House in partnership with Birmingham MIND to support rapid admissions and step-down care.
- Expansion of Talking Spaces and Solihull Oasis to divert and prevent Emergency Department attendance.
- Workforce resilience through targeted reviews of Psychiatric Liaison and Home Treatment Teams, supported by enhanced roster compliance and matron oversight.
- Development of an Urgent Care dashboard to monitor capacity and system challenges in real time.
- Mitigations for anticipated risks—such as increased mental health presentations, Emergency Department pressures, and discharge delays—are in place and include Advanced Clinical Practitioner in-reach, gatekeeping consultants, and escalation protocols.

Clinical Updates

Patient flow has improved, with reductions in Out of Area placements and fewer patients waiting for beds. The Patient Flow Improvement Programme is monitoring Length of Stay (LOS) trajectories across adult acute, older adult, and non-Trust beds. Interface meetings with Community colleagues have been productive and are shaping the inpatient strategy.

Quality and Safety

Low-intensity psychological skills training is being piloted for inpatient staff, with plans for wider rollout. Improvements have been seen in weekly risk huddles and MDT engagement, particularly with increased psychologist involvement.

Training compliance is improving but remains below target in some areas. Home treatment teams and Inpatient North are under 75%, with focused interventions underway.

The Culture of Care programme has launched with executive sponsorship. Two ward managers and two wards have been nominated for development programmes. Staff feedback will be gathered to assess leadership visibility and impact. Face-to-face workshops are in place to ensure wider engagement of staff.

The division has achieved zero spot purchases as of the latest reporting period. Sustaining this will be key to improving our patient experience, reducing our length of stay and improving our financial and operational stability. Acute and Urgent Care has also begun the Culture of Care programme, supported by the QI team and executive leadership. Early engagement has been positive, and the programme is expected to drive improvements in staff morale, leadership, and patient experience.

SUSTAINABILITY

Bsol Mental Health, Learning Disability & Autism Provider Collaborative

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

- A new life course specification for mental health has been issued to Birmingham & Solihull Mental Health NHS Foundation Trust on 9 September 2025 along with a requirement for the Trust to produce a Transformation Plan setting out how it will transition to an all-age model of care.
- A framework for adult inpatient acute and psychiatric intensive support unit beds has been concluded and contract awards progressed.
- Expansion of Mental Health Teams in Schools coverage across Birmingham has commenced with a further roll out planned during Quarter 4 of 2025/26.
- Following a workshop with the Snr Black Leaders Group in Birmingham a number of areas for action have been identified to ensure improvements are made in relation to access, experience and outcomes for disadvantaged communities. These will be included in the local Place Delivery Plans which will underpin the delivery of the Mental Health Strategy.
- A new specification for a counselling offer across BSOL has been developed and will be issued to the market during September 2025 as part of a competitive procurement process.
- An all-age mental health needs assessment has been developed to inform the Mental Health Strategy and associated delivery plans.
- The collaborative participated in the recent Birmingham SEND inspection and will continue to work alongside partners to drive forward the recommendations. A particular area of focus for the collaborative is to continue with overseeing improvements around the Dynamic Support Register and the multi-professional working to avoid admissions.
- The collaborative has commissioned an animation to support Children and young people with a diagnosed Learning Disability to understand and take up Annual Health Checks.
- The Autism Enhanced Support Team (EST) is progressing with the team recruitment plan. This team will work with autistic people to increase community provision, provide consultation and support hospital admission avoidance for this cohorts.
- Toucan funding has been awarded following a successful bid from the LDA commissioning team for funding to fund 2 clinical co-ordinator posts to work with help prevent admission to inpatient beds.

Funding and Finances

BSMHFT continues to report an overspent financial position which has meant increased oversight from the regional NHSE team. We have now produced a financial recovery plan which has been shared with ICB and regional colleagues which sets a trajectory to get back on plan by the end of the financial year.

Unlike in previous years, we are expecting the national planning guidance to be issued in early October, with the aim of submitting our plans by Christmas, much earlier than normal. This will allow

all NHS organisations to be fully prepared by the start of the new financial year. It is also likely that these plans will cover a much longer period than normal so we will be aiming to set out our financial plans for five years, rather than the usual one year.

QUALITY

Care Quality Commission (CQC) Well-led Preparation

We continue to prepare for an anticipated well-led inspection later this year and have been working closely with Corporate Governance colleagues to identify any gaps and consider plans for how these will be addressed.

We have completed an analysis of CQC feedback from the 2022 inspection as well as considering the ratings for well-led for each service/ team and have been utilising this information to create an action plan. The Head of Compliance and Associate Director for Corporate Governance will be delivering a presentation at the next Senior Leaders' Forum in September to further identify any leadership needs and how staff want to be supported going forward.

Areas of focus include care plans and risk assessments, workforce and skill mix, staff training compliance and competence, governance structures and ward to Board arrangements, service user voice up to Board level, medication management, clinical and management supervision, access to therapeutic activities, seclusion and segregation approach and restrictive practice.

The approach to take this work forward is to develop a clear plan of action relating to communication plans and resources, continue our learning from other Trusts that have been through the well-led process under the Single Assessment Framework and working groups to focus on targeted topics.

Regulatory Activity

There has been no recent activity in the last month for CQC inspections or assessments. The Trust has not yet received the report for the inspection of Acute Care wards that was completed in June 2025 and therefore the Section 29As for the Zinnia inpatient wards remain in place until we receive this.

Culture of Care Update

The programme has been successfully rolled out Reaside and was launched in Acute Care in August. The programme details, including the aims and success stories to date were shared as part of a presentation to Trust Board colleagues as part of their development session on September 10th. Please see details below of the Culture of Care details for the relevant wards.

There is also a national Ward Manager Leadership Development Programme, and four managers have registered for this to date. A dashboard is also being developed to showcase performance against the 12 Culture of Care standards, and these are aligned to the CQC I statements.

Eighteen-month projects:

- Forward House
- Sage Ward
- George Ward
- Severn Ward

Six-month project over two Cohorts:

- Hertford House
- Chamomile Suite
- Jasmine Suite
- Cilantro Suite
- Rookery Gardens
- Citrine Ward
- Eden Acute
- Magnolia

Going forward the programme will be rolled out in Older Adults and Specialties between October and November 2025 and Steps to Recovery in December 2025.

LOCAL TRUST, BIRMINGHAM AND SOLIHULL SYSTEM AND MIDLANDS REGIONAL NEWS

Chair and Chief Executive of NHS Birmingham, Black Country and Solihull confirmed

The Chair of the new NHS Birmingham, Black Country and Solihull Integrated Care Board (ICB) has been announced as Danielle Oum, and the Chief Executive has been announced as David Melbourne (Current Birmingham and Solihull ICB Chief Executive).

The move to cluster the two organisations follows a requirement from NHS England in April this year for ICBs to reduce running costs significantly, including through the delivery of functions at greater scale and to shift toward delivery of a strategic commissioning function aligned to the shifts outlined in the Government's national 10-Year Health Plan.

Clustering arrangements have been agreed by NHS England and by ministers, and ICB chairs will shape future ICB leadership arrangements, working with NHS England to progress arrangements for chief executives as soon as possible.

Clustering enables both organisations to work together across borders, develop a range of shared support functions and to have a shared leadership team. It does not constitute a formal merger and both ICBs will remain separate legal entities.

These changes have seen consequent changes in a number of roles and post holders. Including of colleagues, we had worked closely with over recent years, we extend our thanks to these individuals and wish them well in the future.

Further leadership and responsibility structure changes are now being developed and we expect more information on these in the coming months. We are working with ICB Cluster and BSoL colleagues to determine what implications these will/may have for our ways of working a relationships.

The NHS Staff Survey is coming

On Monday 29 September, the NHS Staff Survey 2025 launches - and this year, we're hearing from even more voices, including our Children and Young People division for the first time.

Our feedback from 2024 has already led to real change: a new Authentic Leader programme, the Health Passport and improvements in over 120 teams. Now, we're aiming for 130 team-level results.

The survey is confidential, takes 15 minutes and every colleague is entitled to protected time to complete it. More on this from next week, in the meantime let's make a note in our diaries.

BSMHFT Recovery College

As our Recovery College approaches its 10th anniversary in 2026, the service is entering a period of reflection and positive change. To support this, a decision has been made to temporarily pause all learning sessions. This will give the team, led by Sharon Watkins, time to share their own experiences and gather feedback from colleagues, learners, families and carers.

Over the coming weeks, colleagues and learners will be invited to contribute ideas for the future of Recovery College. Updates will be shared as plans develop. If we've experienced the Recovery College, please look out for opportunities to get involved. Our feedback is vital as we shape the next chapter together.

Thank You to the Recovery College team for their continued commitment. We look forward to what the next decade will bring.

NATIONAL NEWS

2025/26 NHS Oversight Framework

NHS England has now released segmentation scores and 'league tables' for each sector, which rank organisations by their average scores.

We shared our BSMHFT position at the time of publication and have continued to work to understand in more detail the metrics and how our existing performance improvement plans will impact over time.

We are disappointed to be in segmentation 4 and remain committed to making the improvements we recognise and understand we need to in key areas.

Winter Plans

The NHS is strengthening its preparations to winter-proof the health service by running 'stress test' exercises and delivering targeted care for vulnerable patients.

Throughout September, local NHS leaders will take part in scenario-based exercises to test the resilience of their winter plans. These include simulations of staff shortages, surges in demand, and simultaneous outbreaks of multiple viruses.

Sir Jim Mackey, NHS chief executive, said: "Despite record demand this year NHS teams have worked hard to improve waiting times, with last month's Category 2 ambulance response times the fastest for four years – but we know the coming colder months will be much more challenging.

"The NHS has done more preparation to be ready for the winter months than ever before, because we know the last few winters have been particularly tough for patients and staff, and we are determined for this year to be better."

New suicide prevention training rolled out for NHS mental health staff

Available from Wednesday 10 September, the new [e-learning course](#) offers practical, evidence-based advice on how to recognise and support people in crisis, including those experiencing suicidal thoughts.

It builds on new national guidance issued earlier this year, which marked a shift towards a more holistic, person-centred approach to suicide prevention, rather than risk prediction. Drawing on evidence and lived experience, the guidance is the foundation for the training, giving staff the tools to put this new approach into their daily work.

The course is designed for use across all roles and settings and is available for mental health practitioners in the NHS, but also to those working in the voluntary, private and charity sectors.

This is one of a range of measures NHS England is taking to improve mental health support and accessibility. Last year, the NHS rolled out 24/7 crisis mental health support through NHS 111 and is opening six 24/7 neighbourhood mental health centres across the country for those with severe mental illness.

Changes In NHS Roles and Responsibilities

Confirmation reports on a number of further changes across the NHS have been published in recent weeks, including the new Role of Regions, the blueprint for new ICB (and cluster) responsibilities. Further work is also being undertaken to further determine the details for Integrated Neighbourhood Teams, a three-year settlement approach and the new NHS oversight framework and provider responsibilities.

Roisin Fallon-Williams

Chief Executive

Vanessa Devlin

Executive Director Operations

Report to Board of Directors						
Agenda item:	8					
Date	1 October 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 (<i>executive summary, key risks</i>)						
Alert		Advise		Assure	✓	
1. Purpose: This report presents the Board Assurance Framework (BAF) to the Board of Directors for review, constructive challenge, scrutiny, strategic oversight and assurance. It reflects the dynamic and iterative nature of the BAF while providing assurance that strategic risks linked to the delivery of the People, Quality, Clinical Services and Sustainability strategic priorities are effectively mitigated and managed. 2. Introduction: The main purpose of the Board Assurance Framework is to provide assurance to the Board and its Committees that principal risks which could prevent the Trust from achieving its strategic objectives are managed in a robust, proportionate and dynamic way. The HM Treasury Guidance on Assurance Frameworks (2023) on the other hand, defines an assurance framework as: “...a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.” It is worth noting that, the risk appetite categories of the risks on the Trust BAF will be aligned with the new Risk Appetite Framework once it has been ratified by the Board today. Key changes to this iteration of the BAF include: BAF SR3 – This BAF risk has been reviewed and updated with new ‘Gaps in control’ and progress on actions being implemented added. BAF SR4 – This BAF risk has been reviewed and updated with new ‘controls’, ‘Gaps in control’, ‘Gaps in Assurance’ and progress on actions being implemented added. BAF SR7 - This BAF risk has been reviewed and updated with new ‘consequences’, ‘Gaps in control’, a new action, ‘Gaps in Assurance’ and progress on actions being implemented added. Further changes and progress notes are highlighted in orange. 3. Key issues and risks:						

The key issue worth noting is the need to regularly update individual BAF risks while considering, new controls, gaps in controls, assurance, gaps in assurance and adding new SMART actions to further manage each BAF risk to attain its target score.

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, SCRUTINISE** and provide **STRATEGIC OVERSIGHT** of the Trust BAF here enclosed.
2. **GAIN ASSURANCE** that strategic risks linked to the delivery of the Trust's People, Quality, Clinical Services 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	5x3=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	5 x 4 = 20
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 4 = 16
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 5= 25
3. 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

BOARD ASSURANCE FRAMEWORK

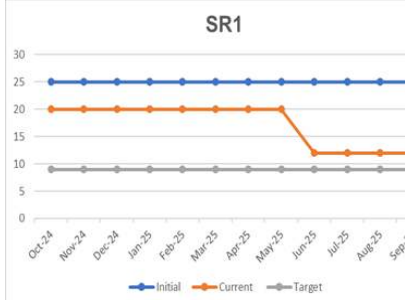
SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	March 2025	DOF / CN	3 x 3 = 9	N/A	4 x 4 = 16
4. Clinical Services: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.							
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: Trust Board Assurance Framework - Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic				SR3 SR6	SR5
4 Major			SR1 SR2 SR8 SR9	SR4 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 there will be moderate impact due to the	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.			

	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	23 rd June 2025	SR1  <table><thead><tr><th>Month</th><th>Initial</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>Oct-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Nov-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Dec-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Jan-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Feb-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Mar-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Apr-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>May-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Jun-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Jul-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Aug-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Sep-25</td><td>25</td><td>12</td><td>10</td></tr></tbody></table>	Month	Initial	Current	Target	Oct-24	25	20	10	Nov-24	25	20	10	Dec-24	25	20	10	Jan-25	25	20	10	Feb-25	25	20	10	Mar-25	25	20	10	Apr-25	25	20	10	May-25	25	20	10	Jun-25	25	12	10	Jul-25	25	12	10	Aug-25	25	12	10	Sep-25	25	12	10
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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	30 th 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	31 st 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	31 st 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.

BOARD ASSURANCE FRAMEWORK

Public Board of Directors

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		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	25
				DATE RISK WAS ADDED	June 2024		
CURRENT RISK SCORE		RATIONALE		TARGET RISK SCORE		RISK HISTORY	

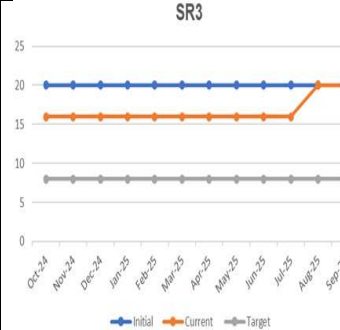
Impact 4 x Likelihood 3 = 12	Despite continuing demand and acuity pressures, workforce is in a healthier position with the vacancy factor reduced, turnover improved and pipelines have been strengthened. The staff survey results show improvements in staff experience particularly against the People Promise. 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.	SR2 <table><thead><tr><th>Month</th><th>Initial</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>Oct-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Nov-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Dec-24</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Jan-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Feb-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Mar-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Apr-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>May-25</td><td>25</td><td>20</td><td>10</td></tr><tr><td>Jun-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Jul-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Aug-25</td><td>25</td><td>12</td><td>10</td></tr><tr><td>Sep-25</td><td>25</td><td>12</td><td>10</td></tr></tbody></table>	Month	Initial	Current	Target	Oct-24	25	20	10	Nov-24	25	20	10	Dec-24	25	20	10	Jan-25	25	20	10	Feb-25	25	20	10	Mar-25	25	20	10	Apr-25	25	20	10	May-25	25	20	10	Jun-25	25	12	10	Jul-25	25	12	10	Aug-25	25	12	10	Sep-25	25	12	10
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DATE OF LAST REVIEW	23 rd 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	- 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.

- NHSP and Direct Engagement being utilised - Divisional Workforce plans in place			
ACTIONS PLANNED			
Action	Lead	Due date	Update
Decrease use of bank in line with growth of substantive workforce.	Head of Workforce Transformation	31 st 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.	- 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	Internal audit reviews 2024-25: - Race Equality Code - Recruitment and Retention. - Complaints - Bank and agency - Disciplinary Process - Sickness Absence Management.	- Data quality concerns for all demographics. - Changes not translating into change of experience at the pace and levels of sustainability we would require.

• Values based recruitment • Stay conversation data • Comprehensive health & wellbeing offer. • Increased % of staff recommending BSMHFT as a place to work. • Improved staff engagement scores. • 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.	• appointment from shortlisting). • Colleagues not adhering to flexible working initiatives in some areas. • Non-adherence to values-based recruitment principles.		
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. • Lack of data to enable harm prevention • 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	18 th October 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 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		3 rd September 2025			
CONTROLS/MITIGATIONS				GAPS IN CONTROLS			

• Process in place to review and learn from deaths • Clinical Effectiveness process including Clinical Audit, NICE • Implementation of PSIRF • Trust Safety Huddle • Safer Staffing Committee • Transition to LFPSE • Patient safety education and training • Implement a culture of continuous learning and improvement. • 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 • QSI 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 above 80%	• Variation in Clinical Governance structures from Ward/Team to Board. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR and documentation framework for RMS highlighted as a challenge. • 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 • Specific audits on MDT Standards, Risk Assessment and Safety Planning • Data dashboard providing teams and Trust with Early Warning System. • Variation in training compliance for ILS/ELS/AVERTS/ETOC • 54 clinical policies out of date

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	31 st 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.

			Acute Wards now live with Programme, monthly programme board in place, additional resources aligned with Division for Delivery
Ensure harm reduction and long-term support for physical health.	ED Q&S	26 th March 2026	Physical health needs assessment completed, implementation plan to be completed Service evaluation scoped to report in November Strategic plan to be derived from the strategy with clear deliverables, in particular to focus on the identification and management of Diabetes
Improving safeguarding awareness and practice relating to service users and their families/carers who experience domestic abuse.	ED Q&S	27 th February 2026	Designated safeguarding lead in place Domestic abuse quality account priority for 25/26 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. September 2025 – Adult (child) to parent abuse (ACPA) thematic review of 42 cases undertaken and report written which was presented to Safeguarding Management Board on 31/7/25. Actions from thematic review 1. Continue to embed Think Family and routine enquiry into clinical practice 2. Develop and deliver bite sized training on ACPA 3. 7-minute briefing on ACPA 4. PEGs resources

			5. Support to staff experiencing this type of abuse (via IDVA)
Embed suicide prevention and safety planning approaches into routine clinical care across all services.	ED Q&S	31 st 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. Identification of variation in the implementation of Dialog+ requires immediate review and support for delivery through CEAG, additional PMO support to be considered. Implementation plan with milestones to be provided to QPESC by November.

BOARD ASSURANCE FRAMEWORK

Public Board of Directors

Ensure robust audit & assurance policies to ensure they are effective and reflect practice.	ED Q&S	26 th 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). Work completed on aligning all audit requirements to current policies. Next step to fully implement the audit programme on AMaT, responsibility HoNs, Matrons and Audit Lead, completion date to be agreed with team Additional training session for Matrons on use of AMaT and compliance requirements September 29th as part of the new Matron Development Days
Improve Quality data and monitoring from a Trust and Divisional perspective (quality metrics and deep dives).	ED Q&S	27 th 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. Implementation of a Trust version of the 'Nottingham Safe Today Care' Dashboard to be implemented as a priority. Draft model with BSMHFT data for Acute Wards and ICCR to be available to QPESC in September, other Divisions to follow and be included by the end of November.
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
<u>Learning for improvement:</u>	Reaside regulatory notice environment and governance.	CQC planned and unannounced inspection reports.	The availability of real time safety data to triangulate information.

• Structured Judgment Reviews reviewed at local safety panels. • Corporate led learning from deaths meeting. • Executive Director’s Assurance Reports to QPES Committee and Board. • NHS Digital Quarterly Data • Commissioner and NED quality visits. • CGC Local review has been completed and actions implemented. • Action in place in respect of the learning from Greater Manchester and Nottingham. • Physical Health Strategy	• Reaside FTSUG Regional escalation. • Reaside CQC Report • External Audit Clinical Governance Review (18 recommendations). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation. • Zinnia CQC report • PFD on learning identification through internal investigations • CQC Inspection ‘North’ Acute Wards • Serious incident Larimar Ward	• Reaside commissioned support programme and Culture of Care Programme. • Door alarm implementation programme. • Internal and External Audit reports. • Triple A reporting to QPES from CGC. • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • QMS update reporting to QPES • QI reporting to Trust and Local CGC’s, STMB and requested for regular QPES/Board- This has been embedded from June 2024 with regular reports built into committee planning structures. • Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board. • Independent annual assessment against the 68 NHS Core Standards for EPRR. • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation Meeting. • 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	• 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
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

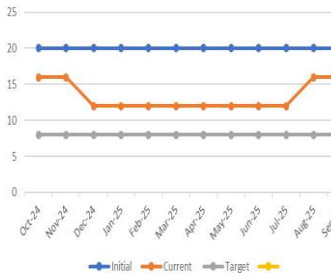
BAF actions updated.
CQC removed regulatory warning notice from Reaside Clinic.
2nd workshop on clinical governance completed – focussed on integrating PSIRF and effective Divisional Governance Meetings.
Culture of Care Programme four more wards sign up to national programme.
Clinical supervision 83% 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.
3rd September 2025 BAF implementation of Dialog+ reviewed and requires more targeted assurance and support for implementation, to be taken forward by CEAG Nottingham style Early Warning System to be implemented for ACUTE Wards and ICCR for September QPESC Review of physical health work and team to report to CEAG, more focus on learning regarding Diabetes diagnosis and care Further training for Matrons on use of AMaT and plan for full implementation with milestones and assurance – CEAG Culture of Care programme progressing well with full launch across Acute Wards Arrangements in place for reporting on progress associated with Larimar Ward to system level assurance meeting Assurance received at CGC in respect of the completion of LRA and ERA risk assessments Clinical and Care input to the Estates Strategy.

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 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		3 rd September 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. - Lack of audit compliance monitoring on MDT standards, risk assessments and safety plans - Implementation of 'In Mustak's Steps' 15 steps for BSMHFT. - Framework for aligning reporting to QPESC using 'I statements'.				

• Culture of Care patient and staff surveys reporting through PEAR • PLACE reports to come to PEAR • Nutrition and Food group to report through PEAR • National CQC Community MH Survey to be delivered and assured on through PEAR			• Addition of subgroups to PEAR to bring in more feedback from patients and their families • Uptake of national community MH survey to be supported through PEAR • Development of ward dashboards • Roll out across all in-patient services of use of 'Reaside model' of use of Patient Reported Outcome Measures				
ACTIONS PLANNED							
Action		Lead	Due date	Update			
Implement a range of opportunities and mechanisms for Service Users and Carers.		Chief AHP	31 st March 2026	On track Patient councils underway in all divisions PREOMS to be reviewed at Board development and implemented via PEAR			
Improve data collection and analysis to reduce patient inequalities.		Chief AHP	27 th February 2026	On track – Dialogue + will support with this PECREF data reviewed at CGC with request for better socialisation and use of PECREF data in driving improvements			
Review oversight and reporting of quality metrics.		Chief AHP	31st March 2026	On track – Constructed in PEAR away day June 2025 New report to come to QPESC each month from November 2025.			
To update the ToR of the PEAR Meeting to ensure a robust directorate representation and engagement.		Chief AHP	30 th 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	30 th 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	31 st 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		• Community Mental Health survey 2024		• Monthly reports on participation and engagement presented QPES • QI Reports		• Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance through PEAR.	

• Patient councils in Secure Care. Urgent care, CMHT and D&F.		• Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey. • Executive oversight of the engagement activities. • Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated through PEAR.	• 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. • Backlog of complaints and gaps in complaints team capacity. • Increase in PALS activity due to ADHD pathway and CYP additional work. • Measure family involvement in risk formulation through MDT standards audit.

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 construction to be piloted in September 2026 meeting
3rd September 2025
- Incorporation of CYP Division into BSMHFT governance, plan agreed for managing ADHD pathway differently agreed at CGC to be monitored through PEAR - Service Evaluations commissioned for physical health and Recovery College. - Introduction of more robust safeguarding checks for EBEs and consideration of where they work. - Reporting on patient and staff experience from Culture of Care Programme to come through PEAR, along with implementation of PREOMS.

Appendix 3: Details of the FPP Board Assurance Framework

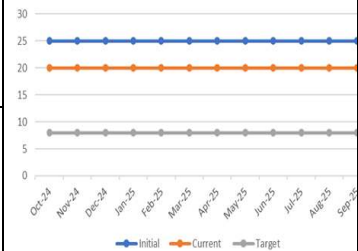
REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 5	Failure to maintain a sustainable financial position NB In this context, a sustainable financial position means an in year AND underlying breakeven over next 2 years and sufficient cash headroom.	- Sustainability - 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		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.		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 5= 25	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	28 th 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.				- 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.			

- ICS expectations and reporting requirements. - 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	30 th 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	30 th Sept 2025	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.
Financial Recovery Plan being compiled for submission to NHSE	Deputy Director of Finance	1 st August 2025	NHSE have requested a financial recovery plan be submitted by 1 st August 2025.
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
Ability to deliver planned financial position dependent on sufficient controls.		- Ability to deliver planned financial position dependent on sufficient controls - Internal and External Audit review. - Audit Committee and FPP oversee financial framework and monthly reporting of financial position and any deviation from plans.	- 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.
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

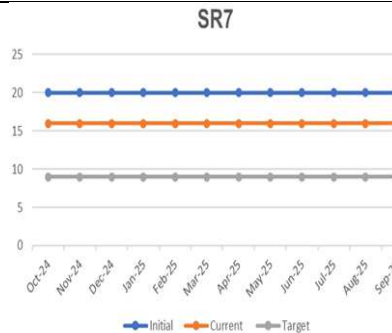
	service users accessing Talking Therapies services.		of social worker availability, funding of placements, availability of appropriate placements. • High bed occupancy levels reducing bed availability. • High CMHT caseload numbers – maintain contact and engagement with service users.	discharge. High 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. <i>Target risk score range 12.</i>	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.		SR6 	
			DATE OF LAST REVIEW	23 rd 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 in use of 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	31 st 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	31 st Dec 2025	On track	
Productivity Improvement Plan developed and implemented within Acute & Urgent Care.	AD for Acute & Urgent Care	31 st 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 - Staff assaults and Patient harm - psychological harm - Services are not responsive or consistent - Regulatory oversight - High bank utilisation - Gaps in ward to board governance - Complaints and concerns - Financial claims - Regulatory costs	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 X 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 September 2025	
CONTROLS/MITIGATIONS			GAPS IN CONTROL	
▪ Culture of Care Programme ▪ Process in place to review and learn from deaths. ▪ Clinical Effectiveness process including Clinical Audit, NICE. ▪ Implementation of PSIRF ▪ Safer Staffing Committee and Bank Gold ▪ 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. ▪ E-roster compliance metrics			▪ 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 ▪ Formal review of Temporary Staffing Services ▪ MHOST review Acute Wards September/October 2025 ▪ E-roster compliance metrics business as usual in Divisional Performance Reviews ▪ Assurance on levels of therapeutic activity on all wards	
ACTIONS PLANNED				
Action	Lead	Due date	Update	

BOARD ASSURANCE FRAMEWORK

Public Board of Directors

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 2025 Roll out across wards to complete self-assessments as part of Well Led preparation and report into CGC/QPESC
Implementing NHSE/CQC Community Standards Develop and implement Clinical Education Framework aligned with CoC standards and Community standards.	ED Q&S	31 st March 2026	NHSE standards not yet available, currently reporting on the learning from Nottingham Implementation of Nottingham Safe Care Today Dashboard, to be used in all Divisional Culture of Care Programme Boards
Promote models of visible leadership, civility and team building.	ED Q&S	27 th February 2026	Executive and Non-Executive visits continue, QPESC visit planned for Reaside Clinic 16 th July Night visits planned October Regular visits in place for all Execs and NeDs, including Xmas plan
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	31 st 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 Additional bank expenditure added with CYP services E-roster compliance variable and for review monthly through Div Performance meetings
Agree a set of metrics aligned to the programme.	EDQ&S/CFO	31 st Oct 2025	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 10 th 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. Implementation of self-assessment process and metrics started

BOARD ASSURANCE FRAMEWORK

Public Board of Directors

Programme to be scaled up from four wards across the Trust to all wards from April on a rolling programme.		EQD&S	31 st 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 All wards now signed up to the programme
Model, plan and assurance on delivery of optimal levels of therapeutic and recovery activities on all wards		Chief Psych/ Chief AHP	31 st March 2026	Agreement of reporting through CEAG and QPES, addition of CP and Chief AHP to Reducing Restrictive Practice Group
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. - Participation Experience and Recovery (PEAR) Group.	- Reaside regulatory notice environment and governance. - Leadership and culture issues identified at Reaside which are being tackled. - Reaside FTSUG Regional escalation. - Zinnia regulatory notices. - Acute Wards Regulatory Inspections, patient acuity and incidents		- Ongoing culture of care and leadership external review of Reaside. - CQC planned and unannounced inspection reports. - Internal and External Audit reports - Triple A reporting to QPES from CGC - Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. - Co-produced Trauma informed recovery focussed training rolled out (NMHT).	- Lack of real time safety data to triangulate information. - Strengthening of processes is required for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded. - Lack of a strong service user/carer voice across all of our governance forums. - Variations in inputs across pathways. Non-compliance e-roster Above plan utilisation of TSS
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

3rd September 2025

- Implementation of training and support in e-roster, clinical supervision and audit now completed and transferred to Divisions with clear expectations of what is business as usual for performance to be monitored through Divisional Performance meetings and assurance taken through Safer Staffing Committee
- MHOST review to be repeated across Acute Wards as part of Culture of Care Programme and to ensure accurate substantive team resource agreed against a plan of Bank use reduction
- Acute Ward Culture of Care Programme reporting into System Quality Improvement Group following serious incident on Larimar and CQC Inspection
- Leadership Team strengthened across Acute and Urgent Care services
- New action in respect of increasing therapeutic activities on wards led by Chief Psychologist and Chief AHP

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 carers. • 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. <i>Target risk score range 9-10.</i>	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 3 = 12	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.		SR8 <table border="1"><caption>Risk History Data for SR8</caption><thead><tr><th>Month</th><th>Initial</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>Oct-24</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Nov-24</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Dec-24</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Jan-25</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Feb-25</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Mar-25</td><td>20</td><td>16</td><td>8</td></tr><tr><td>Apr-25</td><td>20</td><td>16</td><td>8</td></tr><tr><td>May-25</td><td>20</td><td>16</td><td>8</td></tr><tr><td>June</td><td>20</td><td>12</td><td>8</td></tr><tr><td>Jul-25</td><td>20</td><td>12</td><td>8</td></tr><tr><td>Aug-25</td><td>20</td><td>12</td><td>8</td></tr><tr><td>Sep-25</td><td>20</td><td>12</td><td>8</td></tr></tbody></table>			Month	Initial	Current	Target	Oct-24	20	16	8	Nov-24	20	16	8	Dec-24	20	16	8	Jan-25	20	16	8	Feb-25	20	16	8	Mar-25	20	16	8	Apr-25	20	16	8	May-25	20	16	8	June	20	12	8	Jul-25	20	12	8	Aug-25	20	12	8	Sep-25	20	12	8
		Month	Initial	Current				Target																																																			
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Sep-25	20	12	8																																																								
		DATE OF LAST REVIEW	23 rd 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	30 th 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	31 st 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 <i>Divisions have now completed their divisional health inequalities plans.</i>	
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	Likelihood	Total score
					4	5	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	23 rd 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.				- 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.			

• Solihull Children and Young People Transformation. • 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.	• Needs assessment for BSOL is not up to date, which weakens our 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	31 st March 2028	On track
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31 st Dec 2025	On track
Implementation of pilot 24/7 service in East Birmingham.	Akilah Duffus 24/7 Programme Lead	30 th 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	30 th 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:			
21 st October 2024 - Risk newly assessed with inputs from the team and presented for Exec sign-off.			
4 TH 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.			
12 th 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 breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breaches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breaches 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 Minor 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 attack 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						

Report to Board of Directors					
Agenda item:	9				
Date	1 October 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 <i>(executive summary, key risks)</i>					
The key issues to note for consideration by the Committees on which they need to provide assurance to the Board are as follows: New: Following the transfer of CYP services to BSMHFT on 1st July 2025, a separate performance report has been included and in the short term mirrors the Board report provided to Birmingham Women's and Children's Hospital Trust. See Appendix 1 for detail. The report covers the following metrics: - Eliminate Out of Area Placements - Increase CYP Accessing Services (based on national MHSDS figures, month behind) - National <18 eating disorders waiting times (Routine 4 week wait including ARFID*) - National <18 eating disorders waiting times (Urgent 28 days including ARFID*) *ARFID - Avoidant Restrictive Food Intake Disorder pathway - Local CYP Division adult >18 eating disorders waiting times – routine 4 weeks - National Suspected First Episode of Psychosis target - National Talking Therapies 6 weeks waiting time target - National Talking Therapies 18 weeks waiting time target - National Talking Therapies Moving to recovery outcome measure - Local Non-Contract > 18 beds charged (Average weekly Snapshot) - Local All >18 beds charged (Average weekly Snapshot) Data for Talking therapies, eating Disorders and CYP access is a month in arrears NEW: NHSE Oversight Framework for 2025/26 published. Summary presentation shared with Trust FPPC and QPES on 19th August. Trust data published on 4th September. External data published on the 9th September 2025. Technical guidance has been published. - Trajectories for the improvement metrics outlined in Appendix II have 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 key priorities for action. August 2025 data for inappropriate out of area placements at 8 PICU patients below trajectory of 10. Improving trend being achieved in reducing all out of area placements. - Clinically Ready for Discharges – reducing trends but remain high in both Adult and Older Adult services and continue to impact on available Trust capacity to repatriate out of area placements for adult inpatients. System level escalations continue to be taken.					



compassionate



inclusive



committed

- 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 IIa.
 - As at Month 5 there is an income deficit of £334k related to underperformance on activity to date.
 - Both Talking Therapies waiting times targets for 6 and 18 weeks are sustainably being achieved.
 - Reliable improvement rate has met the 68% target this month
- National Length of Stay (LOS) improvement trajectories (adult and older adult inpatient services) - Detail is outlined in Appendix II. To note that both Adult and Older Adult services LOS based on discharge is above national trajectories due to impact of discharging long stay patients which in itself is positive.
As requested at June's 2025 FPPC, LOS data has been provided for current inpatients (Appendix II slide 4: Adults/ Older Adult)
- 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, with continued focus on reducing long waits.
- Sickness – has increased to 5.7%.
- Bank and agency reduction – above trajectory for bank and agency.
- Appraisals – increased to 81.8%.
- Vacancies – Vacancy rate at 8.7%, in July. August data not available
- Fundamental Training increased in last month and below 95% target
- Quality data not yet available for August
- Incidents of Self Harm have increased from 111 to 163 in July
- Patient assaults have increased from 35 to 45 in July
- Prone restraints small increase from 38 to 40 in July
- Staff assaults have remained at 96 in July
- 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 the divisional leadership review meetings.

FPPC is asked to note that the service area deep dive framework, in place since March 2024 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 July 2025, there have been two Performance Delivery Group meetings, and three Service area deep dive meetings. Updates and outcomes 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. CYP data has also



compassionate



inclusive



committed

been included in table 5.

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

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

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Inappropriate out of area Number of placements			Improvement in last month below the national trajectory	3, 12-14
People				
Vacancies			August data not yet available	4
Sickness			Increased to 5.7% in last month above trajectory	4, 21-22
Appraisals			Increased to 81.8% above improvement trajectory but below 90% Trust standard	4, 23-24
Sustainability				
Monthly Agency costs				9

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving trend in last month (49.07%) and below national 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last 3 months (46.54%) and below national target of 50%	4, 19-20
Talking Therapies Reliable improvement rate			Improving trend in last 3 months (68.58%) August just above national target of 68%	4, 17-18
Clinically Ready for Discharge: percentage of bed days			Improvement in last month. August 2025 at 12.74%.	5, 15-16
Clinically Ready for Discharge: Number of delayed days			Improving trend in last month. August 2025 at 2055 bed days.	5, 13-14

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last month (92.8%) below Trust target of 95%.	6, 25-26

Table 5: CYP

CYP Division	On Track	Plan in Place	Progress	Page
Eliminate Out of Area Placements			Improvement in last 2 months above target of 0	
Increase CYP Accessing Services (MHSDS figures, month behind)			CYP access rate based on 12-month rolling remains below target for July data in arrears	1
National <18 eating disorders waiting times (Routine inc ARFID)			Improvement to 100% in last month (July). August data not yet available	2
National <18 eating disorders waiting times (Urgent inc ARFID)			Sustained performance at 100% (July) August data not yet available	2
Local Adult >18 eating disorders (routine)			Improvement in July, August data waited August data not yet available	2
EIP – Suspected First episode of Psychosis seen in 2 weeks			Improved performance in last 2 months above 60% target	
Talking Therapies 6 weeks			Sustained performance above target for July	
Talking Therapies 18 weeks			Sustained Performance above target for July	
Talking Therapies Moving to recovery			Improvement in last month to 55% above target for July	
Non-Contract > 18 beds charged of (ave weekly Snapshot)			Reduction in last month above target of 0	3
All > 18 beds charged for (ave weekly Snapshot)			Total number of beds used (65) below target of 92	

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

FPPC September 2025 Performance Report and Integrated Performance Dashboard

Appendix 1 FPPC September 2025 CYP Division Performance Report

Appendix II FPPC September 2025 FPPC Performance Improvement Metrics

Appendix IIa FPPC September 2025 Talking Therapies Recovery Action Plan - Summary

Appendix III FPPC September 2025 Performance framework update

Appendix IIIa Acute and urgent care (focus on Central Inpatients service)

Appendix IIIb Secure and Offender Health (focus on Men's Scure and FIRST)

Appendix IIIc Integrated Community Care and Recovery (focus on Neighbourhood Teams)

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.

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

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 II 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 have been two Performance Delivery Group meetings and three deep dive meetings focusing on Acute and Urgent care, Secure and Offender Health and Integrated Community Care and Rehabilitation, focusing on Neighborhoods Mental Health Teams (NMHTs) – see Appendix III.

NEW: Children and Young People (CYP) Performance Report

This is the first month for providing the monthly performance report covering the CYP Division following the transfer of the services previously provided by Forward Thinking Birmingham. As previously reported to FPPC, in the short term the CYP report will be presented as a separate report, (Appendix 1) and it should be noted the format is the same as that reported to Birmingham Women's and Children's Hospital (BWCH) Trust Board maintaining continuity.

Members will note that the style of the report is based on 'RAG' ratings, and data going back to April 2025 has been included to provide an oversight of performance trends and highlighting areas for improvement. Please note that Data for CYP Access and talking Therapies is a month in arrears. Eating Disorders is also a month in arrears due to validation work following a change in recording.

In summary, there are three key areas of improvement as outlined below. The Associate Director of Operations for Children and Young People has provided an update on current understanding and actions being taken as follows:

- 1. CYP access target (see Appendix 1 for action plan summary and agreed improvement trajectory)** – Although performance is below the contractual target, CYP

division and partners have achieved a level of access which remains around 2 months ahead of the agreed recovery plan trajectory, in particular work with sub-contracted partners (one specifically) to increase their access to the expected levels which will then see access improve even further ahead of trajectory.

2. **ED adult waiting times routine (Local CYP division target of 95% for 18+ service users, to be seen within 4 weeks of referral)** - Whilst performance at 80% (July) is below the local CYP division standard of 95% for adult eating disorders waiting times, the number of patients is small so a small change in the numerator will impact adversely. It should be noted that capacity within the ARFID (Avoidant Restrictive Food Intake Disorder) pathway is constrained due to increases in referrals. The team has been making good progress with reviewing and defining the referral criteria and pathway which has started to stem referrals to more manageable levels and improved as a result. Monitoring for any fluctuations continues as these changes are still being embedded.
3. **Non-contract over 18s - beds purchased** – At the start of September we are reporting a significant reduction in the number of spot purchase beds being used in the 18-25 patient cohort. By the end of August, there were seven patients in Spot purchase beds with plans to reduce that to 2 patients. These last two patients had clinical presentations that meant repatriations were not yet possible and this was being supported by ICB colleagues and patient advocacy. Alongside this, the division is using far fewer beds in total (10 fewer than plan).

NEW: NHSE Oversight Framework 2025/26

Following the joint presentation to Trust FPPC and Trust QPES members on 19th August 2025, members will be aware of NHS England's recently published its one-year performance management framework setting out how NHSE will assess providers during 2025/26. Members were provided with an outline of the assessment domain areas, metrics, the segmentation process and the proposed scores as published on 19th August 2025.

In summary, the domains areas are:

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

As the national scoring methodology has yet to be published, local replication is challenging although local data where available has been collated for an initial understanding of variance from the national data.

Updated position: NHSE published the finalised data on the Model Hospital platform on 4th September 2025 and the public data was published on the 9th September on the NHS England website.

It should also be noted that at the time of writing changes are continuing to be made to the data. Further work is required to understand the detail of what has been published, including definitions and clarity on the methodologies in place.

The data confirms that the Trust's segmentation score is 4, defined as 'low performing'. The key areas that appear to be impacting on this are the metrics related to:

- Percentage of adult inpatients with > 60-day length of stay (on discharge)
- Percentage of patients in crisis receiving face-to-face contact within 24 hours
- NHS Staff Survey – Raising concerns sub score
- Financial plan - year-to-date variance

Next steps include understanding the detail of definitions and methodologies behind the metrics where possible, ensuring relevant KPI leads undertake review and action for their respective areas. It should be noted that all the above areas of improvement are not new and are already recognized areas of improvement within the Trust and a range of work and actions are already being taken forward to improve the Trust's performance in these areas.

FPPC will be provided with greater detail on the metrics, methodology and action plans at the next meeting.

Trust Performance in August 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:

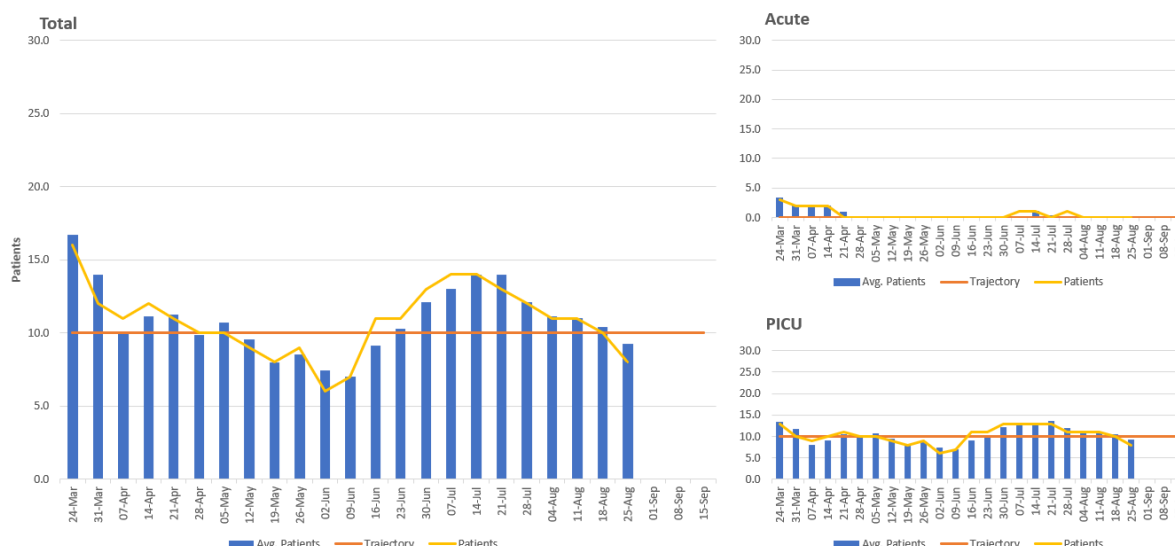
Active Inappropriate Out of Area placements

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.

As at the end of August 2025, the trajectory continues to be met with 0 acute (target 0) inappropriate placements and 8 PICU (target 10). It should also be noted that good progress is being achieved in reducing the numbers of all out of area placements having a positive impact on the financial recovery plan.

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 of inappropriate out of area placements observed and being maintained since end March 2025.

The service continues to experience pressures from Clinically Ready for Discharge patients which continues to impair our ability to eliminate inappropriate out of area placements and improve patient flow.



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. Quarter 2 actions are focused on introducing Advanced Clinical Practitioners workforce to HTT, Introduce Improvements to current gatekeeping process, launch flow policy – based on based on NHSE high impact actions and introduce process to allow nurse discharge at weekends with consultant support.

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 previously 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 II. The Adult and Older adult LOS is over trajectory for the last 2 months with non-trusts beds also over trajectory. The trajectories are based on discharge in line with NHSE methodology. As previously indicated, discharge of long stay patients will impact negatively on the agreed trajectories in the short to medium term and once LOS improvements are achieved routinely with a reduction in longer lengths of stay, this impact will reduce over time.

Based on FPPC feedback at the June 2025 meeting additional information has also been provided on current Length of stay and related number of discharges. This can be found in Appendix II, 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 August 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 £334,891 for April - August 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%). Reliable improvement rate has met the target in August at 68.58%.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have seen improvement, with the latest Trust position showing a reduction to 12.74%. The main drivers for this are reduced delays in both adult and older adult acute services. CRFD in August 2025 in Adult Acute & Urgent Care was at 12.4% (39 patients) and in Older Adult Services at 34% (28 patients).

The main reasons for the delays in adult acute care remain delays in allocation of a social worker and supported accommodation and in older adults is now due to waits for care home placements with and without nursing. Waits for social worker allocation in older adult services have reduced.

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.

Quality - The detailed position on these metric areas is discussed at QPES committee. Data not yet available this month. Data below based on July 2025.

- Incidents of Self Harm have increased from 111 to 163 in July
- Patient assaults have increased from 35 to 45 in July
- Prone restraints small increase from 38 to 40 in July
- Staff assaults have remained at 96 in July

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 II.

- Bank and Agency WTE reduction – The figures for August show that bank WTE is above trajectory at 686.9 WTE and agency is above trajectory at 54.9 WTE
- Staff Appraisals at 81.8% as at August 2025, above improvement trajectory but below the 90% Trust standard.

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

- Staff vacancy levels Vacancy rate at 8.7% in July. August data not yet available.
- Mandatory Training at 92.8%, improvement in month below the 95% target. This is being impacted by the grace period for patient safety level 1 and 2 and Dual diagnosis coming to an end.

Sustainability – (details in finance report)

Integrated Performance Dashboard

August 2025

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PERFORMANCE



PEOPLE



QUALITY



SUSTAINABILITY

Trust

Acute & Urgent Care

ICCR

Corporate

Specialties

Secure Services
& Offender
Health

Performance

Bed Occupancy (%)	92	
Clinically Ready for Discharge: Bed Days	2055	↓
Clinically Ready for Discharge: Bed Days (%)	13	↓
CPA 3 Day Follow Up (%)	87	
CPA 7 Day Follow Up (%)	95	
Eating Disorders: Waiting Time - Routine (%)	100	↑
First Episode Psychosis: Waiting Time (%)	100	↑
Out of Area: Inappropriate Placement Bed Days	346	↑
Out of Area: Inappropriate Placements Active	8	
People on CPA with a Formal Review in last 12 Months (%)	95	
Referrals over 3 Months with no Contact	4054	↓
Talking Therapies: Reliable Improvement Rate (%)	69	↑
Talking Therapies: Moving to Recovery (%)	49	
Talking Therapies: Reliable Recovery Rate (%)	47	
Talking Therapies: Seen in 18 Weeks (%)	100	↑
Talking Therapies: Seen in 6 weeks (%)	94	↑

People

Bank & Agency Fill Rate (%)	93	⬆️
Fundamental Training (%)	93	
Staff Appraisals (%)	82	⬆️
Staff Sickiness (%)	6	⬆️
Staff Turnover: Rolling 12m (%)	5	⬆️

Quality

Abstractions from Inpatient Units	0
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Confirmed Self-Harm	0
Failure to Report	0
Harm to Self	0
Harm to Others	0
Harm to Staff	0
Harm to Property	0
Incidents	0
Inpatient	0
Inpatient	0
Ligations	0
Ligations	0
Patient	0
Patient	0.0
Physical Restraints	0
Physical Restraints / 1000 OBDs	0.0
Prone restraints	0
Prone restraints / 1000 OBDs	0.0
Reported Incidents	0
Staff Assaults	0
Staff Assaults / 1000 OBDs	0.0

Data from Eclipse pending

Sustainability

Agency as % of Pay Spend	1	↑
Agency Staff Spend	£468k	↑
Bank as % of Pay Spend	11	
Capital Expenditure	£299k	
Cost Improvement Programmes	£2,623k	↑
Group Cash Balance	£97,920k	↑
Info Governance (%)	100	
Operating Surplus	-£739k	

	Not meeting target
	Significant IMPROVEMENT
	Significant CONCERN
	Possible improvement
	Possible concern

Last refreshed 10th Sept 2025

Integrated Performance Dashboard

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Secure Services
& Offender
Health

Measure	Latest Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Clinically Ready for Discharge: Bed Days		2716	2405	2543	2242	2339	2055 ↓
Clinically Ready for Discharge: Bed Days (%)		17	15	16	14	14	13 ↓
CPA 3 Day Follow Up (%)	80	89	78	85	83	80	87
CPA 7 Day Follow Up (%)	95	96	90	94	91	90	95
Eating Disorders: Waiting Time - Routine (%)	95	100	100	90	90	80	100 ↑
Eating Disorders: Waiting Time - Urgent (%)	95			100	100	100	
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	100	100 ↑
Out of Area: Inappropriate Placement Bed Days	328	765	379	345	264	435	346 ↑
Out of Area: Inappropriate Placements Active	10	20	12	10	12	12	8
People on CPA with a Formal Review in last 12 Months (%)	95	97	97	97	96	96	95
Referrals over 3 Months with no Contact		3893	3758	3789	3651	3906	4054 ↓
Talking Therapies: Reliable Improvement Rate (%)	68	65	67	63	66	68	69 ↑
Talking Therapies: Moving to Recovery (%)	50	48	49	46	48	46	49
Talking Therapies: Reliable Recovery Rate (%)	50	44	45	43	44	44	47
Talking Therapies: Seen in 18 Weeks (%)	95	99	100	100	100	99	100 ↑
Talking Therapies: Seen in 6 weeks (%)	75	95	94	93	94	94	94 ↑

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

Integrated Performance Dashboard

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Specialties

Secure Services & Offender Health

Measure	Latest Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Bank & Agency Fill Rate (%)		94	96	95	95	93	93 ↑
Fundamental Training (%)	95	96	96	94	93	92	93
Staff Appraisals (%)	90	79	79	80	80	81	82 ↑
Staff Sickness (%)	4	5	5	5	5	5	6 ↑
Staff Turnover: Rolling 12m (%)		6	6	6	5	5	5 ↑
Staff Vacancies (%)		8	8	8	9	9	

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

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Specialties

Secure Services & Offender Health

Measure	Latest Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Absconsions from Inpatient Units		2	2	2	3	5	0
Commissioner Reportable Incidents		0	0	0	0	0	0
Community Confirmed Suicides		0	0	0	0	0	0
Community Suspected Suicides		3	1	0	0	0	0
Failure to Return		16	9	11	13	15	0
Harm (physical) – patients (%)		21	23	19	16	17	0
Harm (physical) – staff/third party (%)		5	6	6	4	5	0
Harm (psychological) – patients (%)		16	17	15	16	14	0
Harm (psychological) – staff/third party (%)		2	2	2	2	2	0
Incidents of Self Harm		223	213	156	111	163	0
Inpatient Confirmed Suicides		0	0	0	0	0	0
Inpatient Suspected Suicides		0	0	0	0	0	0
Ligature no Anchor Point		25	20	29	17	22	0
Ligature with Anchor Point		2	4	2	1	0	0
Patient Assaults		26	28	59	35	45	0
Patient Assaults / 1000 OBDs		1.4	1.5	3.1	1.9	2.3	0.0
Physical Restraints		347	277	259	246	246	0
Physical Restraints / 1000 OBDs		18.2	14.8	13.4	13.1	12.7	0.0
Prone restraints		77	57	56	38	40	0
Prone restraints / 1000 OBDs		4.0	3.1	2.9	2.0	2.1	0.0
Reported Incidents		2621	2525	2586	2758	2830	0
Staff Assaults		94	112	116	96	96	0
Staff Assaults / 1000 OBDs		4.9	6.0	6.0	5.1	5.0	0.0

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

August data not yet available

Integrated Performance Dashboard

August 2025

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Corporate

Specialties

Secure Services & Offender Health

Measure	Latest Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	
Agency as % of Pay Spend		1	3	1	1	0	1	↑
Agency Staff Spend		£482k	£348k	£383k	£320k	£431k	£468k	↑
Bank as % of Pay Spend		8	12	10	9	9	11	
Capital Expenditure		£3,620k	£56k	£597k	£370k	£297k	£299k	
Cost Improvement Programmes		£1,732k	£1,263k	£2,166k	£2,189k	£2,764k	£2,623k	↑
Group Cash Balance		£86,352k	£76,375k	£78,998k	£83,597k	£83,825k	£97,920k	↑
Info Governance (%)		86	95	95	100	100	100	
Operating Surplus		£7,864k	£-1,070k	£1,204k	£-384k	£-528k	£-739k	

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

Out of Area: Inappropriate Placements Active

August 2025



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PERFORMANCE



PEOPLE



QUALITY



SUSTAINABILITY

Trust

Divisions

Services

Commentary

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



Question	Answers
A: What has happened?	The number of inappropriate out of area placements at each month end remains a metric in the 2025/26 national planning guidance. A Trust trajectory agreed with NHSE as part of the 2024/25 national planning requirements will continue in 2025/26 with zero acute inappropriate placements and to reduce and not exceed 10 PICU inappropriate placements each month. Inappropriate out of area placements has fluctuated since January 2024 with large peaks and troughs. August has reduced to 8 placements with 0 in acute beds and 8 in PICU beds below the trajectory of 10 for August 2025. There were 7 inappropriate admissions during August, a decrease from last month with 1 acute and 6 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 2055 overall in August with adults at 854 lost bed days which equates to 12.4%, a reduction of 2%. Adult bed occupancy has increased to 96.7% and length of stay has decreased to an average of 105 days in August. 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.

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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 Q2 actions include: Admission avoidance • Introduce Advanced clinical Practitioners to HTT to enhance capacity and supporting admissions avoidance • Introduce improvements to current gatekeeping process Actions include: ACPs have been recruited and awaiting employment checks, consultation to introduce a later start and finish at midnight and introduce senior nurses Inpatient Care & Reducing Length of Stay • Launch flow policy - based on NHSE high impact actions • Introduce process to allow nurses to discharge at weekends, to maximise discharge opportunities Actions include: Implement flow policy as part of Culture of care work launched in July. Need to identify patient list ahead of weekend with support of the ward Consultant 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 include: 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.

Clinically Ready for Discharge: Bed Days

August 2025

- HOME
- PERFORMANCE
- PEOPLE
- QUALITY
- SUSTAINABILITY

- Trust
- Divisions
- Services
- Commentary

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



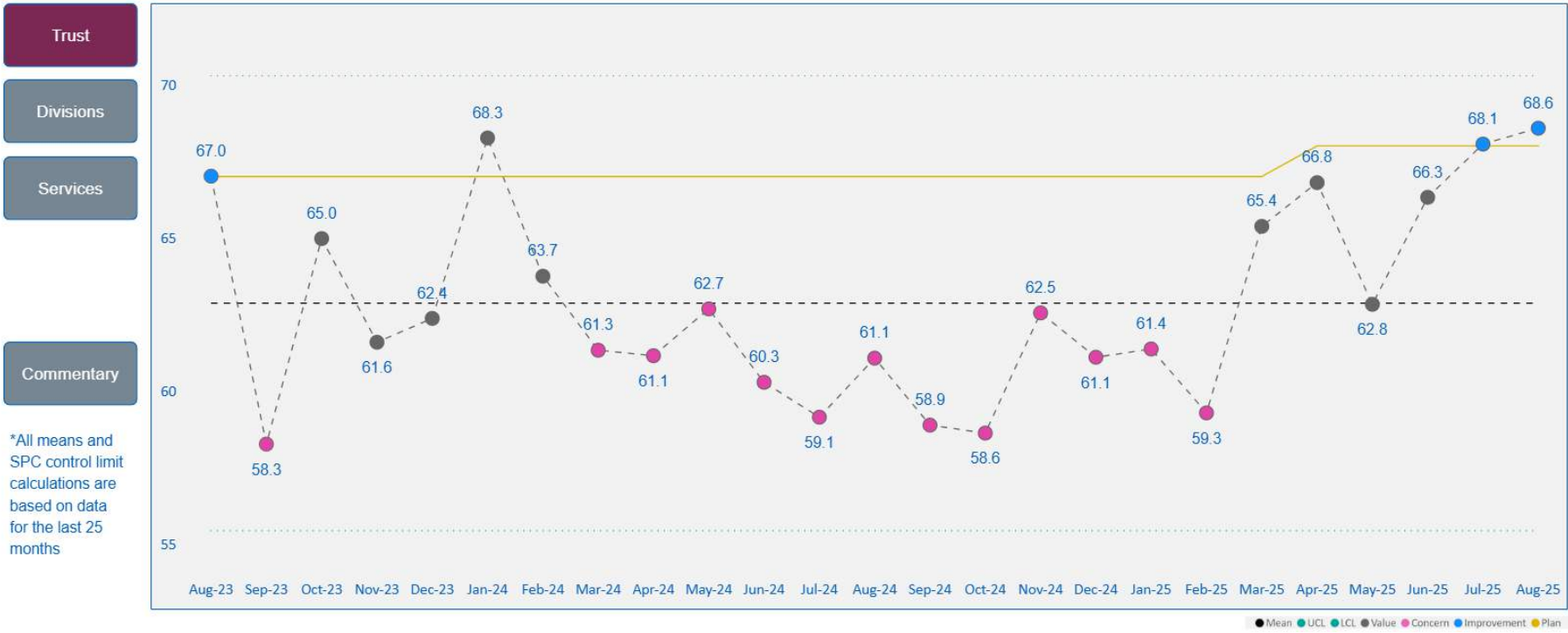
Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. 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. August has seen an decrease from last month to 2055 days with Adults moved from 991 days in July to 854 days in August, which related to 39 patients, with a main delay reason of Social Worker allocation and suported accomodation and older adults moved from 795 days in July to 706 in August and related to 28 patients, who were waiting for care home placements.
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 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 (%)

August 2025



- HOME
- PERFORMANCE
- PEOPLE
- QUALITY
- SUSTAINABILITY



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. August 2025 at 68.58% above the 68% target for the first time in the last 12 months. 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 services 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 (%)

August 2025

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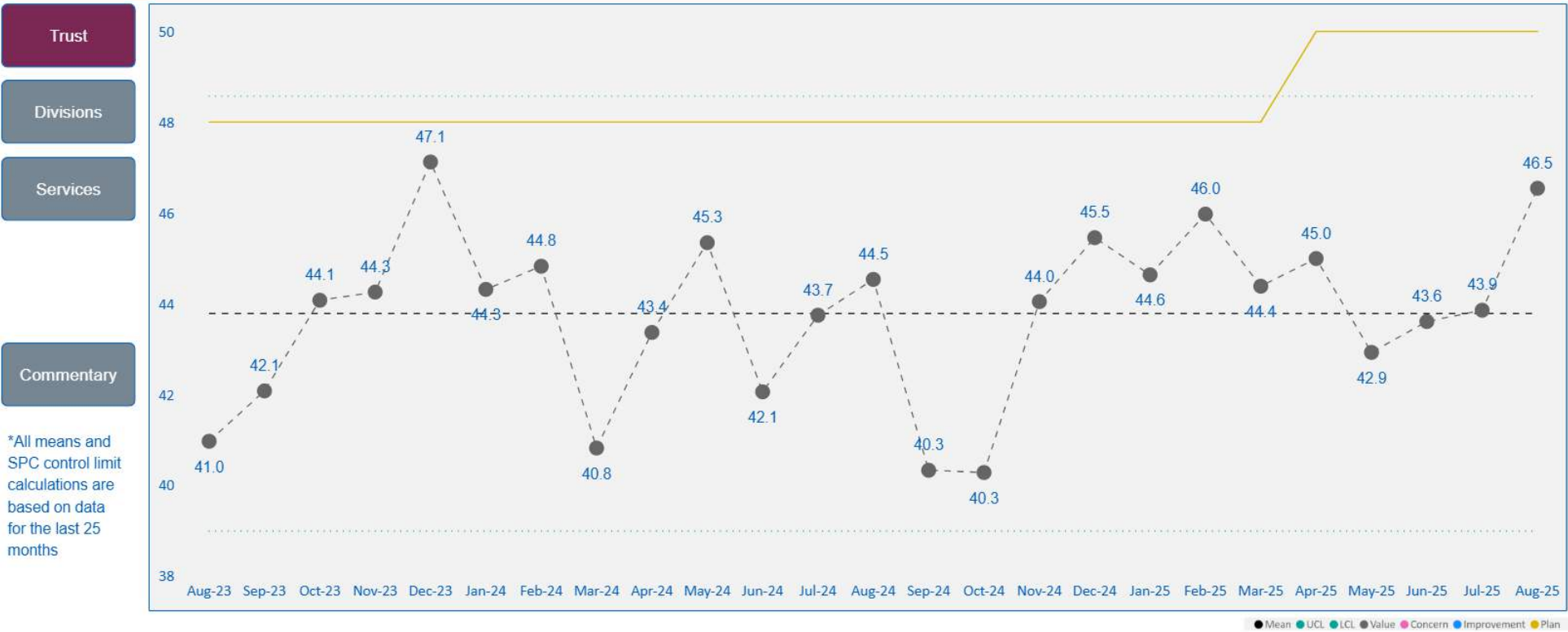
HOME
- 

PERFORMANCE
- 

PEOPLE
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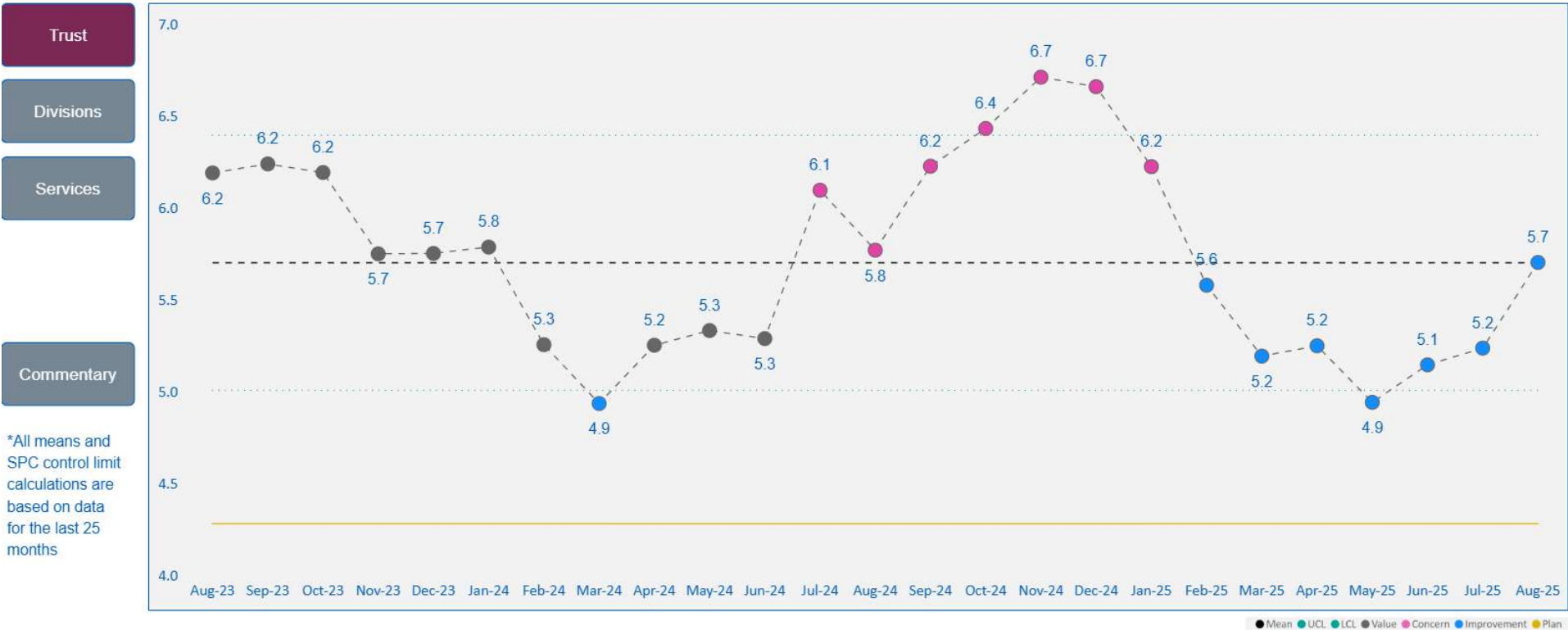
QUALITY
- 

SUSTAINABILITY



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. August 2025 position has seen an increase to 46.54%, 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 services 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.

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HOME
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PERFORMANCE
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PEOPLE
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QUALITY
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SUSTAINABILITY



Question	Answers
A: What has happened?	Trust wide sickness absence rate for August 2025 was 5.7% against 6.1% in July 2025, 5.5% in June 2025 and 5.2% in May 2025. This represents a decrease in the absence level and was accounted for by a 0.3% decrease in short-term absence and a 0.3% decrease in long-term absence. Across the divisions, the following services had the highest absence rates: - Strategy, People and Partnerships 10.3% (3.5% Short Term and 7.3% Long Term) - Secure Services and Offender Health 7.1% (1.7% Short Term and 5.4% Long Term) - Acute and Urgent Care 7.1% (2.3% Short-Term and 4.8% Long-Term)
B: Why has it happened?	An increase in Return to Work Meeting compliance was observed, standing at 60.8% against 59.4% in the previous month. Proactive ongoing management, combined with seasonality, has resulted in a reduction in short-term absence .
C: What are the implications and consequences?	Operational Inefficiencies: High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. Operational Costs: Sickness rates, particularly long-term, present a significant cost to the Trust in the opportunity lost, skill drift and backfill (including bank and agency spend). Increased Risk of Burnout: Ongoing vacancies and low RTW contact rates mean that some employees may experience greater strain, increasing burnout risk and potentially leading to a cycle of recurring sickness.
D: What are we doing about it?	Occupational Health: The new provider is now active and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management. Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling. Return to Work Focus: Key activities are ongoing to measure Return to Work and sickness support compliance, including divisionally targetted support.
E: What do we expect to happen?	Insight-driven targetted actions, led by divisional 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.

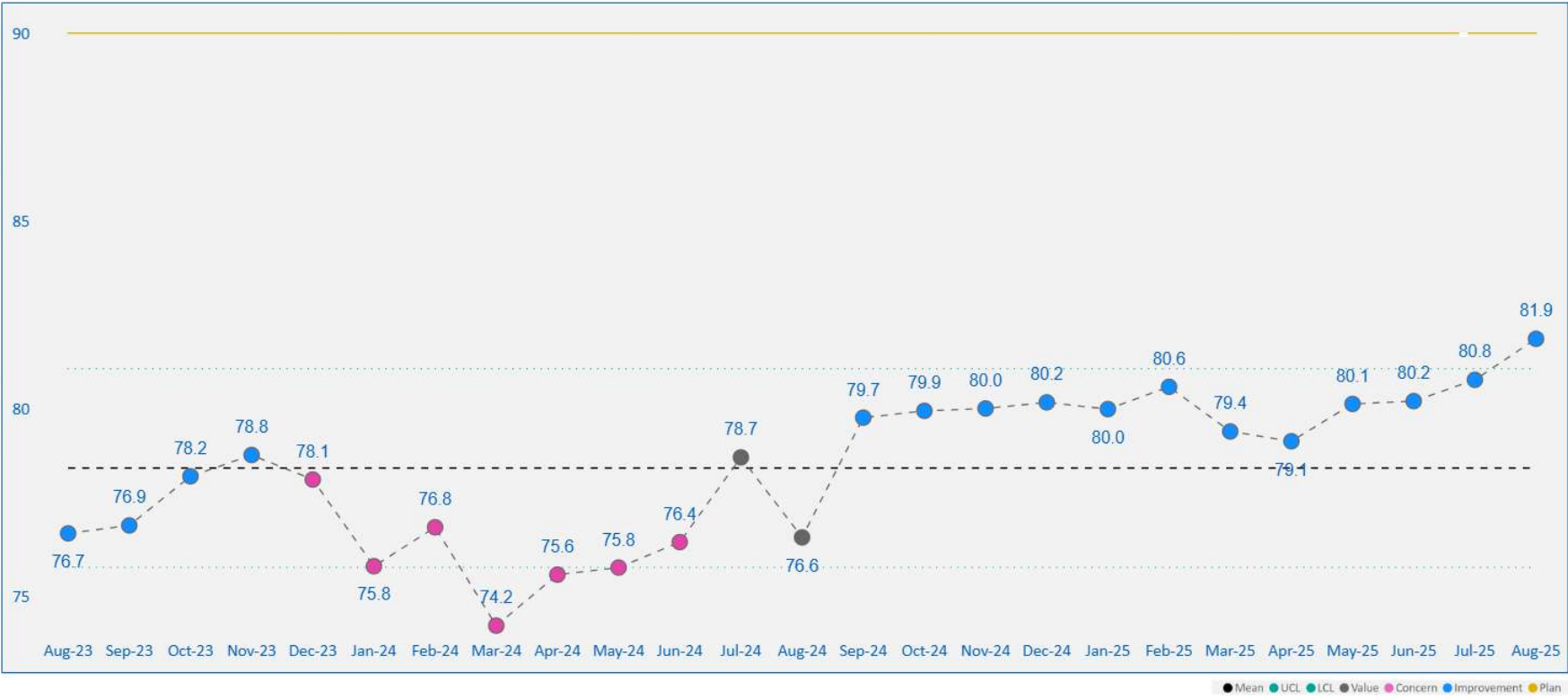
Staff Appraisals (%)

August 2025

- 
HOME
- 
PERFORMANCE
- 
PEOPLE
- 
QUALITY
- 
SUSTAINABILITY

- Trust
- Divisions
- Services
- Commentary

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



Question	Answers
A: What has happened?	Data for August shows Appraisal compliance of 81.8%. This is a 2% increase from May's report (78.4%.) This remains below Trust target of 90 % and commissioners target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: , Chief Exec - 61.5%, Exec-Nursing 72.7%, Exec - Resources - 68.5% and New Care Models 40%.
C: What are the implications and consequences?	The above information demonstrates an upward trend and we would expect appraisal compliance to continue to 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 e.g. refreshed VBA and 1-1 supervision resources on connect. 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?	The BAU appraisal work will continue to positively support staff in achieving quality values based appraisal conversations and also improve compliance.
F: How will we know when we have addressed issues?	When we have 3 months consistently at 85% compliance. FTB areas will be treated as hot spot areas from August onwards to mitigate against fall in compliance.

Fundamental Training (%)

August 2025



HOME



PERFORMANCE



PEOPLE



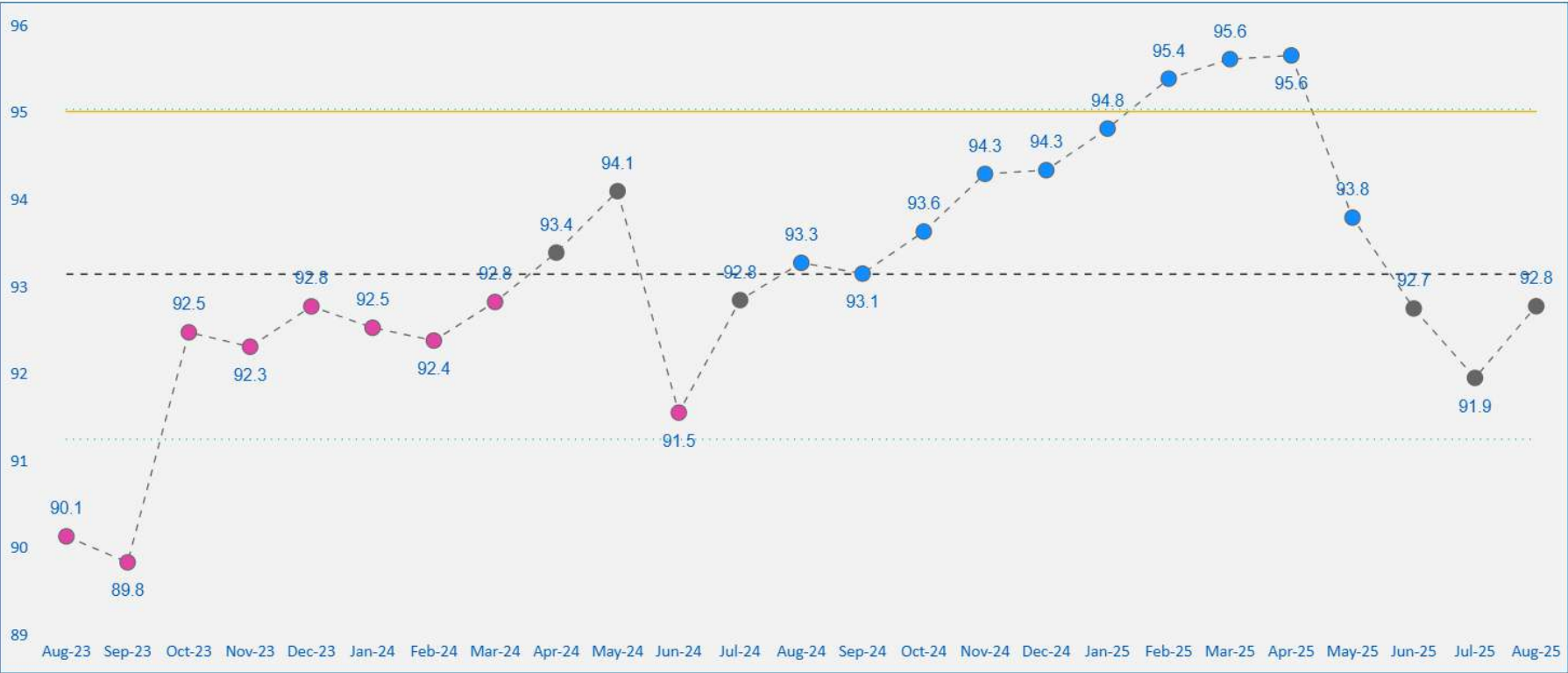
QUALITY



SUSTAINABILITY

- Trust
- Divisions
- Services
- Commentary

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



● Mean ● UCL ● LCL ● Value ● Concern ● Improvement ● Plan

Question	Answers
A: What has happened?	Fundamental Training compliance increased from 91.9% in July to 92.8% in August, falling below the Trust's 95% target for substantive staff, though remaining above the Commissioners' target. Areas currently below 95% compliance include: - Chief Exec - 76.5%, - Exec Director - Medical- 94.3% - Acute and Urgent Care- 93.9% - CYP - 67.6% - Exec Director - Resources 94.7% - New Care Models - 86.7%, - Strategy, People and Partnerships - 94.2% Temporary staffing compliance also declined from 86.8% to 86.7%, 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 in May 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). In addition to this, the transfer of FTB staff has also effected compliance as they previously did not complete the same level of training prior to being TUPE'd over. The following subjects are below 90%: IPC L2 89.7%, Medicine Code 88.9%, MCA 88.4%, MHA 89%, PS L2 81.5%, Recovery Training - Clinical 87.9%, ELS 83.5%, ILS 83.5%, SRS 63.8%
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. • 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.
D: What are we doing about 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

Appendix I - FPPC 18th September 2025

CYP Division - Performance Report

Activity and performance

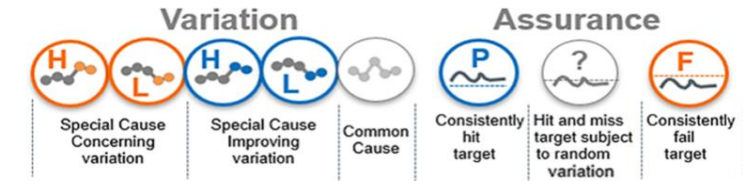
CYP Mental Health	Target	25/26 National Tgt	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Current Vs Previous month Variance	Direction of Travel	Red	Target	Var	Assurance	Trend
Eliminate out of area admissions	zero	zero	4	2	5	0	0	0	↔	15	0			
Increase CYP accessing services (MHSDS figures, month behind)	18163	18163	12865	13590	14270	13828	month behind	-442	↓	16347	18163	n/a	n/a	
<18 Eating Disorders waiting times (routine, incl ARFID)	95% seen in 4 weeks	95%	87.5%	82.4%	81.0%	100.0%	Awaiting Data			90.0%	95.0%			
<18 Eating Disorders waiting times (urgent, incl ARFID)	95% seen in 1 week	95%	100.0%	100.0%	100.0%	100.0%	Awaiting Data			90.0%	95.0%	n/a	n/a	
>18 Eating Disorders waiting times (routine, incl ARFID)	95% seen in 4 weeks		81.8%	66.7%	79.0%	80.0%	Awaiting Data			90.0%	95.0%			
EIP - suspected first episode of Psychosis seen in 2 weeks	60%	60%	60.0%	100.0%	67.0%	68.4%	76.9%	8.5%	↑	50%	60%			
IAPT Six Weeks**	75%	75%	81.0%	84.0%	80.0%	80.6%	Awaiting Data			65%	75%			
IAPT 18 Weeks**	95%	95%	98.0%	97.0%	96.0%	98.3%	Awaiting Data			85%	95%			
IAPT Moving to Recovery Rate**	50%	50%	48.0%	49.0%	45.0%	55.2%	Awaiting Data			40%	50%			
Non Contract >18 beds charged for (ave of wkly snapshot)*	zero		19	16	14	12	7	-5	↓	10	0	n/a	n/a	
All >18 beds charged for (ave of weekly snapshot)*	92		74	72	68	65	71	6	↑	105	92	n/a	n/a	

Data for CYP Access and talking Therapies is a month in arrears. Eating Disorders is also a month in arrears due to validation work following a change in recording

Statistical Process Control - Key

SPC Variation/Performance Icons		
Icon	Technical Description	What does this mean?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	Something's going on! Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	Something's going on! Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	Something good is happening! Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	Something good is happening! Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.
SPC Assurance Icons		
Icon	Technical Description	What does this mean?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.

Summary icons key



An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of the data.

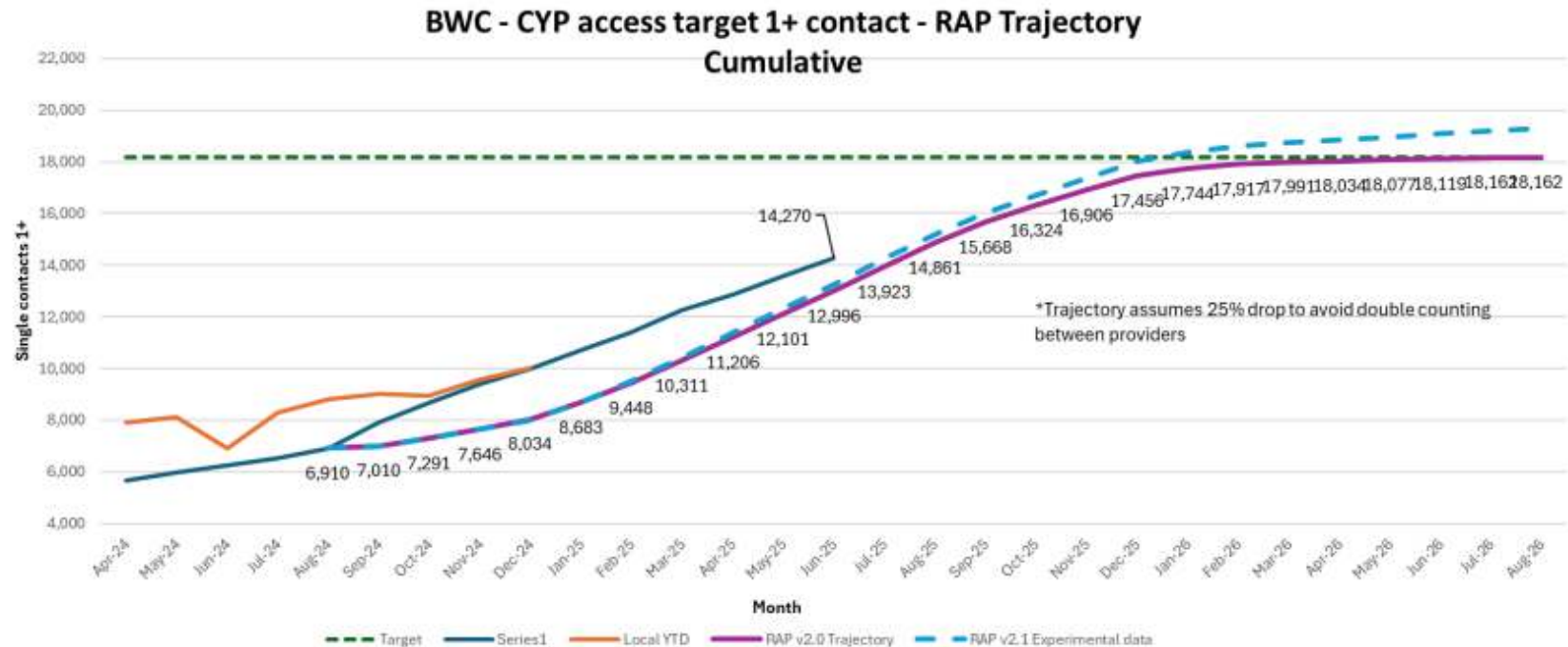
The following generate alerts regarding variation in the chart

- any single point outside the process limits.
- a run of 6 /7 points or more above or below the mean (a shift), or a run of 6/7 points or more all consecutively ascending or descending (a trend).
- two out of three points outside either the upper or lower 2 sigma limit but not crossing the mean line.

All these rules are aids to interpretation and contextual examination of the data is needed.

CYP Access Target – Improvement Trajectory & Action Plan

Delivery against Plan



- Forecasting that cumulative target will be reached by Aug '26 (takes full 12 months after full capacity is mobilised from August '25)
- We are now around 6 weeks ahead of trajectory
- Strong growth in performance continues to be observed
- Some slowing of growth attributed to poor performance in one sub-contract (which is now starting to show some green shoots) and the decision to remove TT contacts for 16-17 year olds from the count.

Next Steps

- Continue close oversight of recovery plan (both internally and in regular commissioner led sessions)
- Progress system led actions (including focus in health inequalities and improvements in referral routes between primary care and secondary Mental health care. These are not running at the same pace as the BWC centric actions and are key to maximizing the opportunity and responding to the Risk summit actions.
- MHPC continue to assess additional contributions from other providers
- Continue to explore learning opportunities from other systems, using benchmarking to identify system peers.
- Reduction of circa 1300 contacts requested via commissioning team decision due to conflict with Talking therapies access data (need to discuss the impact of this across system/partners)
- Planning submission needs to reflect this above change unless 1300 contacts picked up via other means (system led work, increase in other targets etc.)
- Primary welcome service (TCS) recovery plan now needed due to under-deliver

Appendix I - FPPC 18th September 2025

2025/26 Performance metric Improvement Trajectory update

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.

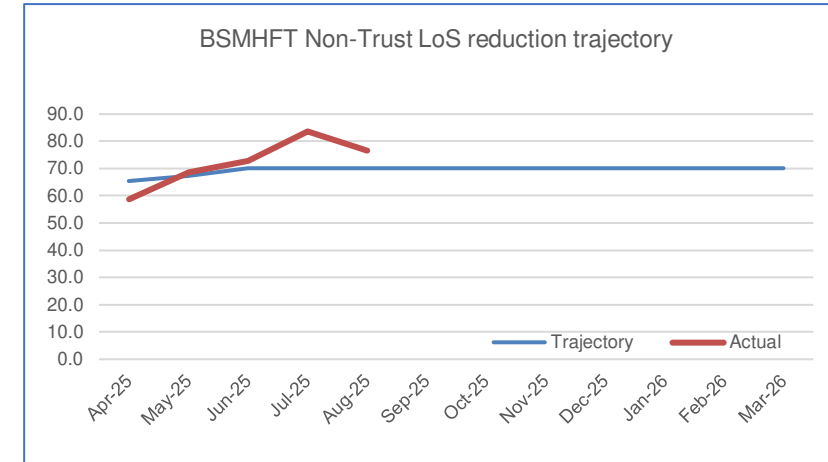
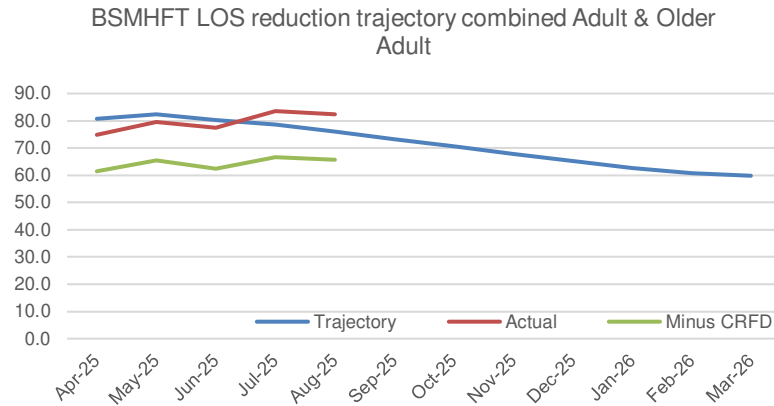
NHSE methodology – Factors to note:

- 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

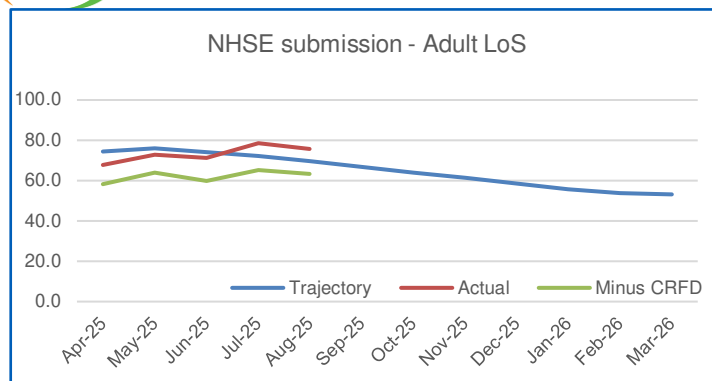


The 3-month rolling length of stay has seen a small decrease in the period April – August and the non trust has seen a decrease.

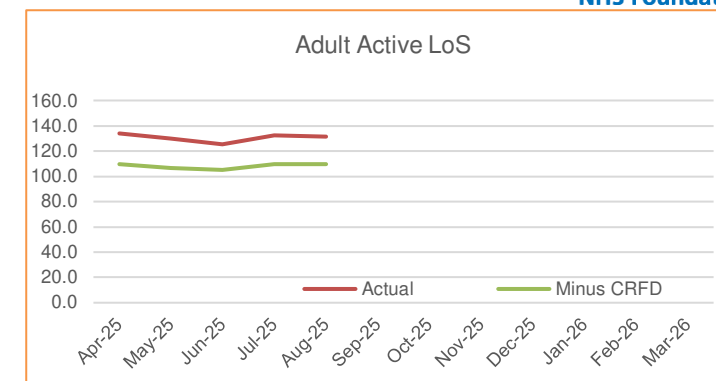
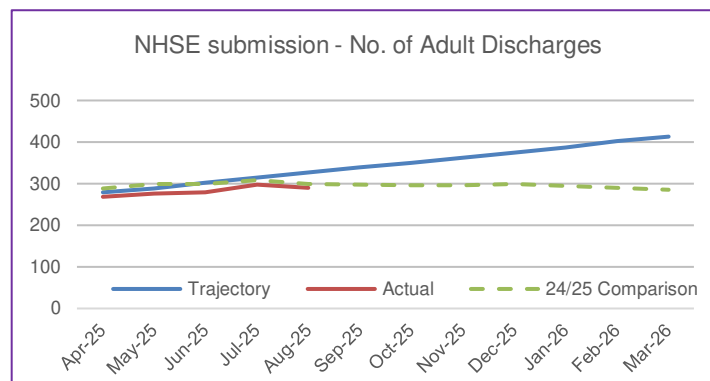
NHSE Methodology: Based on:

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

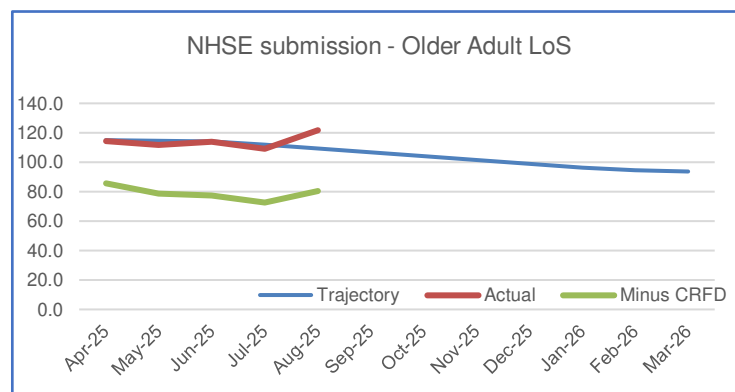
NEW – As requested at June 2025 FPPC meeting, additional data has been added (see next slide 4) which includes the NHSE LOS measures compared to ‘active’ current length of stay position as well as showing the impact of CRFDs on LOS.



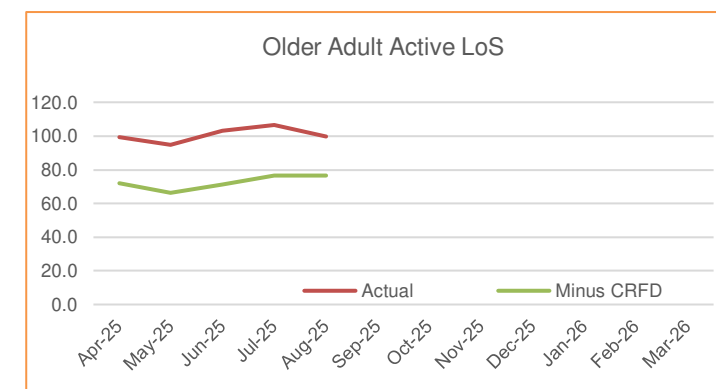
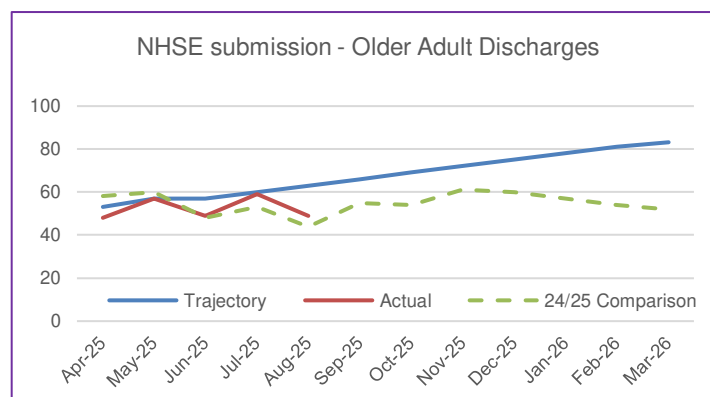
length of Stay- 3 month rolling based on discharge



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.

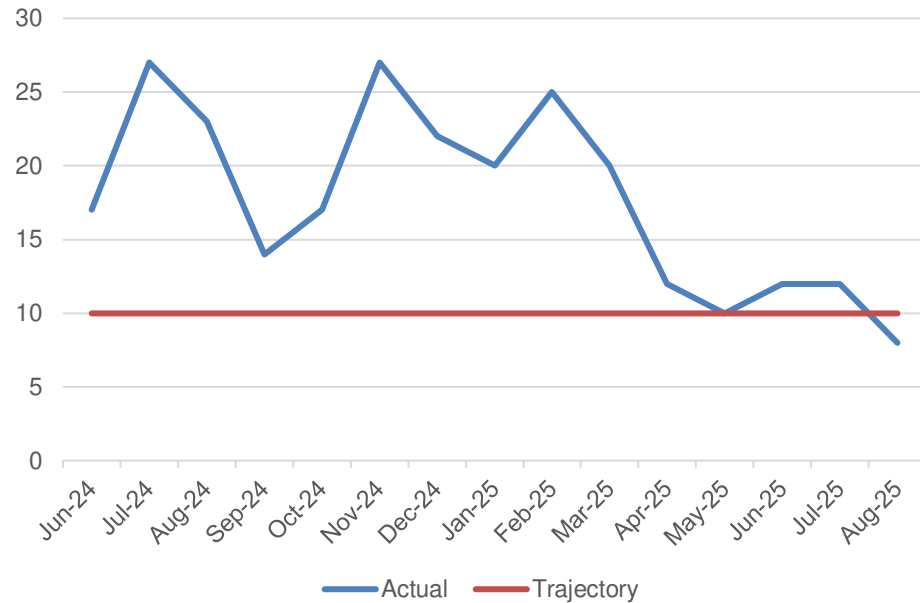
NEW 'Active' Current LOS based on entire inpatient spell, including leave, at each month end.

Discharge of long stay patients will impact negatively on the agreed trajectories in the short to medium term and once LOS improvements are achieved routinely with a reduction in longer lengths of stay, this impact will reduce over time. .

**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.

August 2025 position – Total inappropriate number of placements at 8 (target 10), 0 acute (target 0) and 8 PICU (target 10).

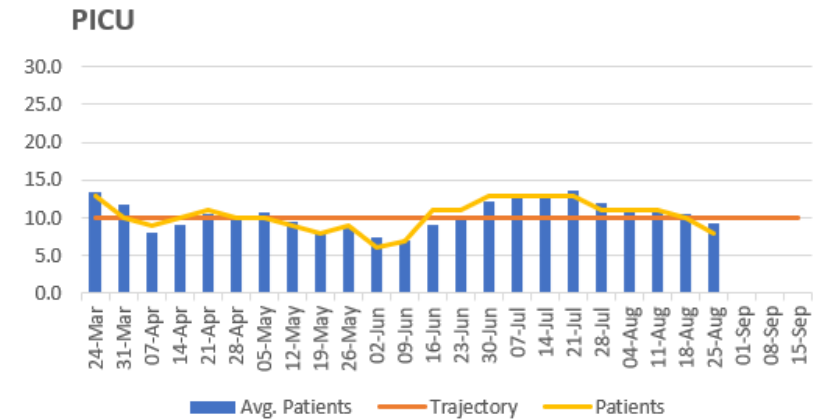
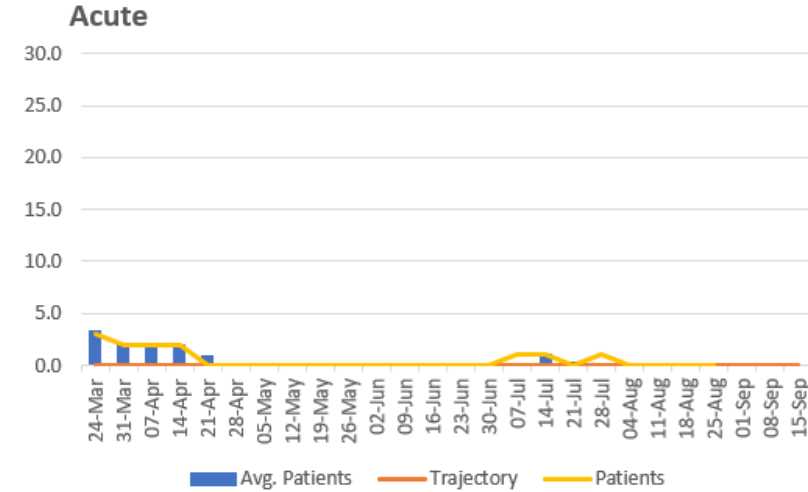
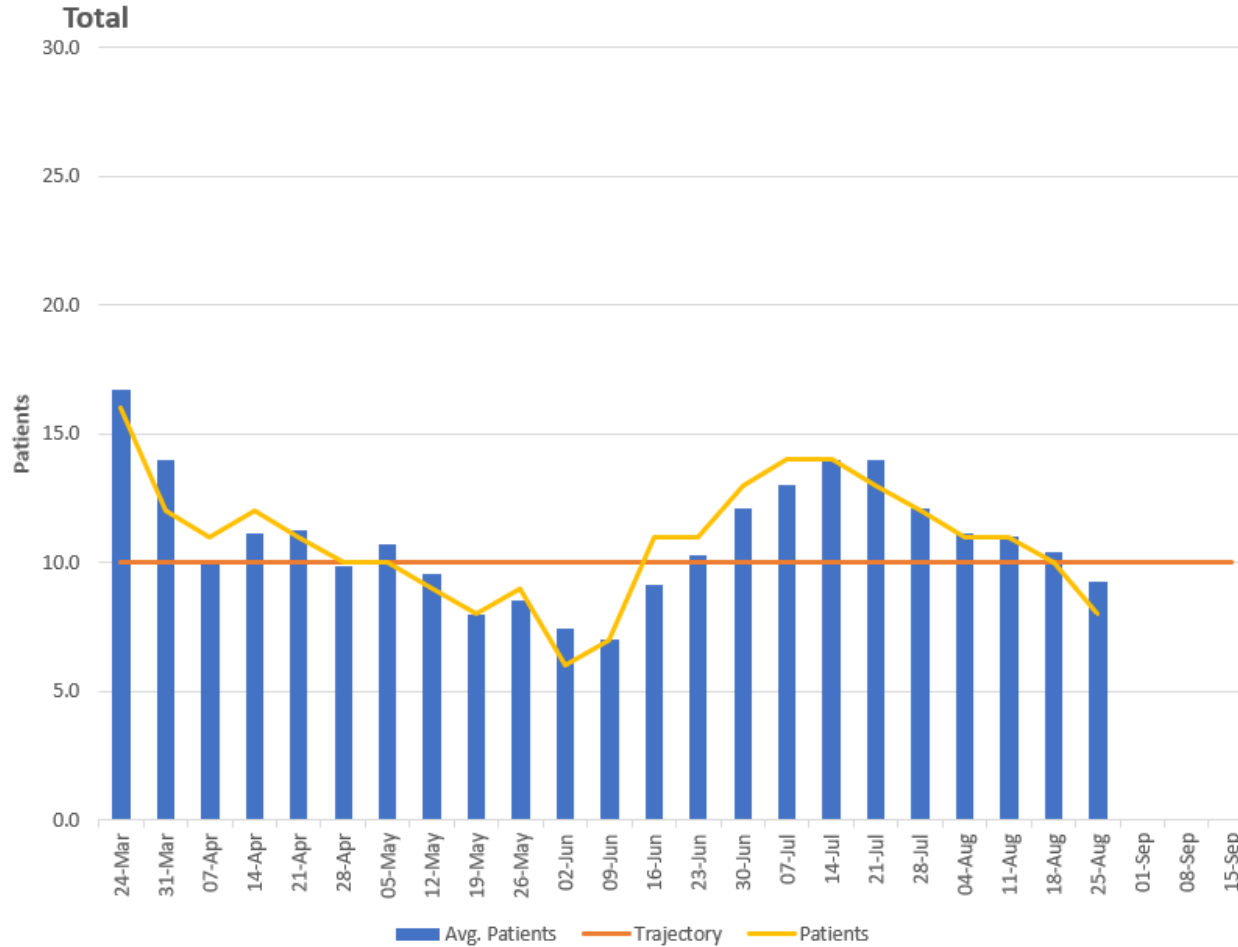
Good progress is being achieved in reducing the numbers of all out of area placements having a positive impact on the financial recovery plan.

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 outline a summary of key actions from the productivity plan for Q2.

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. Q2 actions



Introduce ACP workforce to HTT

Impact: Enhances the capacity of the Home Treatment Team, supporting admission avoidance and optimising patient pathways.

Assumption Impact: Requires recruitment and training of ACP workforce, which may take time and resources.

Recruited successfully and going through checks]



Introduce improvements to current gatekeeping

Impact: Enhances the gatekeeping process, ensuring appropriate admissions and avoiding unnecessary ones.

Assumption Impact: Requires review and enhancement of current gatekeeping protocols, which may involve stakeholder engagement.

Consultation with DMD to introduce a later start and finish at midnight and introduce senior nurses to support mobility of the team.



Launch Flow Policy – Based on NHSE High Impact Actions

Impact: Implements best practices for patient flow, reducing length of stay and supporting timely discharge.

Assumption Impact: Requires adoption and adherence to the new Flow Policy by all relevant staff members.

This will be embedded with Culture of Care Launch in July



Introduce process to allow nurses to discharge at weekends

Impact: Facilitates weekend discharges, reducing length of stay and maximising discharge opportunities.

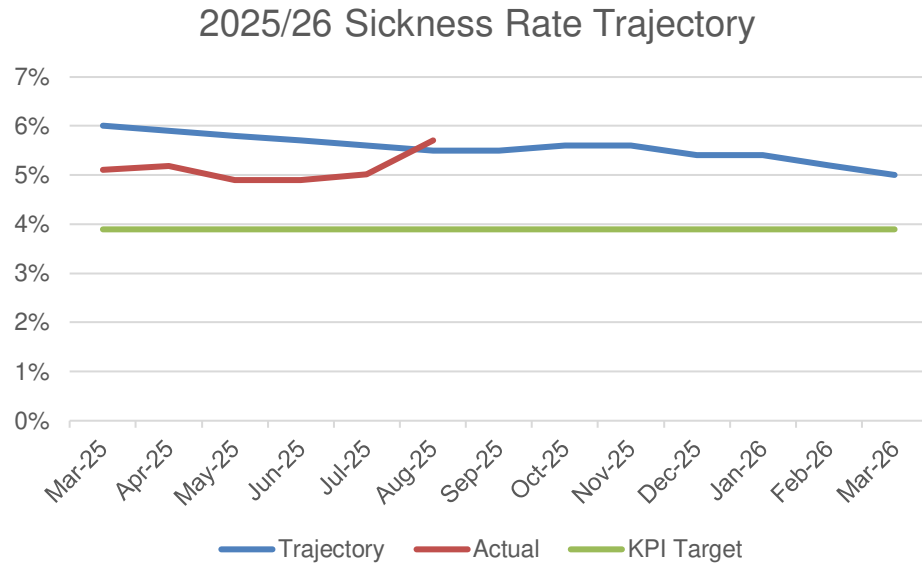
Assumption Impact: Requires adjustments in staffing schedules and protocols to accommodate weekend discharges.

Need to identify patient list ahead of weekend with support of the Consultant of ward. – Clinical Director

Workforce trajectories – 2025/26 update.

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

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.

August 2025 at 5.7% just above the improvement trajectory of 6%. Short term sickness has remained at 1.4% and Long-term sickness has increased to 4.2%

Action Plan:

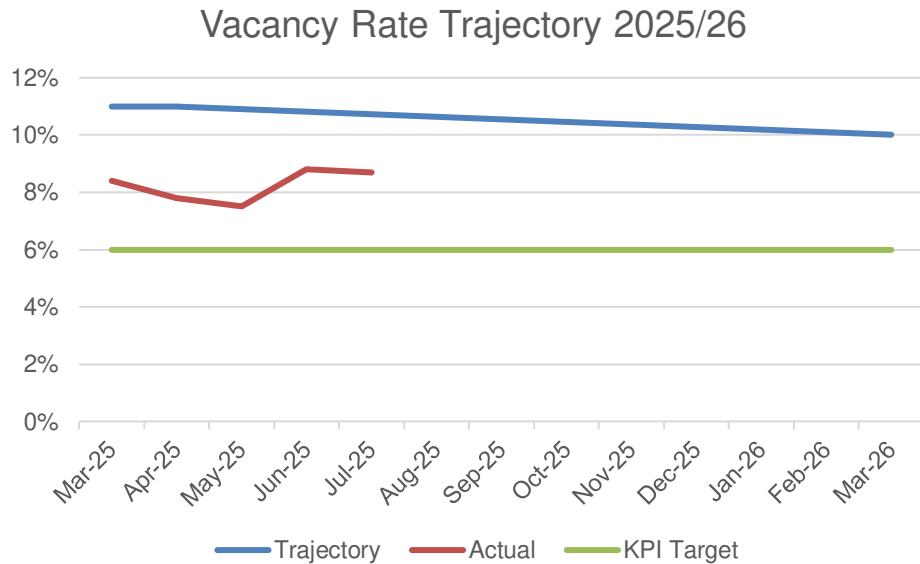
Occupational Health: The new provider is now active, and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management.

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

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



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%. July at 8.7% below the trajectory. August data is still awaited.

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.

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

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 thirteenth 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.

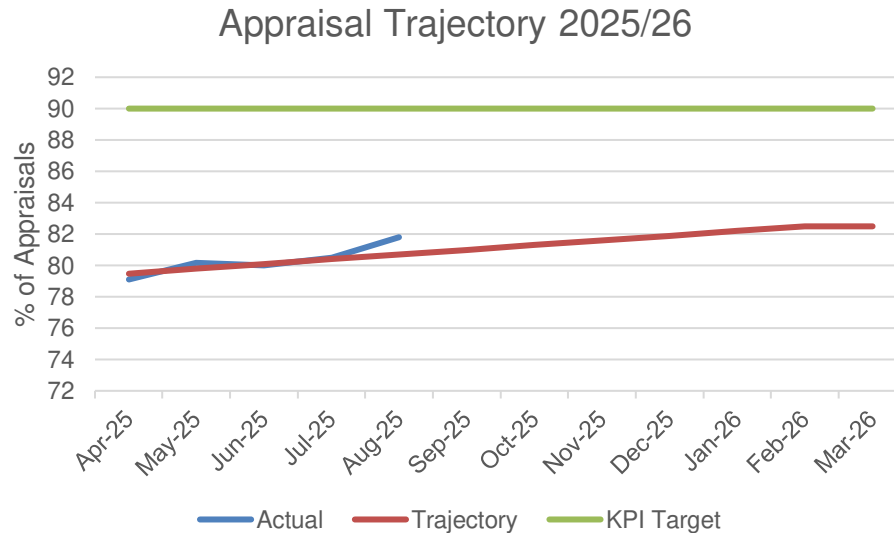
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 September 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.

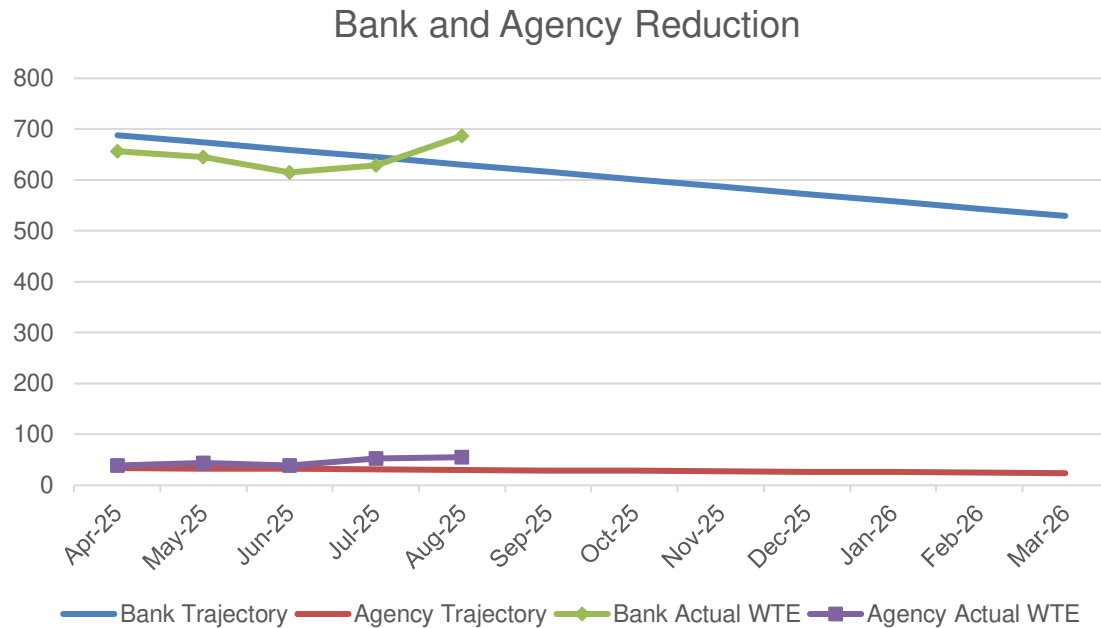
August 2025 appraisal performance increased to 81.8% above trajectory.

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, including refreshed resources on connect
- 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



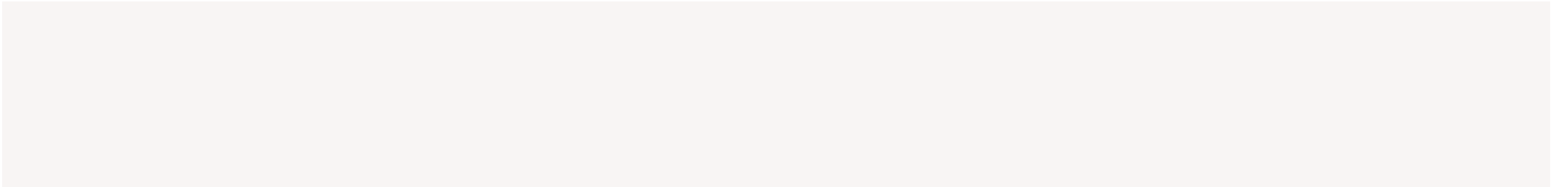
The focus for 2025/26 remains on reducing the numbers of bank and agency staff used within the Trust. The target is to reduce the use of bank workers by 174 WTE and 10 WTE in agency workers by March 2026.

Bank has moved above trajectory in the last month with August at 686.9 WTE

Agency has been just above trajectory for the last 2 months with August at 54.9 WTE

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

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 expediting 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 August 29 bank workers started with the trust, helping to alleviate the need for agency.

Appendix I - FPPC 18th September 2025

2025/26 Talking Therapies Recovery Action Plan Summary

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%



compassionate



inclusive



committed

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

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	743	£427,386	£473,952	£517,966	£44,014
May	812	710	721	£452,901	£459,918	£517,966	£58,048
Jun	812	710	669	£452,901	£426,748	£517,966	£91,218
Jul	812	750	776	£478,417	£495,002	£517,966	£22,964
Aug	812	670	626	£427,386	£399,319	£517,966	£118,647
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	3,535	£5,808,621	£2,254,939	£6,215,600	£334,891

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 July 2025, a Performance Delivery Group was held on the 7th August 2025 and the following service area deep dives have taken place:

- Acute and Urgent care on 18th July 2025 focusing on Central Inpatients.
- Secure and Offender health on the 15th August 2025 focusing on Men's Secure and the FIRST team
- Integrated Community Care and Recovery on the 2nd September 2025 focusing on Neighbourhood Mental Health Teams

1. Performance Delivery Group (PDG) Update – Meeting held on 7th August 2025 and 4th September 2025

PDG's agenda for both meetings was focused on the National Oversight Framework for 2025/26, with an overview presentation of the metrics, the segmentation process and the current proposed scores. As the national scoring methodology has yet to be published, local replication is challenging although local data where available has been collated for an initial understanding of variance from the national data.

The finalized data was published by NHSE on the Model Hospital site for Trusts on 4th September 2025. Publicly the data is expected to be published on 8th September. The data available on the Model Hospital site was reviewed at the meeting and at the time of writing it was noted that further work is required to understand the detail of what has been published, including definitions and clarity on the methodologies in place.

The data confirms that the Trust's segmentation score is 4, defined as 'significantly off track'. The key areas that appear to be impacting on this are the metrics related to:

- Percentage of Inpatients with > 60-day length of stay (on discharge)
- Percentage of patients in crisis to receive face-to-face contact within 24 hours
- NHS Staff Survey – Raising concerns sub score
- Variance year-to-date to financial plan

Next steps include understanding the detail behind the metrics where possible, ensuring relevant KPI leads undertake action of review for their respective areas. It should be noted that all the above areas are already recognized areas of improvement within the Trust and a range of work and actions are already being taken forward to improve the Trust's performance in these areas.

FPPC will be provided with greater detail on the metrics, methodology and action plans at the next meeting.

It should be noted that PDG at its meeting in August also focused on current FPPC performance metrics along with ICS and CYP metrics, underlining the need for up-to-date commentaries from KPI leads regarding the metrics for improvement.

In addition, FPPC is asked to note that a Committee review is underway with plans to streamline and integrate PDG, Sustainability Board and the Strategy and Transformation Group into one meeting. FPPC will be updated on the confirmed approach when finalized.

Service Area Deep Dive Meetings – Update

2. Acute and Urgent Care – 18th July 2025

The service leads focused their deep dive on the Central inpatients service. The related service area presentation is included as Appendix IIIa. 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
Newbridge House	Red	Red	Red	Green	Red	Green
MSH1	Amber	Green	Amber	Green	Amber	
MSH2	Amber	Red	Green	Amber	Amber	
Meadowcroft	Red	Amber	Red	Red	Red	Green
Saffron	Red	Red	Amber	Amber	Red	
Lavender	Red	Red	Red	Amber	Amber	

Quality

Fundamental Training – improvements across all wards noted regarding ELS, ILS, Safeguarding Adults, Safeguarding Children and Clinical Supervision with ELS compliance levels requiring further improvement at the Newbridge House and Saffron wards.

Service user feedback via the Acute Care Patient Council – positive feedback received and suggested areas for improvement related to use of the gym, increased activities and improved engagement from night staff to be reviewed.

Acuity levels - high levels being experienced on Zinnia, bedroom seclusion currently not an option leading to challenges for staff, training opportunities for staff to improve confidence and competence in managing high acuity patients, and utilising de-escalation techniques as well as MHOST staffing being reviewed as priorities.

Process being developed to open additional beds in Newbridge House to support with patient flow and reduce spot purchase admissions.

EDI work on Meadowcroft to support staff being undertaken.

Actions Include:

- Implementation of Culture of Care Programme, additional nursing support to be provided to take forward and to include a focus on Ligature risk Assessments, care planning and risk assessment in practise. Recovery plan with the Clinical Educator to be developed.
- Training and compliance to be on the risk register for the division.
- Service to review learning from work undertake at Reaside.

- Ensure safety huddles support staff to raise issues about acuity on wards or bedroom seclusion. Ensure incidents are appropriately eclipsed.
- Pathway working with ICCR CMHTs – admission of patients known to CMHTs are being raised with the AD and CD for review as part of the safety huddle, where a known patient attends A&E an automatic notification is now made to the CMHT to offer proactive support.

Finance

Service has an overspend of between 5-15% across wards. The over recruited staff will be used to cover gaps in rotas before bank spend is considered which will help reduce the spend going forwards. The overspend on substantive staff needs to be clarified as part of the MOHOST Staffing review.

Detail of the quarterly breakdown of savings recovery plan to be shared with the Director of Finance.

3. Secure and Offender Health – 15th August 2025

The service leads focused their deep dive on the Men's Secure Services and the FIRST Team. The related service area presentation is included as Appendix IIIb. A summary of the agreed service line RAG rating is outlined in the table below:

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

The RAG ratings for Quality and Safety were revised in the meeting for Reaside and Tamarind from a 'green' to 'Amber' due to workforce and culture issues impacting Quality and safety including the night culture (Reaside) and due to recent data on prone restrains (Tamarind)

Overall Discussion

- The CD outlined that there is a Recovery plan which was submitted to NHSE for Reach Out with the following main aims:
 - Reduce delays in prison transfers
 - Reduce Clinically Ready for Discharge numbers
 - Reduce out of area placements
 - Financial recovery and stability
- LOS for Reaside and Tamarind are lower than other providers in the collaborative.
- Using the National Oversight framework metrics as a guide, national benchmarking shows that the use of prone restraint is high and seclusion is an outlier at Tamarind.
- Vacancies in OT and psychology
- Staff survey results on the themes of engagement, morale and wellbeing have improved.
- Lead Consultant will be in place in September enabling a focus on LD and Autism within the division.

Patient Reported Experience Outcome Measures (PREOMs)

The service shared the work they have developed to enable a focus on PREOMs. This was noted as good practise and enable changes to be seen over time and identify areas which need improvement. A supporting dashboard to monitor performance developed by the information team will enable regular tracking and identify areas of focus.

It was also noted that DILAOG+ has been rolled out at Reaside and Tamarind sites.

Action: To share the PREOMs work as good practise with Patient, Experience Assurance and Recovery Group.

Finance and Bank usage

The overspend at Reaside is being driven by use of bank staff. Further work is planned particularly in relation to the relationship with use of restrictive intervention..

Clinically Ready for Discharge (CRFD)

Delays due to social workers remains a continuing challenge. The service is looking to establish an inpatient social worker to enable the process to be speeded up.

The FIRST service have reviewed their model of care to increase patient flow and strengthen relationships with other trusts outside Birmingham. They are also working through plans to develop locality working.

Psychological input into Clinical Teams

There is a recognised need to increase the psychological input into the clinical teams and a business case is planned for submission to the Reach Out Collaborative for recurring funding support.

Physical Health Assessments

There is a recognised need to address inequalities of access to primary care for service users for their physical health needs resulting in A&E attendances which can require high levels of staffing to support. The service is planning to establish Advanced Clinical practitioner roles to lead on physical health and to help support service user needs more routinely.

Tamarind

- Pressures on OT/ Psychology Vacancies
- Work on night culture taking place and external speaker invited to support.
- Service experienced an unexpected death, support being provided to the family, coroners review in February 2026.
- Have received positive feedback from Reach Out Collaborative following a review

Reaside

- Overall positive CQC feedback, Reach Out reviews and Quality Network reviews.
- Positive reports following CQC MHA inspections on Dove, Severn & Hillis Lodge
- Environmental improvements in progress (Bathroom refurbishments)
- Governance in place around on-going estates works/ IPC. Alarm upgrade completed.
- Increase in patient access to activities.
- 8 remaining HCA vacancies which are being recruited to
- Joining Tamarind in sessions being run about behaviours and regular Freedom to Speak Up clinics in place
- HR clinics running monthly

4. Integrated Community Care and Recovery – 2nd September 2025

The service leads focused their deep dive on the Neighbourhood Mental Health Teams (NMHTs). The related service area presentation is included as Appendix IIIc. 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
Neighbourhood MH Teams	Green	Green	Amber	Green	Green	Amber/Green

The RAG Rating for 'External & Strategy' was revised at the meeting from a 'green' to an 'amber/green' due to ongoing work with GP practises and building relationships with the Primary Care Networks.

Quality and Safety

- Clinical supervision improvement in one of the teams required
- Staff survey focused actions being carried out.
- NMHTs are part of the divisional clinical governance and patient safety panel

Director of Quality and Safety highlighted that the National Community MH patients survey is due to go live soon and importance to publicise to encourage take up for feedback.

Operational Performance

- A locality model has been introduced in Solihull integrating the CMHTs and NMHTs to form a Community Health and Well Being Service.
- Introduced booking system practise to book appointments 5 weeks in advance to reduce DNA rates and trust cancellations. QI project in place to reduce DNAs.
- Joint referral processes planned including NMHT, CMHT, Birmingham Healthy Minds and psychology, will reduce hand offs and improve joint working relationships
- Majority of service users being seen within 4-week access target

Finance/ ARRS roles

A number of staff across 19 Primary Care Networks (PCNs) are funded through the Additional Reimbursement Roles Scheme (ARRS), these can cause challenge as the roles are not mandated and are non recurring and can as a result cause cost pressures if PCNs withdraw in favour of some non-MH roles. This remains an ongoing area of discussion and to improve understanding and contribution of the roles to PCNs.

Director of People, Strategy and Partnerships to share feedback from a recent visit to a NMHT and GP Practises as part of developing external relationships.

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
17-Jan-25	Acute & Urgent care	Urgent Care: Psychiatric Liaison/Bed Management	Amber	Amber	Amber	Amber	Green	Amber
21-Mar-25		Home Treatment	Amber	Amber	Amber	Red	Amber	Amber
21-Mar-25		HTT West	Green	Amber	Green	Amber	Green	Amber
21-Mar-25		HTT North	Green	Green	Green	Amber	Amber	Amber
21-Mar-25		HTT South	Red	Red	Red	Red	Red	Amber
21-Mar-25		HTT Zinnia	Amber	Amber	Amber	Amber	Red	Amber
21-Mar-25		HTT Solihull	Red	Red	Amber	Red	Red	Amber
24-Apr-25		South inpatient Psychology	Amber	Amber	Amber	Amber	Green	Amber
24-Apr-25		Melissa ward	Amber	Amber	Amber	Green	Red	Green
24-Apr-25		Japonica	Amber	Amber	Amber	Amber	Red	Amber
24-Apr-25		Tazetta	Green	Green	Green	Green	Red	Green
24-Apr-25		Magnolia	Green	Green	Green	Green	Red	Amber
24-Apr-25		Caffra (PICU)	Green	Green	Green	Green	Red	Green
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
18-Jul-25		Newbridge House	Red	Red	Red	Green	Red	Green
18-Jul-25		MSH1	Amber	Green	Amber	Green	Amber	
18-Jul-25		MSH2	Amber	Red	Green	Amber	Amber	
18-Jul-25		Meadowcroft	Red	Amber	Red	Red	Red	Green
18-Jul-25		Saffron	Red	Red	Amber	Amber	Red	
18-Jul-25		Lavender	Red	Red	Red	Amber	Amber	

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
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	Green	Green	Amber	Green	Green	Amber
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
2-Sep-25		Neighbourhood Teams						
20-Jun-25	Secure	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
15-Aug-25		Reaside	Amber	Amber	Green	Amber	Amber	
15-Aug-25		Tamarind	Amber	Amber	Green	Amber	Green	
15-Aug-25		FIRST	Green	Amber	Green	Green	Green	
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

Training

Ward	ELS	ILS	Safeguarding adults	Safeguarding Children	Clinical supervision
Newbridge House	75%	100%	84.6%	92.3%	81%
MSH1	93.3%	91.7%	91.7%	100%	100%
MSH2	100%	91.7%	100%	90.9%	94.4%
Meadowcroft	80%	94.1%	81.3%	94.1%	88.5%
Saffron	75%	100%	91.7%	91.7%	95.8%
Lavender	100%	92.9%	84.6%	92.3%	95.8%

Fundamental training compliance has increased across all wards, and continues to be an area of focus for Ward Managers.

*Data from
11/07/25*

Service User / Carer Experience

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

Ward	SU Feedback (July 2025)	
	Positive	Suggested Improvements
Newbridge House	• Almost all feedback is positive • Staff engagement and support is good	• Staff to be trained for gym equipment use – both staff and patients keen for this.
MSH1	• Ward are engaging in collecting SU feedback, and encouraging uptake of the EBE programme • Providing signposting to different organisations • OT utilising the discharge pack	• More variety of snacks
MSH2	• Ward are engaging in collecting SU feedback. • Providing signposting to different organisations. • More activities taking place (HCA led) and patients have been enjoying these.	• To establish morning meetings
Meadowcroft	• Signposting materials handed to staff for TWR, Recovery College and FFTs	• Food timetable in bedrooms
Saffron	• Patients are happy with the staff engagement and activities on the ward.	• Patients would like more encouragement to take part in activities when the ward is unsettled as otherwise, they tend to isolate in their rooms.
Lavender	• Patients engaging well with staff & the daily activities • Patient requested a larger display of the activity timetable – this has been printed and displayed in communal areas	• Inconsistency between day and night staff, with day staff being more engaging

Areas for Improvement

- High acuity of patients in Zinnia is leading to challenges:
 - High number of patient on patient, and patient on staff assaults.
 - Bedroom seclusion is currently not permissible.
Consideration being given as to whether we should issue guidance on this and then measure adherence to the guidance.
 - Considering training opportunities for staff – to improve confidence and competence in managing high acuity patients, and utilising de-escalation techniques.
 - MHOST staffing being reviewed and looking to implement in Zinnia as a priority.

Achievements

- Process being developed to open additional beds in Newbridge House to support with patient flow and reduce spot purchase admissions.
- Focus on 'People' KPIs has led to improvements.
- EDI work on Meadowcroft to support those staff who are facing racial abuse from patients.

Secure and Offender Health Directorate Accountability Framework domains self-assessment

Tamarind

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Tamarind Centre	Amber	Green	Green	Amber	Green	

Quality and Safety

- Unexpected death of a service user July 2025 –staff respond promptly & appropriately, date set for coroner’s inquest. Family given support.
- Reach Out Review completed awaiting report – positive feedback.
- EBE involvement now embedded enhancing service user representation
- Sustainable community Initiatives – sports, music production and podcasting programme has been well received promoting engagement and wellbeing
- Working closely with Clinical Inequalities Leads to raise staff awareness & understanding of PCREF
- Culture of Care programme started – successful event in July
- Dialogue+ rolled out.
- Alarm/ pager system resolved since last deep dive. Ongoing repair and maintenance of estates – building now 13 years old
- Majority of B6s and B7s have completed ERA/LRA training.

Operational Performance

- KPIs remain above Trust targets since last Deep Dive (reported as green)
- CPA completed in first 3 months and 6 monthly 94%
- Factors affecting length of stay include long waits for BCC to carry out Social Worker Assessments – long waiting lists to transfer to local CMHTs/ AOT/ LSU. Eg X1 on Laurel over 560 days CRFD.
- Lack of national male MSU beds has resulted in number of patients waiting on the REACH OUT OOA bed list and knock on effect for admission waiting times from prison.

Workforce and Culture

- Fully recruited for Medics, RMNs & HCAs
- OT/ Psychology Vacancies.
- Band 5 & B3 Development Programmes up and running since – well received
- No major employee relations issues
- Ongoing work to address night culture & sexual safety (including external speaker)
- Sickness up by 2% since last deep dive (LTS 4.5%)
- Culture of Care- EBEs involved in completing PREOMS on all wards.
- EBE presented it at PCG on 14.8.25



Secure Care PREOM - Tamarind Centre



This report collects information recorded in Secure Care PREOM (Patient Reported Experience and Outcome Measure) forms and presents average scores by quarter. The averages are calculated by dividing the sum of each score by the number of forms completed (but not including forms where the service user has refused to record scores). The maximum possible score for each question is 10 and for the total score is 80.

Select Quarters

All Quarters

2 Quarters

Select Wards

Acacia

Cedar

Hibiscus

Laurel

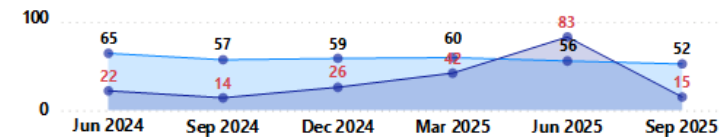
Lobelia

Myrtle

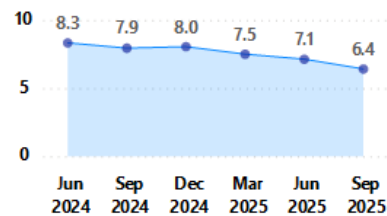
Sycamore

Secure Care PREOM - Totals

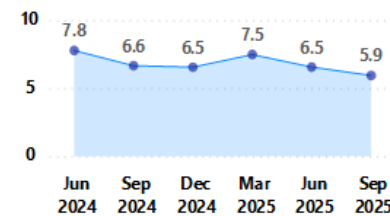
● Average of Total Score ● Forms Completed



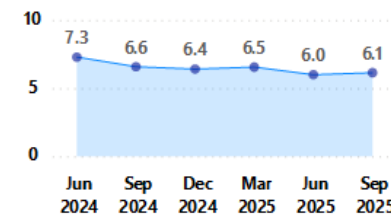
1. Having Hope



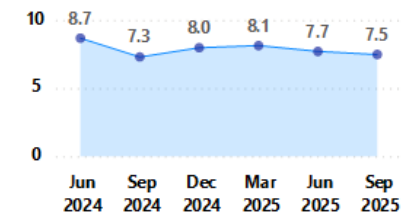
2. Equal Say



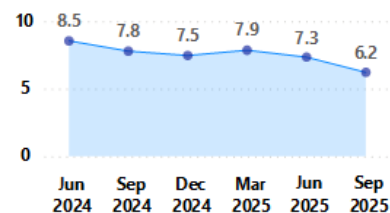
3. Part of Improving the Service



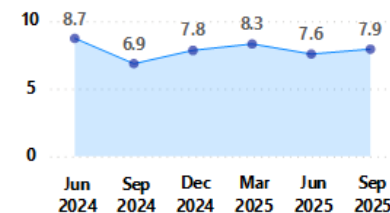
4. Understanding my Mental Health



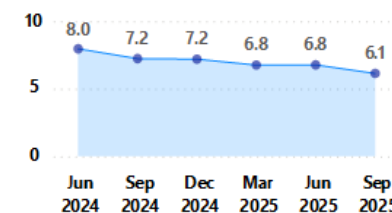
5. Feeling good about myself



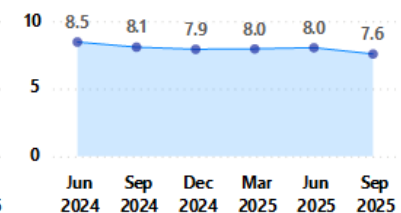
6. Feeling Safe



7. Interesting Activities



8. Supported to Stay in Contact



[Contact Us *](#)

User: BSMHT\m-martinezrubio

Refreshed Date: 01/08/2025 15:41

Report ID:

Finance

- Is overspent by £20k, pay is over by £101k of which Nursing and HCA overspend is £183k, this is offset by EPC's income which overperforming by £88k.

- Working above 93%, at 98% occupancy for significant part of the year
- Working closely with managers to reduce bank spend & improving roster management.
- Zero Agency spend.

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

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

Reaside

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Reaside & Hillis	Amber	Green	Green	Amber	Amber	

Quality and Safety

- Section 29A notices removed, overall positive feedback from CQC, QN and Reach Out Reviews.
- Positive reports following CQC MHA inspections on Dove, Severn & Hillis Lodge
- Environmental improvements in progress (Bathroom refurbishments)
- Reduction in Restrictive Practices
- EBE involvement now embedded
- On going Culture of Care programme
- Dialogue+ rolled out.
- Governance in place around on-going estates works/ IPC.
- Increase in patient access to activities.
- On going work with pathway to independence.
- Increase in paid roles for service users- plan to roll out further to open on site barbers and coffee shop (Service user Lead)
- Capital funds bid in place to improve sportsfield.

- Alarm upgrade completed.

Operational Performance

- KPI's largely on target, although sickness remains above trust target.
- 100% CPA Completion

Workforce and Culture

- On going Culture of Care programme
- Fully recruited for RMN's, 8 HCA Vacancies (Recruitment 22/8)
- OT/ Psychology Vacancies.
- No issues with medical workforce
- On going challenges with culture- largely during night shifts
- Regular FTSU clinics in place
- SLT Walk arounds continue.
- Delays in resolving HR cases.
- HR Clinics running monthly

Finance

- Overspend on Nursing workforce
- Overspend on sponsorship, no budget line in place for this.
- EPC's in place
- Working over target occupancy of 93% currently at 97%
- Zero Agency use
- Working closely with managers to reduce bank spend & improving roster management- Piloting auto roster
- Bi Monthly finance reviews in place.

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

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



Neighbourhood Mental Health Teams (NMHTs)

Community Mental Health and Wellbeing Service

Neighbourhood Mental Health Teams (NMHTs) and Community Mental Health Teams (CMHTs) are the two pathways working together under the umbrella of the **Community Mental Health and Wellbeing Service.**

Neighbourhood Mental Health Teams

The Neighbourhood Mental Health Teams are the front door to the service and they bridge the gap between GP only mental health care and traditional secondary care. They are multi-disciplinary teams offering support to individuals whose needs won't be met by talking therapies but may not need to be under a Community Mental Health Team.

Quality and Safety



Supervision

Regular Management Supervision	
Neighbourhood MH Team East	82%
Neighbourhood MH Team North	92%
Neighbourhood MH Team Solihull	86%
Neighbourhood MH Team West	44%
Neighbourhood MH Team South	71%

Clinical Supervision	
Neighbourhood MH Team East	71%
Neighbourhood MH Team North	90%
Neighbourhood MH Team Solihull	86%
Neighbourhood MH Team West	91%
Neighbourhood MH Team South	78%

Mandatory Training

Fundamental Training	
Neighbourhood MH Team East	92.5%
Neighbourhood MH Team North	97.6%
Neighbourhood MH Team North Solihull	93.6%
Neighbourhood MH Team South Solihull	87.9%
Neighbourhood MH Team West	95.6%
Neighbourhood MH Team South	91.1%



- John Travers attends business meetings to discuss results with Hub Managers
- Hub Managers disseminate results and discuss with their teams
- Clinical Services Managers meet with teams and agree 3 areas of focus for the coming 12 months
- Agreed actions are regularly reviewed by the ICCR DLT

Governance

- NMHTs are part of the core membership of CGC and the patient Safety Panel
- There is a robust system for sharing lessons and reviewing actions across both pathways

Operational Performance



Solihull Community Mental Health and Wellbeing Service

- Integrated core mental health teams is a core aim of community transformation plans, to effectively meet the bio-psychosocial support needs of those experiencing mental health difficulties in the community.
- It is expected that joint working as integrated teams will enable collaborative working between community mental health provisions and neighbourhood partners, thus reducing the need for multiple referral and transition points.
- Whilst the NMHT and CMHT are both part of the CMHWS, the operational arrangements mean that both functions typically delivered as separate teams that interface with each other, rather than operating in a truly integrated way.
- Due to the geographical spilt of the 'North' and 'South' Solihull patches, having a single NMHT interfacing 2 CMHTs (Newington & Lyndon) and 5 PCNs with different local population needs have identified areas for improvement and an opportunity to pilot local integrated and co-located CMHWS teams.
- Approval to proceed with pilot obtained from ICCR associate director in Jan-24.



Aims and Outcomes

- Improved integration of both pathways within CMHWS
- Improved staff experience and morale
- Improved patient experience and outcomes
- Improved performance through joint working arrangements to minimise barriers and the need for additional transition points
- Improved GP understanding of single team provision and pathway

- Teams are now fully integrated into the CMHWS, including shared functions such as admin, Psychological Services and 18 to 25 provision.
- Staff feedback has been positive. They enjoy this way of working, have gained a greater understanding of each pathway, feel that the Hub Manager is more visible and present (as they are not having to travel across two sites), and the NMHT practitioners have reported that they no longer feel isolated
- Have implemented a revised appointment booking system, which has reduced Trust cancellations and allowed for greater flexibility to book appointments based on changing clinical need. Work is ongoing to analyse the impact on DNA rates, however early indicators demonstrate some improvement in this area.
- Performance for both Hubs is good across several different KPIs. Some areas that require further improvement (such as completion of DIALOG+ care plans) however plans are in place to address these.
- Resilience in the workforce and managing demand has significantly improved as staff will cross cover both pathways, when needed



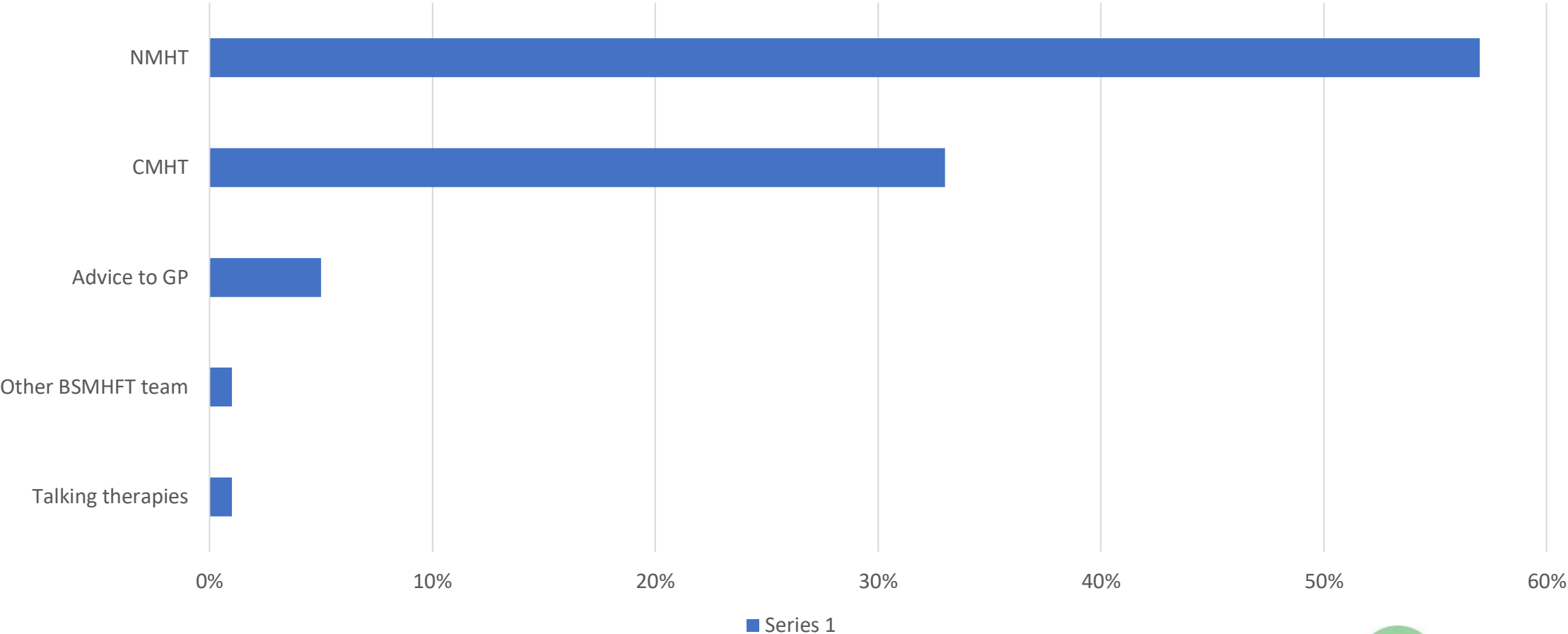
Joint Referrals Process

- Collaborative discussion at the referral/triage stage between NMHT and CMHT, and now including BHM and CMHT psychology
- Supporting the allocation to the most appropriate pathway and person at the point of referral
- Reducing pass-around of referrals
- Better relationships, better understanding of services, better outcomes



Examples of NMHT impact on CMHT – referral allocations

West Joint referrals meeting outcomes – May 2025



Examples of NMHT impact on CMHT - referrals

Start of joint referral meeting

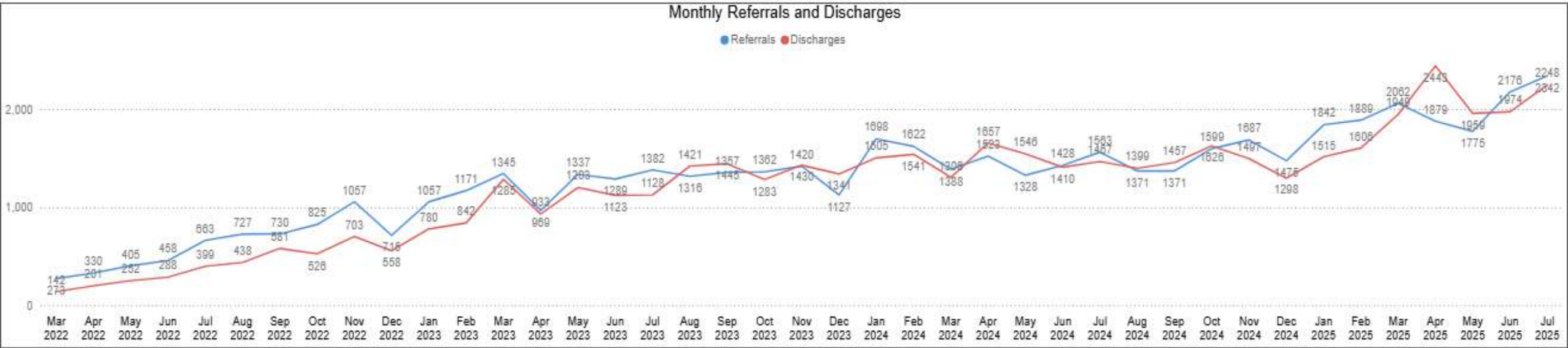


Start of joint referral meeting



Referral data

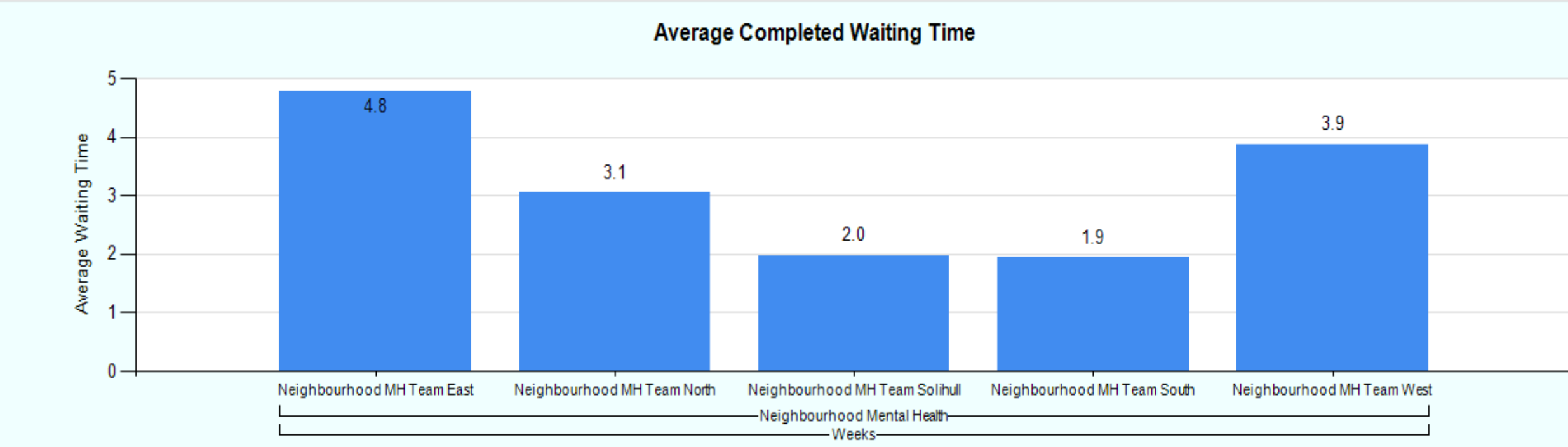
From March 2022 to July 2025..... Total 53200



Year	2022 (from March)	2023	2024	2025 (up to June)
Number of referrals	6174	15103	18034	13895

Waiting times – completed waits

Service Referral to First Contact (Completed)



Examples of NMHT impact on CMHT - discharges

NMHT Discharge Data - 12 months from 1st August '24 to 31st July '25

Total discharges – **20911**

Total with discharge reason 'escalated to secondary care' – **613 (2.9%)**

Last 7 months....escalated to secondary care

Jan '25	Feb '25	March '25	April '25	May '25	June '25	July '25
3.6%	2.2%	2.1%	2.2%	3.4%	2.3%	2.6%

Improvement Initiatives

- Focus so far on front door and making access easier and quicker
- Supporting with CMHT caseloads to prevent escalation where safe to do so
- CMHTs are now focusing on management of caseloads through validation of complex cases and PIFU (Patient Initiated Follow Up)
- Operational performance is monitored across the CMHWS in fortnightly meetings chaired by the Associate Director
- Quality Improvement project started in East NMH to improve DNA rates
- Clinical Service Managers for the CMHWS review the list of service users in A&E daily and request teams to follow up and look at potential future prevention. This includes the NMHTs
- Active work in East with the 24/7 team to improve local provision and access
- Working with Acute and Urgent Care to strengthen relationships and pathways



Workforce and Culture



Our team roles and focus on prevention

Public Board of Directors

Assessment, intervention, liaison with other agencies

Supporting more complex social issues, and link with BCC

Medication reviews and support for GPs and staff

In partnership with The Active Wellbeing Society. Supporting people to engage in SMI annual physical health checks.

In partnership with MIND and LWC. Focusing on social determinants and barriers to accessing support. Strong links with VCSFE



Neighbourhood Mental Health Teams

Assessment and prescribing within GP surgeries

Supporting with complexity, clinical education

Engagement with PCNs and other partners, and leadership of team

Clinical support and supervision of staff, support into PCNs



Supporting with complexity and support for GP



Our teams and work within PCNs

- Our teams are configured around PCNs, and some of our staff are ARRS workers (Additional Reimbursement Roles Scheme). They are 50% funded by PCNs and partly work within the PCN, holding clinics in GP surgeries
- We have ARRS workers in 19 of the 35 PCNs in Bsol



Our teams and work within PCNs

- Hub Managers are regularly meeting with PCN leads, practice managers and GPs
- ARRS roles are continuously reviewed to ensure effectiveness
- Ongoing promotion to PCNs to support uptake of ARRS roles
- Presentations and engagement with the GP Clinical Reference Group and GP Support Unit
- One of our Physical Health Connectors (contract with The Active Wellbeing Society) was recognised at the Smartcare PCN awards, by being awarded for her work to support those on the Serious Mental Illness register access physical health checks

- All Neighbourhood Teams are performing within budget, and there are no particular hotspots or areas of concern. Baseline staffing continues to be monitored as we understand demand.
- Because ARRS roles are 50% funded by PCNs there is potential for this to be a changing picture (i.e. if a PCN withdraws or a PCN requests a further ARRS role), potential cost pressure, reviewed on an ongoing basis.

Strategy, Transformation & External



Strategy, transformation and external – Interface work

- **MAT (Multi Agency Team) meeting**

This is a meeting led by NMHT in each locality, which has attendance from primary and secondary care, talking therapies, and VCSFE such as drug and alcohol services. It brings people together to aid better communication and to discuss clinical cases which may require a multi-agency approach

- **INT (Integrated Neighbourhood Teams) and Locality Hubs**

NMHTs are working with the Community Care Collaborative on the PCN based INT model. We are offering some resource into the 5 initial INT PCN sites, and we are exploring options to support the roll-out, with the initial focus in East



Strategy, transformation and external – Clinical work

- **Complex Emotion and Trauma**

After recognising a gap between primary and secondary care for those with a need around managing emotions, we are currently piloting a DBT skills group for NMHTs. We are working closely with the CASCADE team

- **Bipolar and Psychosis screening tool**

We are piloting the use of a screening tool in 2 NMHTs with the aim of earlier identification and assessment, earlier specialist care, earlier treatment and diagnosis, and better clinical outcomes

- **Specialist Psychotherapy Service**

We are in the planning stages of a pilot in which SPS would accept transitions directly from NMHT and BHM, rather than having to go through CMHT. This would dissolve traditional barriers in referrals to SPS

Strategy, transformation and external – continued work with partners and VCFSE

- **Peer Support Workers**

We are enhancing our teams by introducing Peer Support Workers. There are some roles that will be based with the recovery college but will in-reach to NMHTs, and there are some roles based within NMHTs specifically to support those experiencing domestic violence

- **Examples of engagement with communities through VCFSE**

East NMHT have recently met with a Somali Women's group to think about how we can better engage the community and what the barriers are for them

We are working with the lead for the Nechells Pod to hold a clinic there, supporting people to access services in their communities

- **The Active Wellbeing Society and Birmingham MIND embedded into workforce (see workforce and culture slide)**



Service user feedback - April

96% of respondents said they would or they might use the service again

*She took the pressure and any associated anxieties away and **made me feel more hopeful** that there was help for me.*

Staff member* was very good **he listened to all my concerns and my wife's he was not rushing he took **time care and patience** to hear me he was very thorough in his work thank you*

*I was **listened to**, all my options were clearly explained, I wasn't hurried at all. I felt **reassured**.*

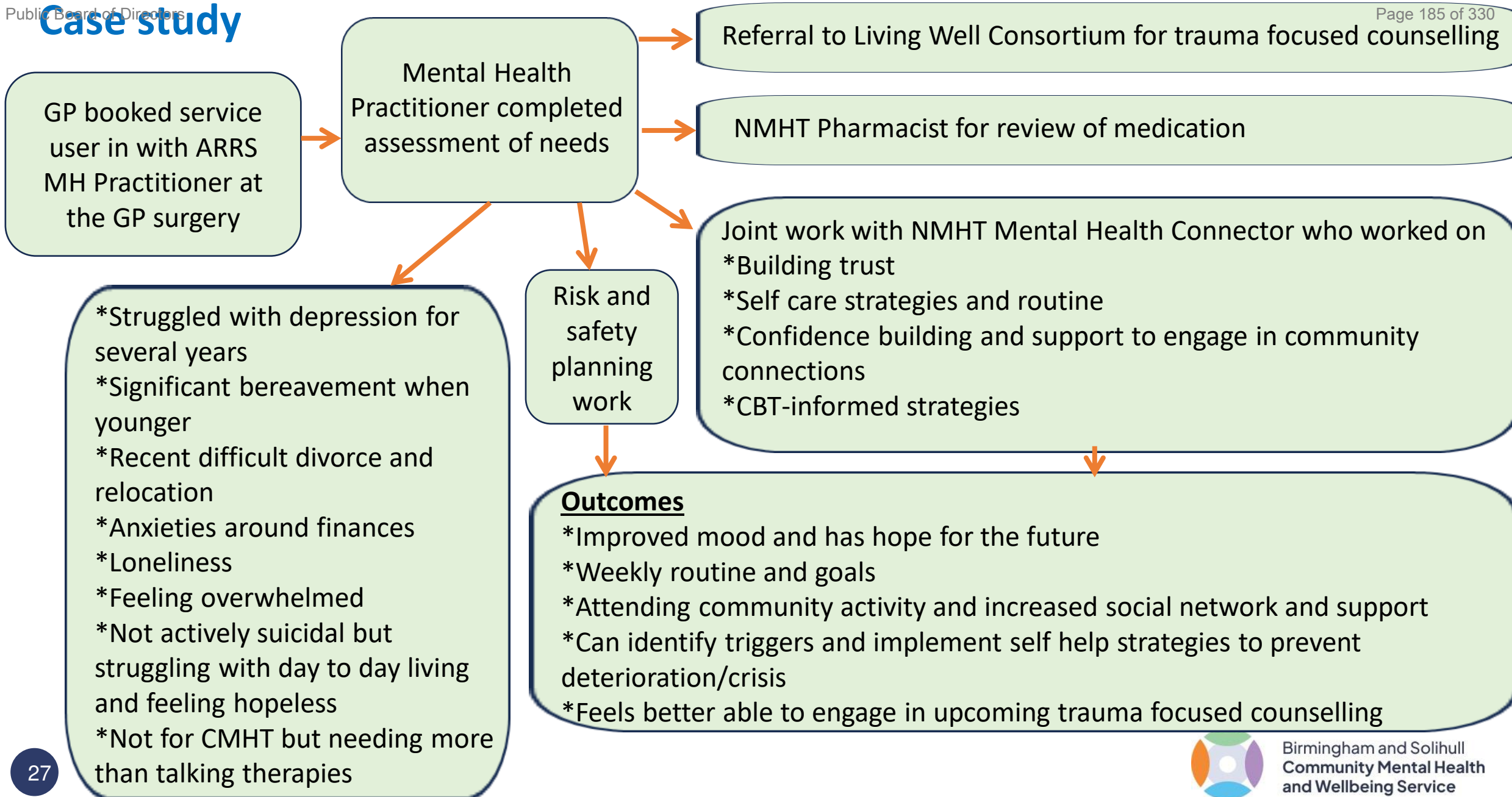
*I would have definitely **struggled without them**. I couldn't praise my mental health practitioner enough.*

*Thank you for providing a **safe space** for me to open up ! It was wonderful and I actually feel helped and **seen for the first time** !*

*Nurse **listened** to me
Made me feel **comfortable**
Helped my anxiety*



Case study



RAG ratings

Quality and safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation and External	Overall
GREEN	AMBER	GREEN	GREEN	GREEN	GREEN

Committee Escalation and Assurance Report

Name of Committee	Quality, Patient Experience and Safety Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	17 September 2025
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report, inc Safe Care Today Dashboard • Regulatory Compliance Report • Assertive and Intensive Action Plan • Patient Safety and Customer Relations Report • Mental Health Legislation Committee Escalation Report • Patient Experience and Recovery (PEAR) Group Assurance Report • Family and Carer Proposal • Reducing Restrictive Practice Report • Clinical Governance Committee Assurance Report • Winter Plan and Board Assurance Statements • Safeguarding Annual Report 2024/25 • Safeguarding Management Board Assurance Report
Alert:	• Data quality issues were highlighted, and the Committee discussed the need for robust oversight of data to ensure that reporting was consistent. • The Committee noted that there were low levels of compliance in safeguarding children and adults training for CYP. A deep dive into all non-compliant areas was being undertaken. • The Committee was alerted to an issue under the Mental Health Act, noting that there were instances of wards and team where there was no permanent assigned Responsible Clinician in post. Current practice was to assign a nominal Responsible Clinician, however the issue remained a challenge to meeting MHA requirements.
Assure:	• The Committee was assured by the Safeguarding Annual Report for 2024/25 and formally endorsed the report. • The report into Reducing Restrictive Practice provided positive assurance, particularly in relation to working across divisions to embed good practice. • The Committee received assurance on the progress of the Larimar incident and plans for internal investigation. • The Committee was assured by the Assertive and Intensive Action Plan, noting the comprehensive reporting and approach. • Winter Plan and Board Assurance Statements were reviewed and endorsed by the Committee.



Advise:	The Committee received information on the intention to roll out the Culture of Care programme to acute wards. An update was received on the development of a Safe Care Today dashboard, which would complement early warning data and the Integrated Performance Report. The Committee was advised on continued preparations for a CQC well-led inspection. The Committee had endorsed a proposal to incorporate five Family and Carer principles into the new Trust strategy.
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: Kat Cleverley, Company Secretary



Committee Escalation and Assurance Report

Name of Committee	Quality, Patient Experience and Safety Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	19 August 2025
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • National Oversight Framework (joint section with Finance, Performance and Productivity Committee) • Board Assurance Framework Risks • Regulatory Compliance Report • Complaints Progress Report • Clinical Governance Committee Assurance Report • Clinical Effectiveness Advisory Group Assurance Report • Quality Partnership Model
Alert:	The Committee wished to alert the Board of Directors to the management and analysis of complaints process, which was currently being closely monitored. There were a number of deep dives planned, benchmarking data was being reviewed, and the incorporation of health inequality data was being considered to ensure complaints were reviewed and concluded on time.
Assure:	• Assurance was received on the processes to manage clinical effectiveness, including increased recommendation and action tracking and management of clinical audits. • Positive assurance was received on swifter allocation of complaints and closer working with other agencies to conclude on time.
Advise:	• The Committee welcomed the introduction of quality and safety partners under the Quality Partnership Model. • The Committee received information on draft CQC reports into recent inspections and was advised of the progress of external and internal investigations into the Larimar incident. • The Committee noted the preparations that were ongoing for a CQC well-led inspection.
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. The Committee highlighted the increase in risk scores for SR3 and SR4, and recommended this to the Board of Directors.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Linda Cullen Non-Executive Director	Minutes available from: Kat Cleverley, Company Secretary

Report to Board of Directors						
Agenda item:	11					
Date	1 October 2025					
Title	Quality and Safety Report					
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality and Safety/Chief Nurse					
Executive Director	Lisa Stalley-Green	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 safety, clinical effectiveness, patient experience, regulatory responsiveness and progress, continuous learning and quality improvement. Patient Safety Investigation and Review Updates During the reporting period there has been an inpatient death from a suspected natural cause in an Acute Inpatient ward. This will be examined through a Structured Judgement Review (SJR) under the Learning from Deaths (LfD) process. There has also been a suspected suicide reported within the CYP service, a patient under the Home Treatment Team for Children & Young People, this will discussed at their local PSIRF meeting to agree the most appropriate learning response. At present, we have four Patient Safety Incident Investigations (PSIIs) open, the most recent relates to an inpatient death on Larimar Ward. Terms of reference for this investigation have been drafted and shared with the ICB, who confirmed they had no further input. The family has also received the terms of reference and have been invited to contribute to these. The investigation includes External Reviewers and will be completed by the end of November. A number of learning responses have been completed. One explored physical observation practice and the timely completion, where it was found that cognitive overload was a factor, with staff relying on memory due to technology not functioning reliably. In addition, timeframes set within the portal did not adequately account for the time required to log on and record observations, creating further barriers. A review of the "What Handover" tool was also undertaken using the SEIPS framework, which identified						

that the format of the form was not helpful, with duplication contributing to poor quality handover. Recommendations include improving where the information can be pulled through automatically and considering an electronic white board on wards and action log as part of the tools and technology available to support staff. To address risks linked to AWOL incidents, approval has been secured to digitalise AWOL paperwork and to ensure patient telephone numbers are automatically pulled through into the leave agreement portal, enabling staff to confirm details with patients at the point of leave.

In response to learning from a PSII, the EDI team will shortly be hosting an event aimed at improving cultural competency and specifically deepening understanding of the Somali community. Alongside this, a quality improvement project has been commissioned following a themed review of incidents involving racial abuse towards staff. A highly interactive learning event was also held September, delivered in partnership with Women and Theatre, which focused on assessment practice, telephone contact, and family engagement.

Finally, we continue to strengthen compassionate engagement with both staff and families following incidents. A framework has now been agreed for involving families and service users in After Action Reviews (AARs), ensuring that their perspectives and experiences are embedded in the learning process. This forms part of our broader commitment to openness, compassion, and continuous improvement in patient safety.

Safe Care Dashboard

The new Safe Care Dashboard Prototype can be found at Appendix One

The Trust is developing a ward to board safe care dashboard which can be reviewed in Divisional governance meetings and then assured on through a corporate level Quality Assurance Group reporting into Clinical Governance Committee, Quality and Patient Experience & Safety Committee and Board. The data is drawn from a number of areas so will require the Informatics Team to review their use of resources and reduce any duplication with the Trust Integrated Performance Report. The dashboard has been shared with Teams, Non-Executives, the ICB, NHSE and CQC as part of the System Quality Improvement Group for feedback and any additional essential metrics. By December we would expect to see effective use of the dashboard at all levels in the organization for improvement and assurance.

Bronze, Silver, Gold Escalation

Following the Clinical Governance Committee and escalation from the Acute and Urgent Care Division the Home Treatment Team services have entered the Bronze, Silver, Gold improvement process due to issues with capacity, leadership and quality standards. Progress will be monitored through the CGC.

Culture of Care

The Board Strategy Session recently received a presentation on the innovative work completed at Reaside Clinic in establishing a framework for Patient Reported Experience and Outcome Measures (PREOMS), this framework will be shared across the Trust for implementation in all the inpatient wards

with the support of the Patient Experience Team. The work will be steered by the Patient Experience and Recovery Group.

Regulation Activity

Care Quality Commission (CQC) Well-led Preparation

We continue to prepare for an anticipated well-led inspection later this year and have been working closely with Corporate Governance colleagues to identify any gaps and consider plans for how these will be addressed. We have completed an analysis of CQC feedback from the 2022 inspection as well as considered the ratings for well-led for each service/ team and have been utilising this information to create and action plan. The Head of Compliance and Associate Director for Corporate Governance will be delivering a presentation at the next Senior Leaders' Forums in September and October. We plan to share feedback from Nottingham Mental Health Trust following their recent Well Led Review and will further prepare leaders and staff for the opportunity to showcase their improvements, achievements, best practice and grip of risk areas to further identify any leadership needs and how staff want to be supported going forward.

Areas of clinical focus include – care plans and risk assessments, workforce and skill mix, staff training compliance and competence, staff survey, governance structures and ward to Board arrangements, service user voice up to Board level, medication management, clinical and management supervision, access to therapeutic activities, restrictive practice, seclusion and segregation approach.

Current Well-led ratings for the Trust and service level:

- Overall – Requires Improvement
 - Dementia and Frailty – Requires Improvement
 - Acute Care – Requires Improvement
 - Secure Care – Requires Improvement
 - Steps to Recovery – Requires Improvement
 - Urgent Care – Requires Improvement
 - CMHTs - Good
 - Cilantro – Good
 - Reaside – Good

The approach to take this work forward is to develop a clear plan of action relating to communication plans, resources, learning from other Trusts that have been through the well-led process under the Single Assessment Framework and working groups to focus on targeted topics.

There has been no new activity in the last month for CQC inspections or assessments. The Trust has not yet received the report for the inspection of Acute Care wards that was completed in June 2025 and therefore the Section 29As for the Zinnia inpatient wards remain in place until we receive this.

Following the completion of the rapid quality review of Larimar and the findings from the Mental Health Provider Collaborative (MHPC)/ Integrated Care Board (ICB) and the Care Quality Commission's (CQC) visits in July, there is now an improvement plan in place for the ward. A weekly triple A report is also being completed by the Matron to advise key stakeholders on activities and any areas for improvement

on the ward. The Compliance team has also been completing remote audits on the qualitative aspects of care plans and risk assessments as a further level of assurance. These have largely shown positive progress with issues identified in previous audits being addressed.

One of the key outcomes of the rapid review was the establishment of a monthly quality oversight group chaired by the Chief Nurse for the ICB with NHSE, CQC and members of the Trust in attendance. Updates provided included the updated improvement plan, summary of key actions and changes made to date and a presentation detailing the launch of the Culture of Care in Acute and Urgent Care. These documents were well received and improvements by noted by the group, however it has been requested that more data is provided at the next meeting to visibly demonstrate the improvement journey. We believe the early warning dashboard currently being developed will meet this need.

The new Mental Health Lead for the CQC visited the Trust on September 11th as he was in the area for another event. He was hosted by our Chief Executive and went to the Oleaster.

Culture of Care Update

The programme has been successfully rolled out across all three Secure Hospitals and was launched in Acute Care in August. The programme details including the aims and success stories to date were shared as part of a presentation to Trust Board colleagues as part of their development session on September 10th. Please see details below of the Culture of Care details for the relevant wards. There is also a national Ward Manager Leadership Development Programme, and a number of managers from across Divisions have registered for this to date. A dashboard is also being developed to showcase performance against the 12 Culture of Care standards, and these are aligned to the CQC I statements.

Eighteen-month projects:

Forward House, Sage Ward, George ward and Severn Ward

Six-month project over two Cohorts:

Hertford House, Chamomile Suite, Jasmine Suite, Cilantro Suite, Rookery Gardens, Citrine Ward, Eden Acute and Magnolia

Going forward the programme will be rolled out in Older Adults and Specialties between October and November 2025 and Steps to Recovery in December 2025.

The Mental Health Provider collaborative provides 'safe and well' checks for patients and the Trust would like these to be shared with the safeguarding team and Associate Chief Nurse following visits and follow an escalation process where immediate concerns are raised. Currently the CQC provide a report

Recommendation

The Board is asked to: Discuss the report and review the supporting data set and dashboard. Identify any gaps or additional work or assurance required.

Enclosures

Safe Care Dashboard

Safe Care Data Set



Early warnings Dashboard

Overview: Inpatients

Code	Indicator	Standard	Indicator value	Previous value	Reporting frequency	Reporting period
Inpatient Care						
1.1	Number of patients waiting for a bed		27	43	Monthly	August 25
1.2	Number of patients clinically ready for discharge		23	31	Monthly	August 25
1.3	Number of readmissions within 28 days		2	5	Monthly	August 25
1.4	Deaths within 30 days post discharge		0	0	Monthly	August 25
1.5	Wards with staffing under 80%		0		Monthly	August 25
1.6	Wards with staffing over 125%		6		Monthly	August 25
1.7	Number and proportion of patients requiring enhanced observations (1:1 or greater)		12.6%	13.7%	Monthly	August 25
1.8	Number of patients secluded		9	14	Monthly	August 25
1.9	Episodes of seclusion		11	19	Monthly	August 25
1.10	Number of patients prone restrained for anything other than intramuscular tranquilisation		14	13	Monthly	August 25
1.11	Number of patient prone restrained for more than 10 minutes		5	3	Monthly	August 25
1.12	Episodes of rapid tranquilisation		139	95	Monthly	August 25
1.13	Number of incidents where patients went AWOL and came to harm		1	0	Monthly	August 25
1.19	Number of total incidents of moderate harm and above		28	40	Monthly	August 25
1.20	Risk Assessments Updated by Ward (%)		98%	98%	Monthly	August 25
1.21	Safety Plans Updated by Ward (%)		48%	45%	Monthly	August 25
1.22	Action Plans Updated by Ward (%)		82%	79%	Monthly	August 25
1.23	Clinical Supervision (%)	>95%	82%	82%	Monthly	August 25

Overview: Inpatients

Code	Indicator	Standard	Indicator value	Previous5.8 % value	Reporting frequency	Reporting period
Inpatient Care						
1.24	Ward Risk Audit		94%	91%	Monthly	August 25
1.25	Ward Named Nurse Audit		81%	-	Monthly	August 25
1.26	Ward Care Plan Audit		-	-	Monthly	
1.27	Ward Patient Record Audit		-	-	Monthly	
1.28	PALS Cases		12	13	Monthly	August 25
1.29	Complaints		3	6	Monthly	August 25
1.30	Compliments		0	1	Monthly	August 25
1.31	Safeguarding Referrals		10	8	Monthly	August 25
1.32	Safeguarding Training Compliance		95.7%	95.4%	Monthly	August 25
1.33	IPC Monthly Audit (%)	>95%	91.9%	91.9%	Monthly	August 25
1.34	Hand Hygiene Audit (%)	>95%	91.7%	85.8%	Monthly	August 25
1.35	Infection Prevention and Control Training (%)	>95%	94%	94%	Monthly	August 25
1.36	Ward Incidents		753	694	Monthly	August 25
1.37	Bed Occupancy		96.9%	96.7%	Monthly	August 25
1.38	Sickness Rate		8.7%	9.5%	Monthly	August 25
1.39	Short Term Sickness Rate		2.8%	3.7%	Monthly	August 25
1.40	Long Term Sickness Rate		5.9%	5.8%	Monthly	August 25
1.41	ELS/ILS Training Compliance		88%	89%	Monthly	August 25
1.42	AVERT Training Compliance		98%	98%	Monthly	August 25
1.43	Oliver MacGowan Training Compliance		99%	99%	Monthly	August 25
1.44	Harm Free Days		76%	80%	Monthly	August 25

Overall: Community

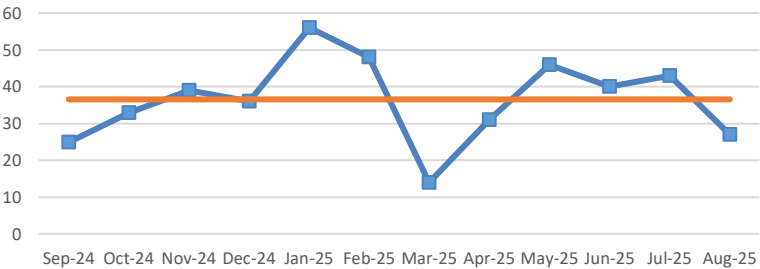
Code	Indicator	Standard	Indicator value	Previous value	Reporting frequency	Reporting period
Community service metrics (Local MHTs - LMHT, EIP & MHSOP CMHT)						
2.1	Compliance with 72 hour follow up standard	80%	78.8%	83.5%	Monthly	August 25
2.2	Compliance with 18 weeks wait standard for assessment		90.0%	88.6%	Monthly	August 25
2.2	Compliance with 18 weeks wait standard for assessment (SNOMED)		62.3%	60.8%	Monthly	August 25
2.4	Compliance with 18 weeks wait standard for treatment		75.0%	71.4%	Monthly	August 25
2.5	Number of patients awaiting CCO allocation not on the active caseload of another NHT team					
2.6	Contact DNA Rate		18.6%	18.7%	Monthly	August 25
2.7	Patients declined for service and death within 6 months (placeholder)					
2.8	Patient Risk Assessments up to date community		76.7%	79.7%	Monthly	August 25
2.9	Clinical Vacancy Rate in Community Teams					
2.10	Compliance with 14 day follow up by CMHT after HTT discharge		38.2%	39.4%	Monthly	August 25
AMH & MHSOP Crisis & HTT metrics						
3.1	Clinical Vacancy rate in crisis response service					
3.2	Patient risk assessments updated		90%	92%	Monthly	August 25
3.3	Proportion of very urgent patients seen within four hours					
3.4	Proportion of very urgent patients seen within four hours face to face					
3.5	Proportion of urgent patients seen within 24 hours					
3.6	Proportion of urgent patients seen within 24 hours face to face		57.1%	56.0%	Monthly	August 25
3.7	Proportion of patients seen by Home Treatment within 72 hours post discharge (3 day follow up)		78.8%	83.8%	Monthly	August 25

Overview: Urgent Care

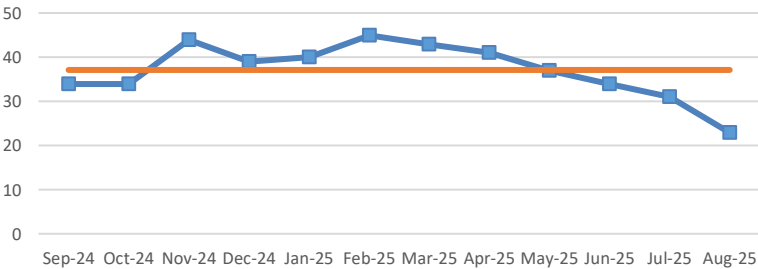
Code	Indicator	Standard	Indicator value	Previous value	Reporting frequency	Reporting period
Urgent Care						
4.1	Psychiatric Liaison Response to Emergency Department Referrals (1 hour)		88.9%	88.2%	Monthly	July 25
4.2	Average time spent in Place of Safety (Hours)		13	13	Monthly	July 25
4.3	Inpatient Admission Rate from Place of Safety		20.2%	29.3%	Monthly	July 25
4.4	Average time spent in Psychiatric Decision Unit (Hours)		39	57	Monthly	July 25

1. Inpatient Services

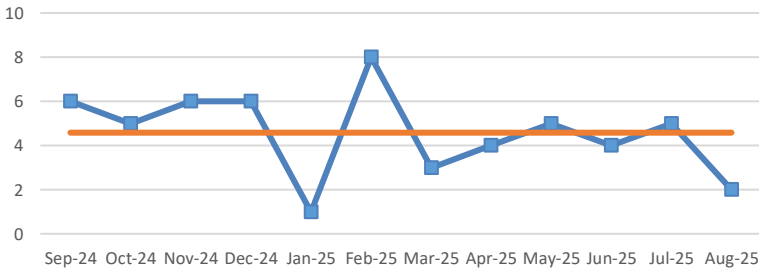
1.1 Patients Requiring Admission



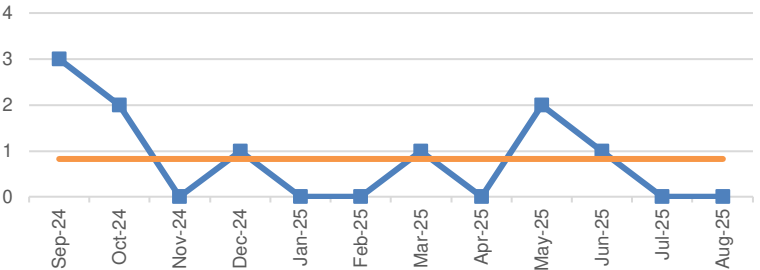
1.2 Patients Clinically Ready for Discharge



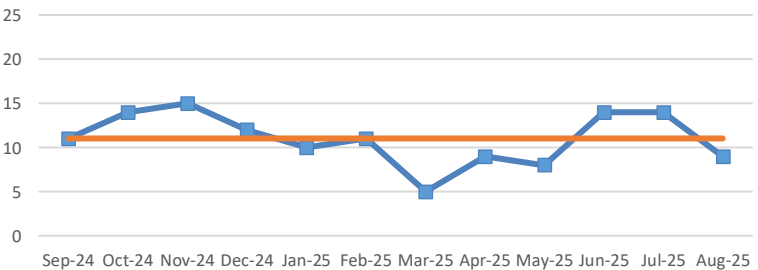
1.3 Number of readmissions with 28 days



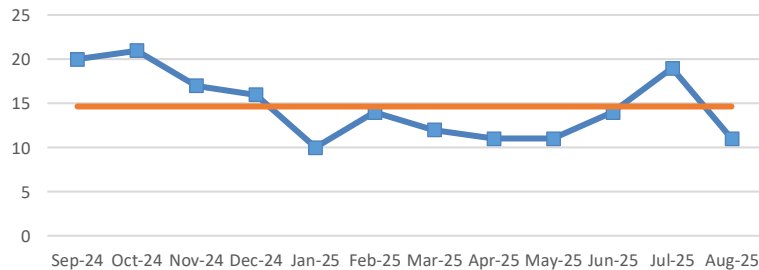
1.4 Deaths within 30 days post discharge



1.8 Patients Secluded



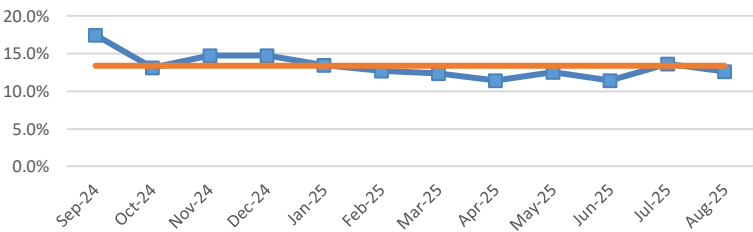
1.9 Episodes of Seclusion



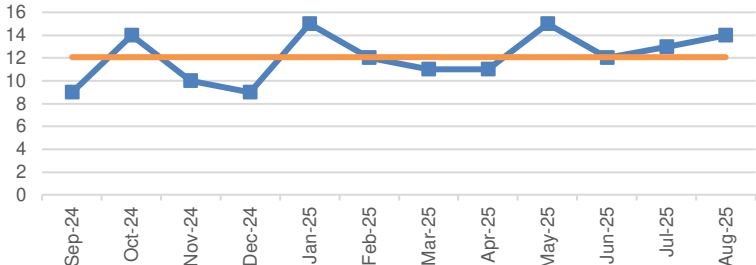
— Monthly Performance
— Average Performance (last 12 months)

1. Inpatient Services

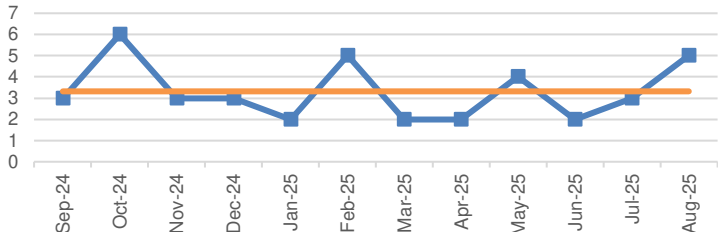
1.7 Proportion of Patients requiring Enhanced Observations



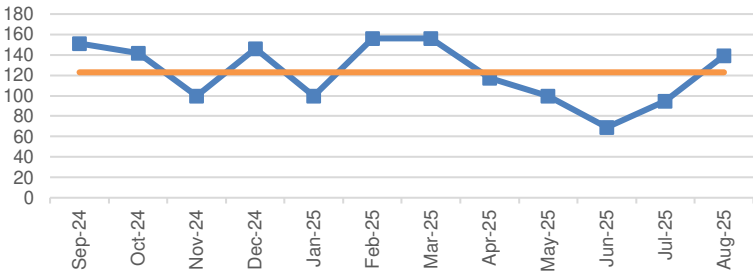
1.10 Patients in Prone Restraint (excl. RT)



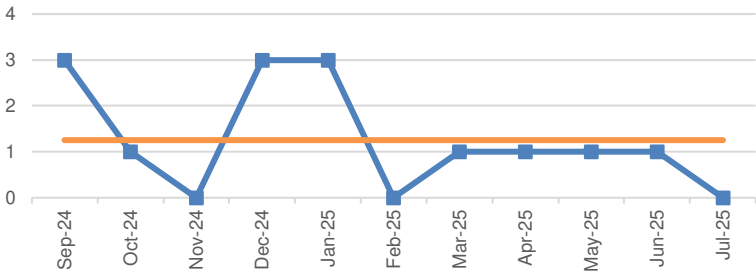
1.11 Patients in Prone Restraint for over 10 mins



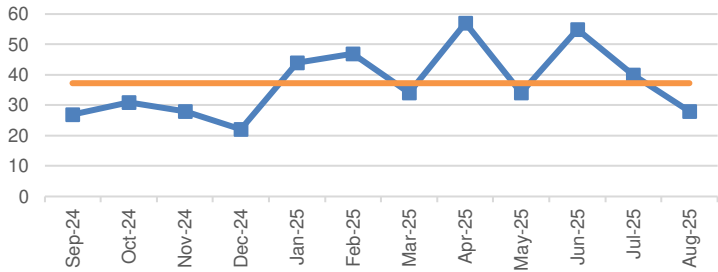
1.12 Episodes of Rapid Tranquilisation



1.13 AWOL Harm Incidents



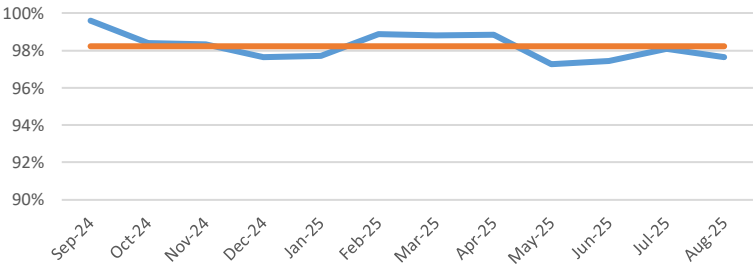
1.19 Incidents of Moderate Harm and above



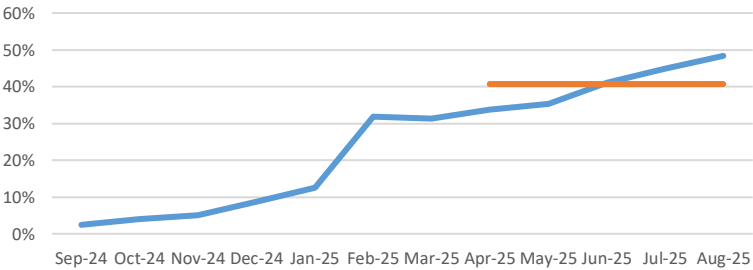
— Monthly Performance
— Average Performance (last 12 months)

1. Inpatient Services

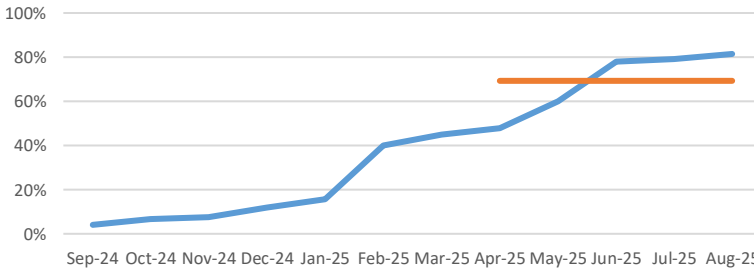
1.20 Risk Assessments Updated



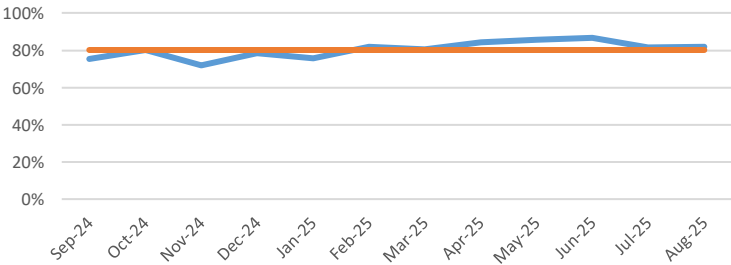
1.21 Safety Plans Updated



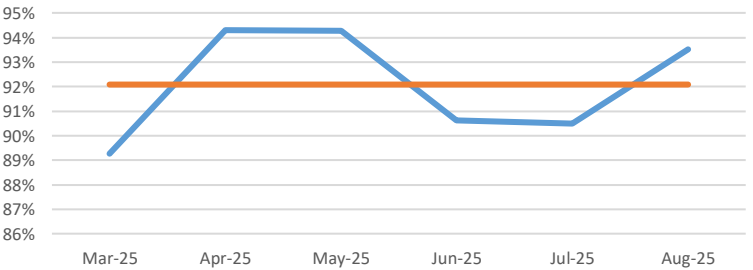
1.22 Action Plans Updated



1.23 Clinical Supervision



1.24 Ward Risk Audit



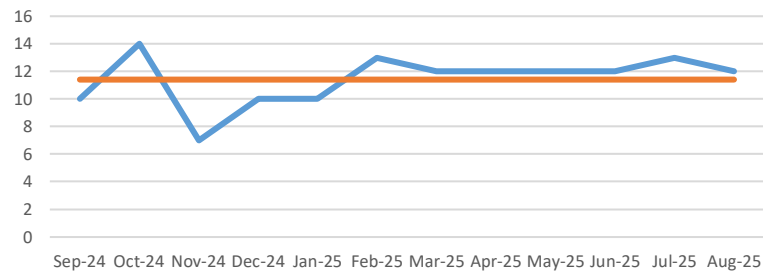
1.25 Ward Named Nurse Audit



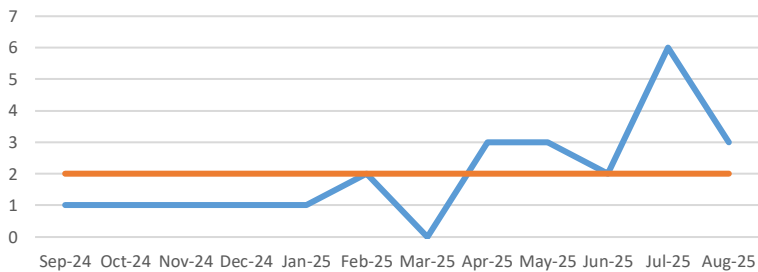
Monthly Performance
Average Performance (last 12 months)

1. Inpatient Services

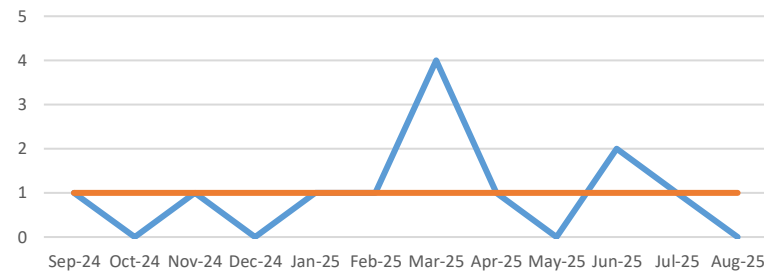
1.28 PALS Cases



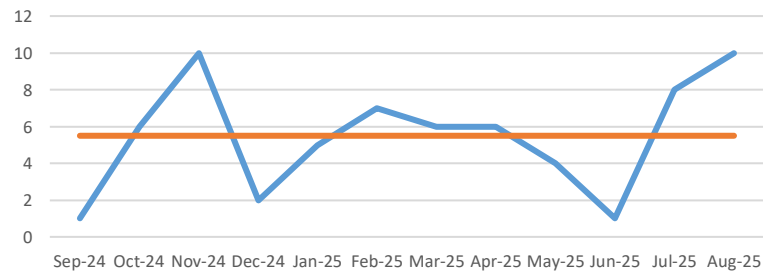
1.29 Complaints



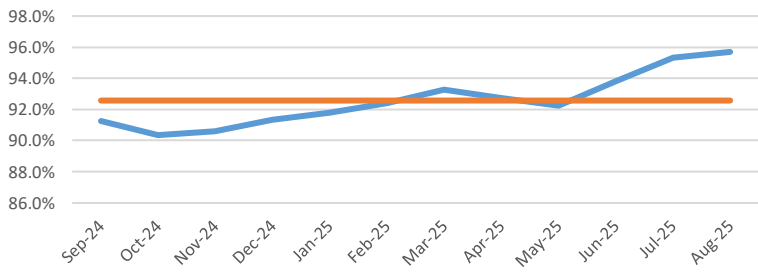
1.30 Compliments



1.31 Safeguarding Referrals



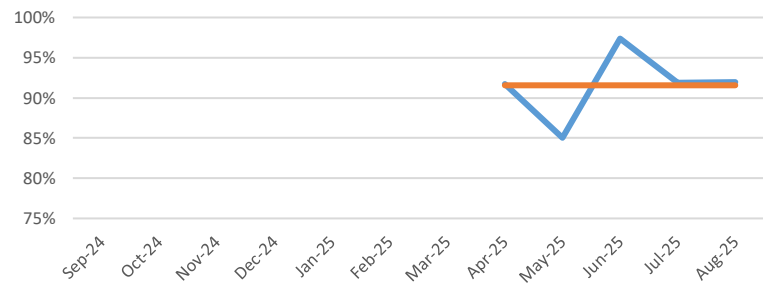
1.32 Safeguarding Training



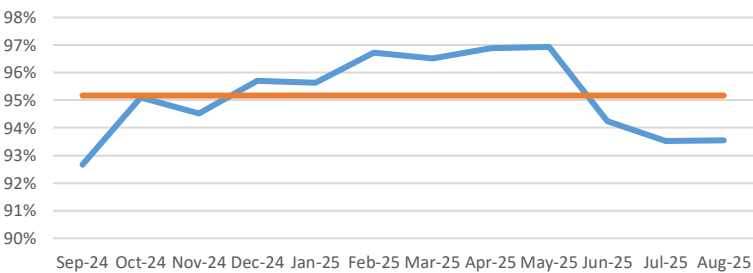
Monthly Performance
Average Performance (last 12 months)

1. Inpatient Services

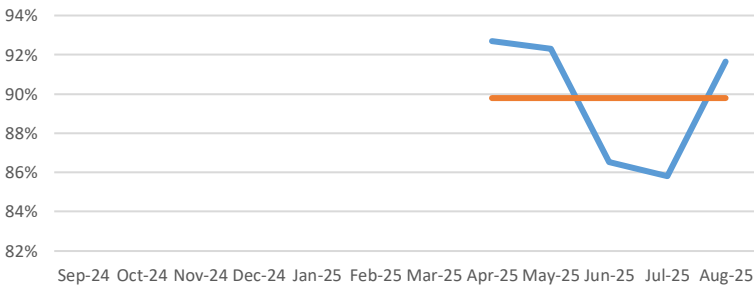
1.33 IPC Monthly Audit



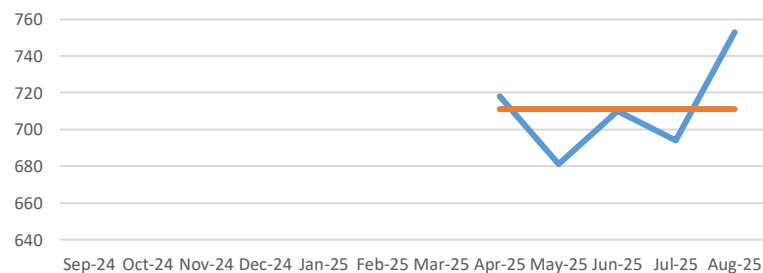
1.35 Infection Prevention and Control Training



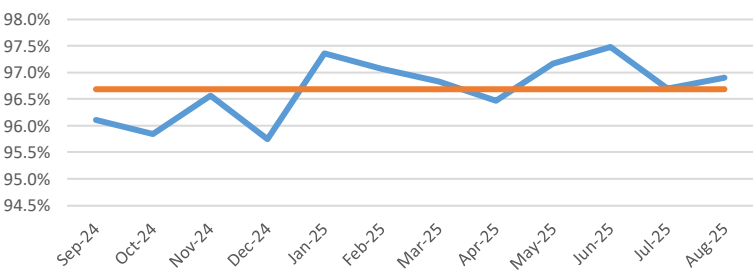
1.34 Hand Hygiene



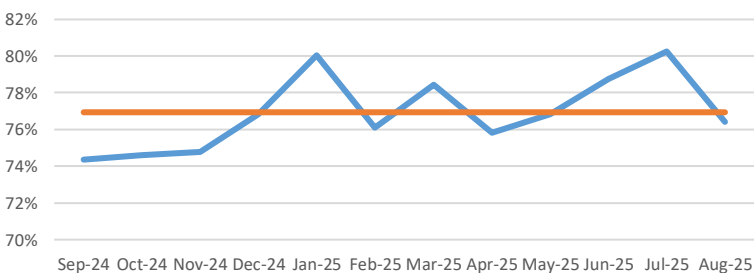
1.36 Ward Incidents



1.37 Ward Occupancy



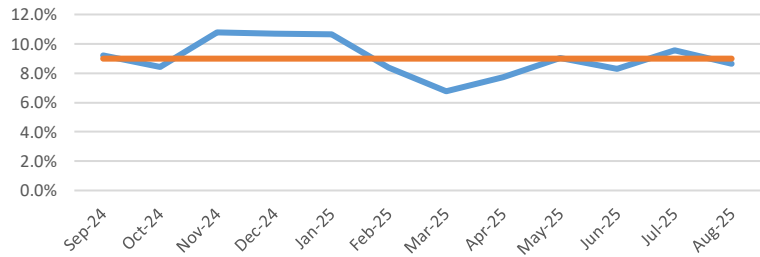
1.44 Harm Free Days (%)



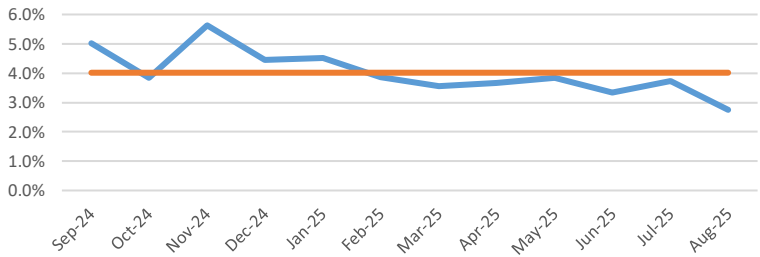
— Monthly Performance
— Average Performance (last 12 months)

1. Inpatient Services

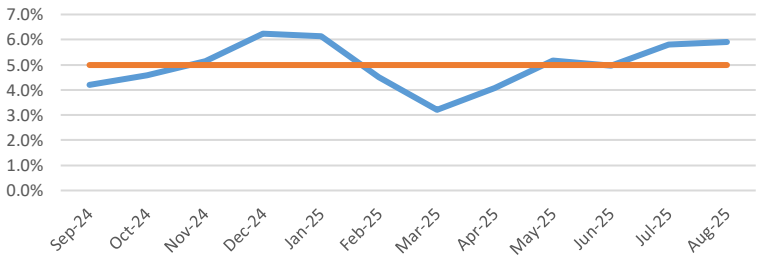
1.38 Sickness Rate



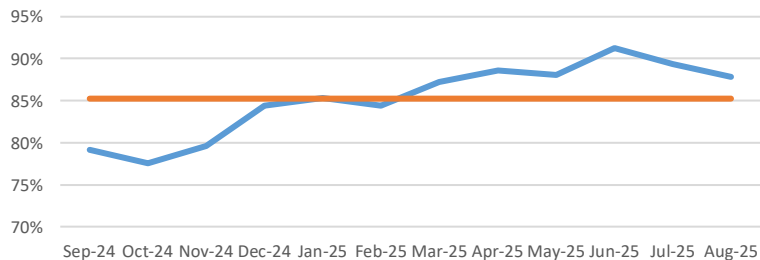
1.39 Long-Term Sickness Rate



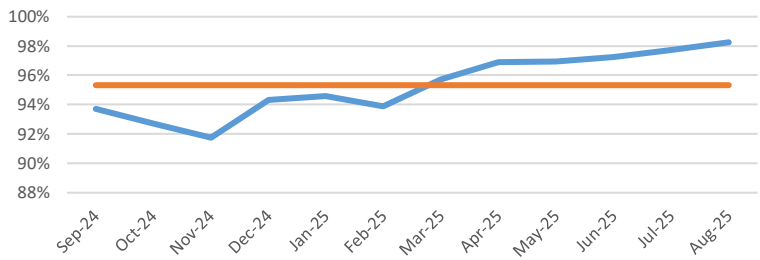
1.40 Short-Term Sickness Rate



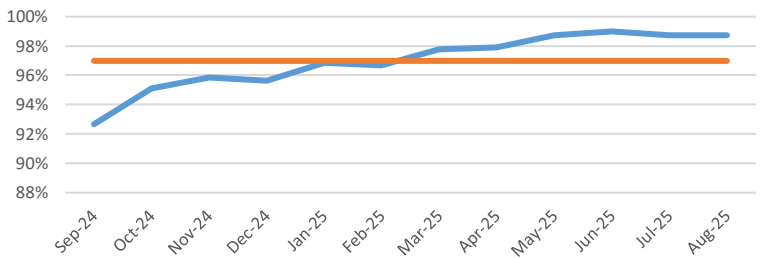
1.41 ELS/ILS Training



1.42 AVERTS Training

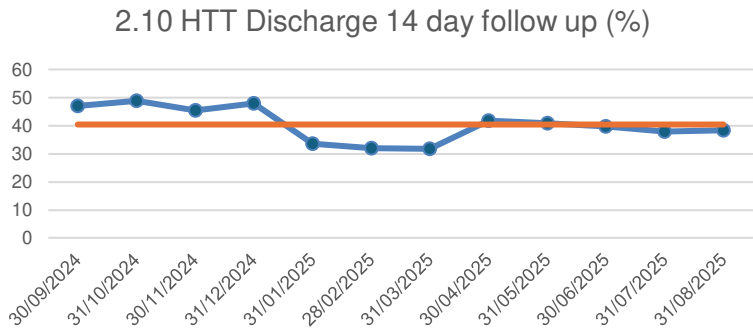
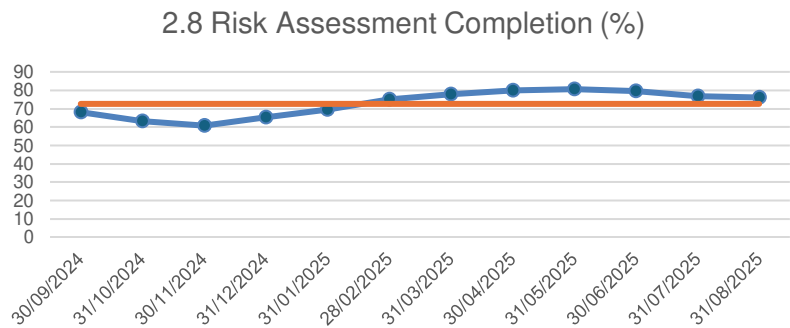
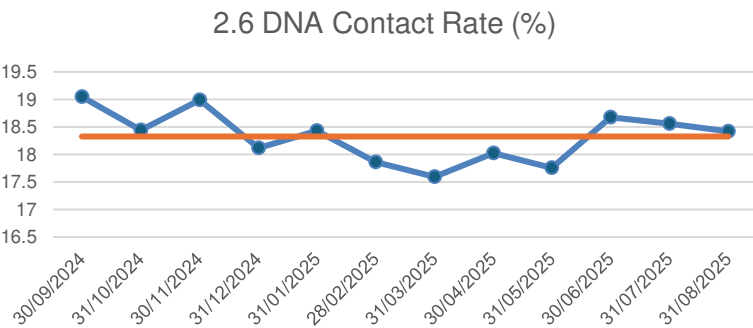
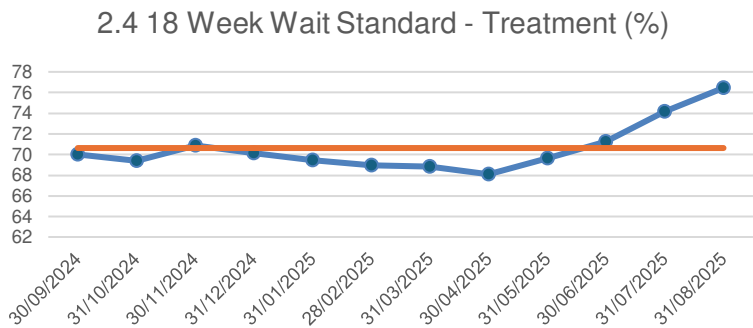
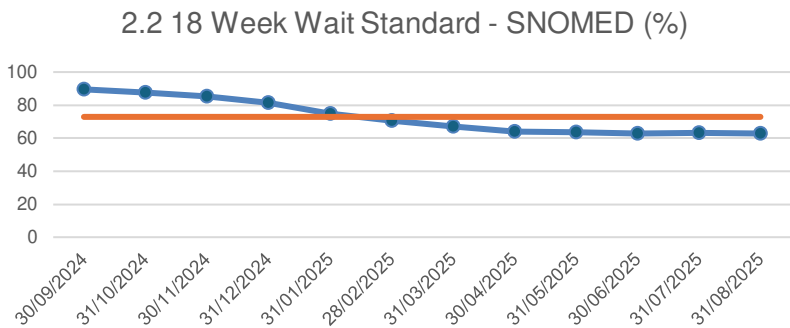
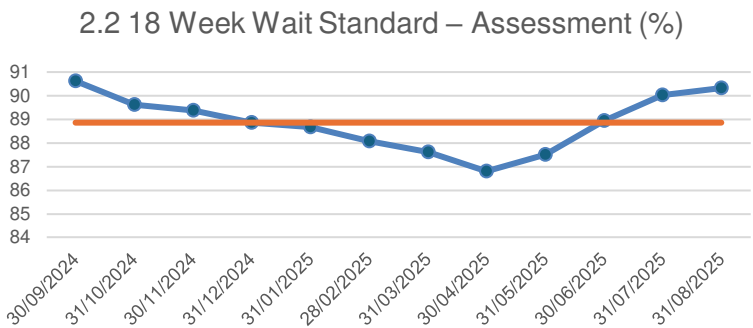
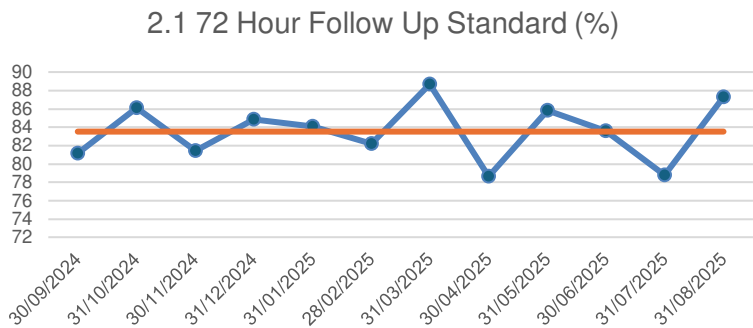


1.43 Oliver MacGowan Training



Monthly Performance
Average Performance (last 12 months)

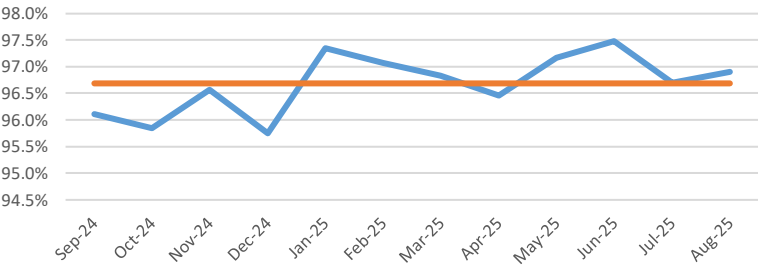
2. Community Services



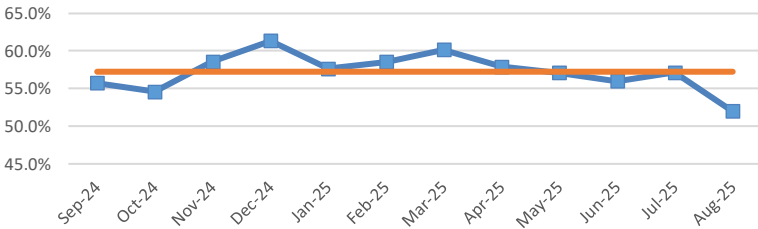
Monthly Performance
Average Performance (last 12 months)

3. Crisis Services

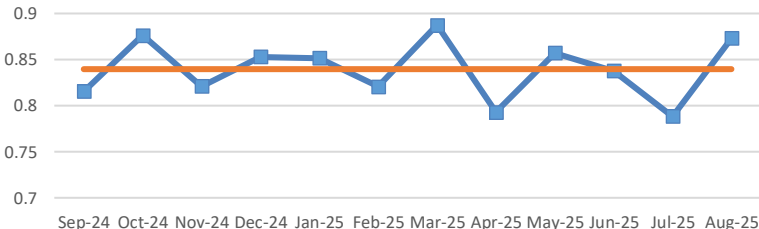
3.2 Risk Assessments Updated by Home Treatment



3.6 Urgent Home Treatment patients seen within 24 hours (face to face)

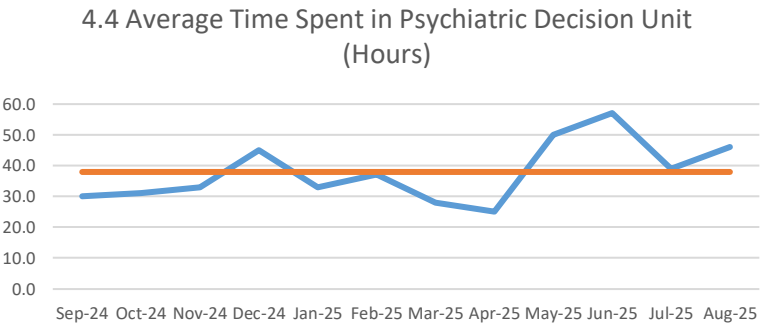
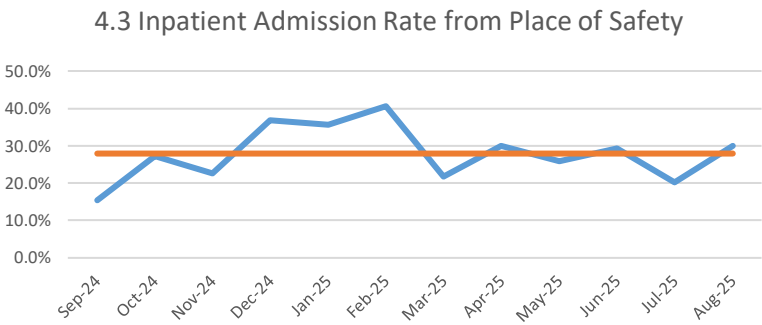
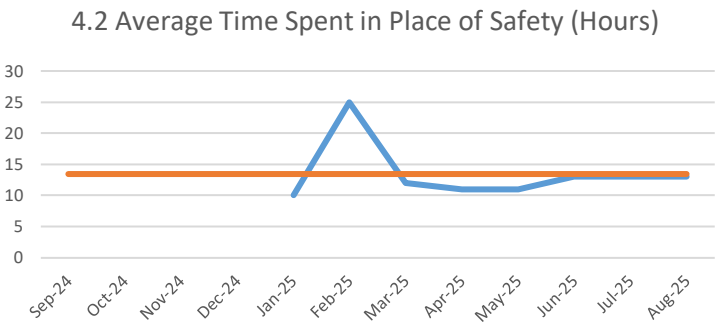
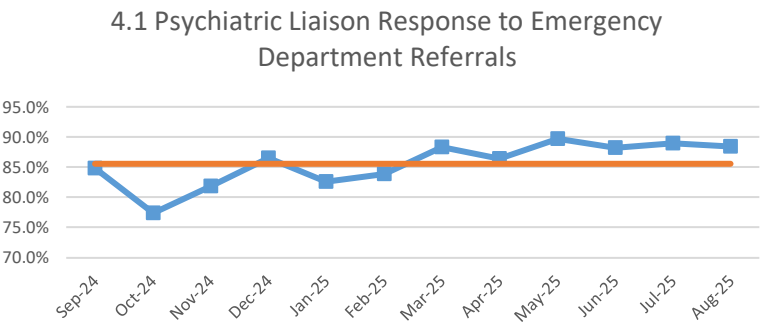


3.7 Home Treatment 3 Day Follow-up Post Discharge



Monthly Performance
Average Performance (last 12 months)

4. Urgent Care Services



— Monthly Performance
— Average Performance (last 12 months)

Early warnings Dashboard

Example Ward

Overall

Audits

Staff Training

Workforce

Customer Relations

Finance

Restrictive Practice

Incidents

Enhanced Observations

Discharge Delays

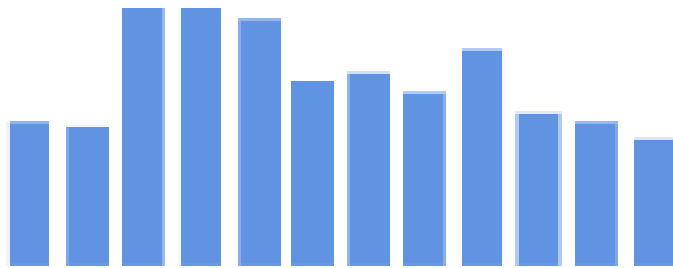
IPC

Safeguarding

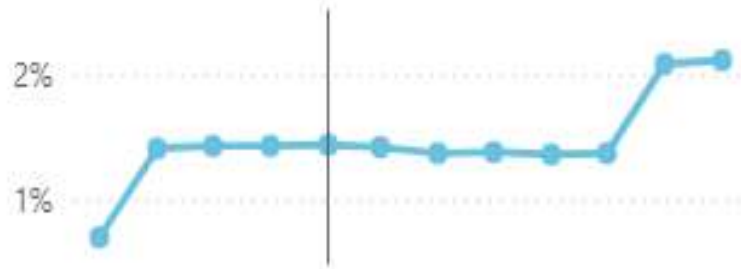
Freedom to Speak Up

Early warnings Dashboard

Example Ward



Staff Sickiness
Rate



Staff Turnover

Workforce



Return to Work



Vacancy Rate

Early warnings Dashboard

Example Ward

		Value	Previous Value
Audits	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
Staff Training	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
	Metric 4	-	-
	Metric 5	-	-
Workforce	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
	Metric 4	-	-
Complaints	Metric 1	-	-
Finance	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
Restrictive Practice	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
	Metric 4	-	-
	Metric 5	-	-
	Metric 6	-	-

		Value	Previous Value
Incidents	Metric 1	-	-
	Metric 2	-	-
	Metric 3	-	-
Enhanced Observations	Metric 1	-	-
	Metric 2	-	-
Discharge Delays	Metric 1	-	-
	Metric 2	-	-

Report to ICCR CGC					
Agenda item: 10					
Date	1 st October 2025				
Title	BSMHFT Assertive & Intensive Action Plan Update August – September 25				
Author/Presenter	Author - Renu Bhopal Padhiar, Associate Director – ICCR Presenter – Lisa Stalley-Green, Fabida Aria				
Executive Director	Lisa Stalley-Green – Chief Nurse Fabida Aria, Executive Medical Director	Approved	Y	ü	N
Purpose of Report		Tick all that apply ü			
To provide assurance	x	To obtain approval			
Regulatory requirement		To highlight an emerging risk or issue			
To canvas opinion		For information	x		
To provide advice		To highlight patient or staff experience			
Summary of Report					
Alert		Advise	ü	Assure	ü
Purpose and background All Midlands ICBs completed the Midlands Mental Health Maturity Index Self-Assessment Tool at the end of 2024. The Midlands NHS England Mental Health Team Clinically reviewed the Community Mental Health Assertive & Intensive Outreach Self-assessment and action plan submitted The plan incorporates the findings and recommendations made by the following: - Original Assertive and Intensive Action plan (following self-assessment) - Clinically Led review (NHSE) of self-assessment and action plan - Findings of CQC inspection- Nottingham - Independent Homicide Review (Nottingham) The MH Assertive Intensive Review Action Plan 2025 is a comprehensive and detailed document. outlining a multi-agency, system wide approach to improving mental health services for individuals with complex needs and aims to: - Improve engagement with individuals with serious mental illness (SMI) who are hard to reach. - Strengthen assertive and intensive community treatment pathways. - Address gaps identified through internal reviews, CQC inspections, and independent investigations This report provides an update on the Assertive and Intensive Action plan actions and a Progress Summary for August - September 2025:					

Summary of Action Updates Following 4th September Touch Point:

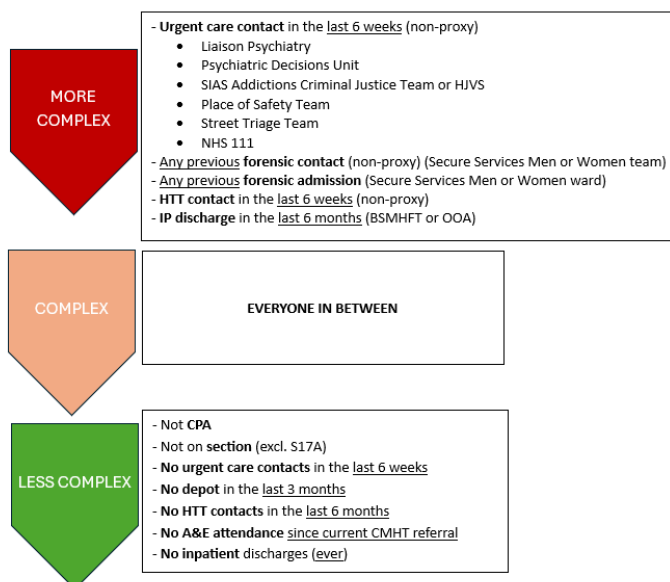
• Data & Caseload Validation

- 106 More Complex and 1014 Complex cases that were requiring clinical review having not been seen in the last 12 months have now been completed.
- Monthly BAU reporting cycles commenced from the 1st of September for More Complex and Complex cases, with randomised audits being completed per CMHT team (12 in total) to review quality of care and recording. This is application for CPA cases and Care Support Cases. Exceptions are to escalate to MDTs for urgent discussion and action. Outcomes will be tracked and brought back to the fortnightly KPI Meeting for monitoring.
- Diagnostic data monitoring continues through monthly FPP cycles, with immediate escalation of identified gaps.
- Demographic data collection QI project is underway, looking at all elements of demographic data that is missing including DNA and scoping options for improvement. Text message options are currently being explored with support from James Reed.

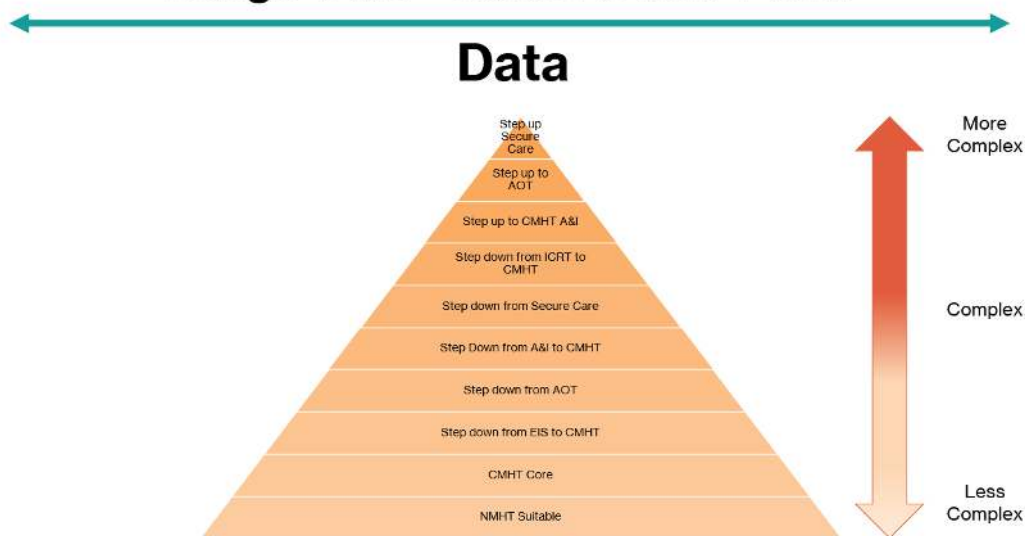
• Cohort Identification & Oversight

- Ongoing work is taking place across the pathway (Secure Care through to NMHTs) to confirm the distribution of More Complex, Complex, and Less Complex cases across CMHTs by group (e.g., Secure Care, AOT, EIS, ICRT). Workshop is planned for the first in October with colleagues from across the pathways to confirm the factors to be considered when moving service users through the pathway due to complexity. The Case Review form will be modified to support recording.

COMPLEXITY



Stage Two - Case Review Form



- PIFU SOP has been completed and presented through governance committees in August and September to be taken to ROAD in October to enable RIO updates to be completed. Timeline for PIFU roll out to be confirm at October ICCR Programme Board.
- **A&E and Frequent Attender Pathways**
 - Link worker is now in post; PLT alerts are live.
 - Red Flag Process for calls from Family/Carers and Support Roles has been rolled out across CMHTS and will be reviewed for the end September 2025.
 - Piloting of a “frequent duty callers tracker” in East CMHT to log and review repeat contacts, with feedback and review scheduled for end of September 2025.
- **Training and Supervision Updates**

Intervention/Training and Supervision Options:

Work has started to scope intervention, training, and supervision options for staff working with complex and more complex service users. Secure Care input has now been confirmed through James Reed. An initial draft plan has been developed following discussions with AOT colleagues. The main gaps are input from Psychology and Secure Care. Workshop is scheduled for early October 2025 to finalise the approach and support has been offered from Trust Psychology Lead – Sunny KALSY-LILLICO.

Dual Diagnosis and Motivational Interviewing Training:

 - Acute care is piloting training materials, with plans to amend and roll out to all CMHT areas by January 2026.
 - Bespoke training is being developed for urgent care and HTT, with consideration for other tailored training needs.
- **Governance**
 - Meetings have taken place with ICB colleague to confirm wider governance interface, monthly CQRMs will be stood up with the ICB from October 2025 to enable BSMHFT and the MHPC to provide joint updates to ICB colleagues.

- Extraordinary System Quality Group took place on 8th August 2025, and it was agreed that qualitative metric dashboard would be developed to support reporting on a monthly basis.
- Meeting took place on the 29th of August to confirm dashboard measure; action delivery being overseen by corporate governance team. Initial draft will be taken to Trust Board in October in readiness for the ICB CQRM in October.
- **Medication Monitoring**
 - Discussions are ongoing about using non-collection of medication as a flag for follow-up, with options being scoped.
 - Work is underway across the CYP and ICCR division to look at a DNA approach being rolled out for Depot clinics, CSMs and Matrons are scoping this process working alongside leads.
 - ICB colleagues are supporting discussions with ICB GP leads.
- **Care Planning and Family Involvement**
 - Discussion have commenced with the L& D team to mandate Dialog+ training across ICCR, proposal has been taken to the SME group and is due to be progressed for a final decision to be made. Training will be spilt into role specific training across two days.
 - Bipolar and Psychosis Training roll out has commence across the North and West CMHT teams with a focus on Carer voice and involvement.
 - Family carers' strategy is being refreshed and linked with Dialog+ care package.

Recommendation

Confirmation of Assurance from the Board

Enclosures

A& I action plan v20.

Report Title

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

Board Assurance Framework		
Strategic Risk	Tick ✓	Comments

Body of Report

Report to Quality, Patient Experience and Safety Committee						
Agenda item: 10						
Date	1 st October 2025					
Title	BSMHFT Assertive & Intensive Action Plan – June- August 2025					
Author/Presenter	Author - Renu Bhopal Padhiar, Associate Director – ICCR Presenter - Lisa Stalley-Green, Executive Director of Quality & Safety (Chief Nurse)					
Executive Director	Lisa Stalley-Green Fabida Aria, Executive Medical Director	Approved	Y	ü	N	
Purpose of Report			Tick all that apply ü			
To provide assurance	x	To obtain approval				
Regulatory requirement		To highlight an emerging risk or issue				
To canvas opinion		For information		x		
To provide advice		To highlight patient or staff experience				
Summary of Report						
Alert		Advise	ü	Assure	ü	
Purpose and background All Midlands ICBs completed the Midlands Mental Health Maturity Index Self-Assessment Tool at the end of 2024. The Midlands NHS England Mental Health Team Clinically reviewed the Community Mental Health Assertive & Intensive Outreach Self-assessment and action plan submitted The plan incorporates the findings and recommendations made by the following: - Original Assertive and Intensive Action plan (following self-assessment) - Clinically Led review (NHSE) of self-assessment and action plan - Findings of CQC inspection- Nottingham - Independent Homicide Review (Nottingham) The MH Assertive Intensive Review Action Plan 2025 is a comprehensive and detailed document outlining a multi agency, system wide approach to improving mental health services for individuals with complex needs and aims to: - Improve engagement with individuals with serious mental illness (SMI) who are hard to reach. - Strengthen assertive and intensive community treatment pathways. - Address gaps identified through internal reviews, CQC inspections, and independent investigations						

This report provides an update on the Assertive and Intensive Action plan actions and a Progress Summary for June–August 2025:

Summary of Action Updates Following 7th August

- **Data & Caseload Validation**

- 106 More Complex and 1014 Complex cases that were requiring clinical review have now been completed.
- Monthly BAU reporting cycles due to commence from the 1st September for More Complex and Complex cases, with randomised audits being completed per CMHT team (12 in total) to review quality of care and recording. Exceptions to be escalated to MDTs for urgent discussion and action. Outcomes will be tracked and brought back to the fortnightly KPI Meeting for monitoring.
- Diagnostic data monitoring continues through monthly FPP cycles, with immediate escalation of identified gaps.
- Demographic data collection QI project is underway, looking at all elements of demographic data that is missing including DNA and scoping options for improvement.

- **Cohort Identification & Oversight**

- Ongoing need to confirm the distribution of More Complex, Complex, and Less Complex cases across CMHTs by group (e.g., Secure Care, AOT, EIS, ICRT).
- Discussion on monitoring and BAU oversight is ongoing.
- PIFU SOP has been completed and due to be presented through governance committees in August and September and then to be taken to ROAD in October to enable RIO updates to be completed. Timeline for PIFU roll out to be confirm at October ICCR Programme Board.

- **A&E and Frequent Attender Pathways**

- Link worker is now in post; PLT alerts are live.
- Piloting of a “frequent duty callers tracker” in East CMHT to log and review repeat contacts, with feedback and review scheduled for end of September 2025.

- **Training and Supervision Updates**

Intervention/Training and Supervision Options:

Work has started to scope intervention, training, and supervision options for staff working with complex and more complex service users. Secure Care input is still needed to ensure full participation, but AOT and EIS are already involved. An initial draft plan has been developed following discussions with AOT colleagues. The main gaps are input from Psychology and Secure Care. A further workshop is scheduled for September 2025 to finalise the approach.

Dual Diagnosis and Motivational Interviewing Training:

- Dual diagnosis training is being delivered in partnership with CGL and other partners.
- Level 1 (e-learning) has 86.2% compliance in ICCR; Level 2 (full day, face-to-face) is now mandatory and part of the traffic light system.
- Acute care is piloting training materials, with plans to amend and roll out to all areas by January 2026.
- Preceptorship training includes addictions and motivational interviewing, with further review of the motivational interviewing offer underway.
- Bespoke training is being developed for urgent care and HTT, with consideration for other tailored training needs.

Supervision Arrangements:

- Group supervision/consultation slots are being considered, with proposals for 1:4 virtual sessions to allow for case discussion across EI, AOT, and ICRT.
- There is a review of clinical supervision for CPNs holding more complex cases, and MDT standards are being reviewed to ensure alignment with the needs of these cases.
- Enhanced supervision and formulation spaces are being scoped, with links to Secure Care colleagues.

• **Partnership and System-Wide Training:**

- Partnership Operations & Co-Production (POC) meetings have been established to bring together VCFSE stakeholders, clinical leads, and frontline staff to improve operational working and address barriers.
- The Partnership Platform shares intelligence and information about community offers, with regular themed presentations to support staff awareness and training on health inequalities and related topics.

• **Next Steps:**

- Secure Care and Psychology input are required to complete the training and supervision framework.
- Data gathering on dual diagnosis training and supervision is being improved, with updates expected at the next meeting.
- Further workshops and meetings are scheduled to refine and implement the training and supervision offer across the system.

• **Governance**

- Meetings have taken place with ICB colleague to confirm wider governance interface, monthly CQRMs will be stood up with the ICB from September 2025 to enable BSMHFT and the MHPC to provide joint updates to ICB colleagues
- Extraordinary System Quality Group took place on 8th August 2025 and it was agreed that qualitative metric dashboard would be developed to support reporting on a monthly basis.
- Meeting scheduled for 27th August to confirm dashboard measure, action delivery being overseen by corporate governance team.

• **Demographic Data & Cultural Competency**

- Demographic data collection improvements are underway, including a new communication passport and monthly monitoring.
- Cultural competency training has been rolled out in ICCR, with plans to mandate pan-Trust via PCREF.

• **Medication Monitoring**

- Discussions are ongoing about using non-collection of medication as a flag for follow-up, with options being scoped.
- ICB colleagues are supporting discussions with ICB GP leads

• **Care Planning and Family Involvement**

- Updates on Lyndon Audit and Dialog+ care reviews are pending.
- Family carers' strategy is being refreshed and linked with Dialog+ care package.
- Dialog+ training to be mandated across ICCR

- **Risk Management and Governance**
 - Addition of Risk Management Group, weekly Patient Safety Panel, and professional meetings to strengthen oversight.
- **Experts by Experience**
 - Next steps for Experts by Experience involvement are being reviewed and confirmed.

Recommendation

Confirmation of Assurance from the Board

Enclosures

Report Title

Strategic Priorities

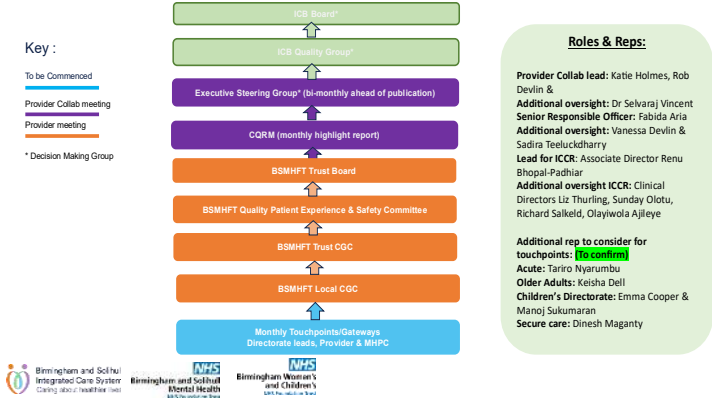
Priority	Tick ✓	Comments
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability		

Board Assurance Framework

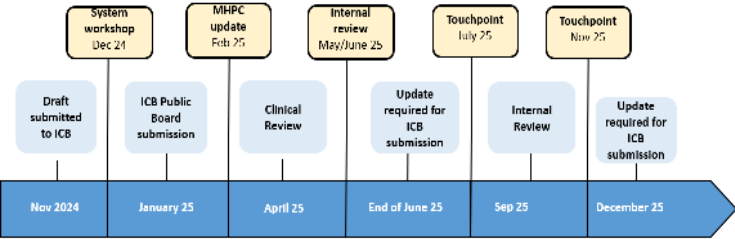
Strategic Risk	Tick ✓	Comments

Body of Report

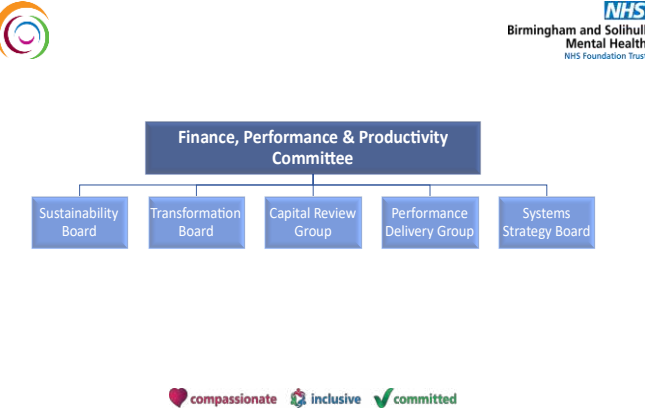
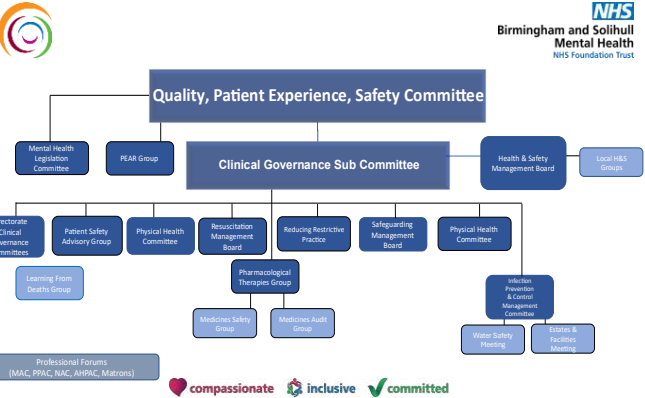
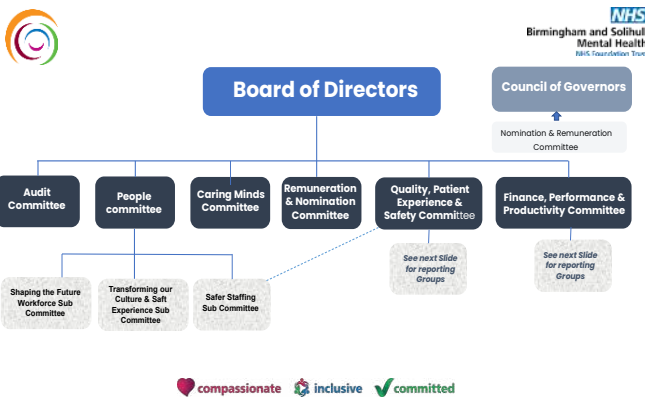
Assertive and Intensive Review System Governance



Assertive and Intensive Review



Focus Areas



Group	Frequency	Dates for plan submission	Format (verbal/ full plan/ highlight report)	Presenter	Key contact /email for plan submission
ICB Board	Bi Monthly		t.b.c.	Jenny Watson	Jenny Watson
ICB Quality Committee	Quarterly	October 15th - papers due 8th January 21st – papers due 14th	t.b.c.	Jenny Watson/Lisa Stalley-Green	Jenny Watson/Lisa Stalley-Green
Executive Steering Group* (bi-monthly ahead of publication)	Bi-monthly	17 June 19 Aug 21 Oct 16 Dec	Highlight report inc. action plan	Jenny Watson	Kat Cleverley
CQRM (monthly highlight report)	Monthly	17 June 17 July 21 Aug 18 Sept	Highlight report	Deputy Director of Operations	Andrew Carter
BSMHFT Trust Board	Bi-monthly	6 Aug 1 Oct 3 Dec	Highlight report inc. action plan	Lisa Stalley-Green/Fabida Aria	Kat Cleverley
BSMHFT Quality Patient Experience & Safety Committee	Bi-monthly	23 July 17 Sept 19 Nov	Highlight report inc. action plan	Liz Thurling	Hannah Sullivan/Kat Cleverley
BSMHFT Trust CGC	Monthly	1 July 5 Aug 2 Sept 7 Oct	Highlight report inc. action plan	Liz Thurling	Jackie Shakespeare
BSMHFT Local CGCs	Monthly	Community: Last Tuesday of month	Highlight report inc. action plan	Liz Thurling/Sunay Olotu	Liz Thurling/Mark Collier
	Monthly	UEC	Highlight report inc. action plan	Emmanuel Agiam	?
	Monthly	Specialities	Highlight report inc. action plan	Leona Tasab	?
	Monthly	Childrens	Highlight report inc. action plan	Emma Cooper	?
Touch Point Meetings - Directorate leads	Monthly				

Assertive and Intensive Review System Governance

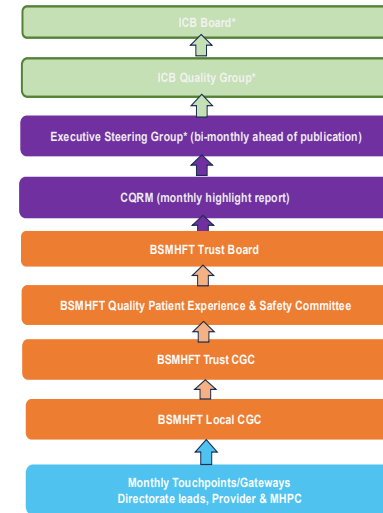
Key :

To be Commenced

Provider Collab meeting

Provider meeting

* Decision Making Group



Roles & Reps:

Provider Collab lead: Katie Holmes, Rob Devlin &
Additional oversight: Dr Selvaraj Vincent
Senior Responsible Officer: Fabida Aria
Additional oversight: Vanessa Devlin & Sadira Teeluckdharry
Lead for ICCR: Associate Director Renu Bhopal-Padhiar
Additional oversight ICCR: Clinical Directors Liz Thurling, Sunday Olotu, Richard Salkeld, Olayiwola Ajileye
Additional rep to consider for touchpoints: **[To confirm]**
Acute: Tariro Nyarumbu
Older Adults: Keisha Dell
Children's Directorate: Emma Cooper & Manoj Sukumaran
Secure care: Dinesh Maganty

Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS Birmingham and Solihull Mental Health
NHS Foundation Trust

NHS Birmingham Women's and Children's
NHS Foundation Trust

AAP	Assertive & Intensive Action Plan
CLR	Clinically Led Review

[illegible]

[illegible]

[illegible]

[illegible]

Short-term, low cost actions	Longer term actions
Ensure all service users in this group have an assigned, and appropriately experienced and competent key worker (or care coordinator)	There is 24-hour access to interpreters and translation services available
Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of non-engagement	Out of hours access to the service for service user that need it
Eliminate 'blanket' policies and practices of using DNA as a reason for discharge	Staff working with this service user group have small caseloads.
Discharge plans should include early warning signs of relapse and subsequent actions. These plans are shared with the patient, the family, detailed on the patient record, and shared with other agencies.	Providing access to a full range of evidence-based treatment and interventions, including psychological therapies
Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs.	There is a dedicated provision in place that can support this service user group
All service users are assessed to see if they are eligible for intensive and assertive community treatment	Holistic support is provided, including support with housing and substance misuse
Key workers (or care coordinators) stay in contact with the service user (and their inpatient care team) during inpatient admissions	Staff have access to relevant training and clinical supervision to support them to work with this service user group
Daily planning meetings and weekly MDT's take place for all service users requiring intensive and assertive community treatment	There are measures in place to evaluate the impact of services, including the regular reporting of appropriate outcomes
Assessments and care plans are co-produced with the service user and their family or carers	Clear pathways are in place to 'step up' care to services such as rehab & assertive outreach
All providers will be able to identify the population of people with serious mental illness where engagement is a challenge and	NICE, recommended medication principles are followed. Pharmacy expertise is available to staff supporting this cohort. Ensure Staff
in need of intensive and assertive community treatment.	are following a process for people who are non-concordant with medication & process for checking and reviewing medication. To ensure staff have training and supervision structures to access should there be complexities around medication interventions.
Personalised risk management procedures are in place.	Risk assessments are individualised and risk formulation is part of every psychosocial assessment.

Theme	Area for Consideration/Action
Assertive Outreach / Case Management	Strengthen in action plan; assess contact with emergency services.
Clinical Pathways	Address needs of co-morbidities (esp. learning disabilities, autism);
Clinical Pathways	Strengthen anti-social behaviour interventions
Clinical Pathways	Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs; consider if action requires further detail. Consider communication with primary care and how effectiveness be measured. Consider integrated links with VCSE partners to support discharge. Consider having a named executive for oversight
Non-Attendance / Disengagement	Consideration of strengthening this area in the action plan in relation to ensuring involving GPs around discharge. On the risk assessment section of the Maturity Index Tool score is predominantly working well or working well but needs improvement. In relation to the Independent Homicide Review consider if the action in the action plan requires strengthening in this area. Have the actions demonstrated that practices have changed/improved including engaging with primary care and consider action to improve involvement of GPs in MDT discussions about discharge.
High Use of Inpatient Services	In relation to the Independent Homicide Review consider strengthening this area in the action plan in relation to inpatient services contribution in action planning to safely meet the needs of this cohort
Caseload Management	Review CMHT caseload sizes (target 10–12 per staff); evaluate impact on patient contact and medication compliance.
PCREF & JSNA	Align with action plan to address health inequalities; utilise for policy and medication adherence improvements.
Medication Management	Do we know if staff are monitoring people who are discontinuing medication against advice and disengaging from services? This was identified as a gap in the Birmingham and Solihull ICB benchmarking report findings and consider having an action in the action plan in relation to this area. Consider current policies/procedures and how will effectiveness be measured, the balance between patient confidentiality and input from family and carers, incorporating learning from patient safety incidents and utilisation of PCREF to adapt to
Experts by Experience (EbE)	Strengthen role of peer support workers in policy development; leverage BSOL transformation insights, ensure action plan includes perspectives from service users and staff about concerns. The BSOL CMH transformation programme had strong EbE representation and has/could this expertise and programme of work be used in action planning.
Risk Management	In the action plan consider how will the risk recommendations (NICE guidance 2022) be embedded within the organisation. Consider an action to review if workforce training includes the importance of staff working with families in psychosocial/risk assessments where needed. Consider
Checks in place that staff act upon triggers	Consider strengthening this in action plan through reviewing risk assessment and safety planning process and training for staff regarding risk assessment, Early Warning Signs and safeguarding. Consider how can technology be used to facilitate this.
Workforce Training	Consider an action related to undertaking a skill gap/needs analysis to consider the upskilling of staff within the CMHT in line with NICE recommended therapies. Consider having a dedicated executive who has ownership of the workforce training related actions.
Governance	Ensure Risk Management Reviews feed into governance processes.
Claire Murdoch recommendations	Personalised assessment of risk across community and inpatient teams joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies) Multi-agency working and information sharing Working closely with families Eliminating Out of Area Placements in line with ICB 3-year plans.

Rating

Yes but needs improvement

Relating to Staff

Theme	Opportunities for Improvement
Demand and Capacity	- Develop national standards/tools for staffing levels and caseloads- Proactive, long-term workforce planning- Standards for staff skills, competencies, and progression- Secure long-term, flexible funding to support innovation and QI
Balancing Risks, Harms, and Long-Term Recovery	- Create standards for managing risk in recovery-focused care- Clarify roles, responsibilities, and care priorities- Invest in community services to manage risk and safety- CQC guidance on suitability of community estates- Support time for learning from deaths and reflection- Address thresholds/gaps between primary and secondary care- Promote early intervention and prevention
Medicines Management	- Improve collaboration between GPs and providers for medicine monitoring- Introduce national standards for community mental health medicines- Upgrade digital systems to flag disengagement and track meds- Address pharmacist workforce shortages and capacity
Service Provision and Commissioning	- Include commissioning in improvement programmes- Reduce disparities in access to specialist services- Tackle urban-rural inequalities in commissioning
Patient Experience and Meaningful, Co-ordinated Care	- Reassess removal of CPA and clarify key worker functions- Develop robust, multi-person discharge/disengagement protocols- Create standards for consistent patient engagement- Better understand and include voices of marginalised and SMI groups- Involve patients and carers throughout the care journey- Collaborate with NHSE on pilot models for personalised care
Systems Working	- Facilitate collaboration between sectors and services- Champion parity of esteem and investment in mental health- Improve digital integration for care continuity- Promote shared learning and engagement with wider stakeholders
Data and Technology	- Standardise and align datasets across providers- Improve access to and transparency of data use- Ensure systems interoperability (e.g., meds, EHRs)- Align CQC metrics with system partners
Good Practice and Innovation	- Define clear standards and outcomes for community services- Implement monitoring and oversight frameworks- Create national forums for sharing innovation and lessons- Promote replicable models of good practice and digital tools
CQC as a Key Lever for Change	- Maintain ongoing engagement with NHSE and providers- Use influence to shape national strategy and funding- Share good practice and insights from the 2-year programme
CQC Inspections	- Develop flexible inspection methods based on provider context- Reinstate relationship managers to improve local understanding- Recognise workforce challenges and assess psychological safety- Focus inspections more on high-risk medicines policies

Ten areas for improvement with recommendations at a local Trust level

Areas for improvement	Recommendations
Area for improvement 3 – Recommendation implementation We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.	The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process.
Area for improvement 4 – Serious incident policy We found that the Trust's serious incident policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.	The Trust needs to ensure that its Patient Safety Incident Response is in line with NHS England's new patient safety framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.
Area for improvement 5 – Family engagement We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to coproduce aspects of care planning with VC and his family, particularly around safety and scenario planning.	The Trust should determine what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care and the Patient and carer equality framework), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.
Area for improvement 6 – Clinical information sharing We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.	The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.
Area for improvement 7 – Across organisational working We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.	The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.
Area for improvement 8 – Governance arrangements In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.	The Trust and the Integrated Care Board should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.
Area for improvement 9 – Policy development and review	The Trust should ensure that all Trust policies are current, updated and written in a manner that

I have cut an extract from the NHS England commissioned independent investigation into the care and treatment provided to VC (January 2025). These recommendations are made with the anticipation that there will be collaboration across the healthcare system to achieve the required change. Whilst these recommendations are directed at the Trust who provided care and treatment for VC, all Trusts need to assure themselves in the following areas as described in the Table:

We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day-to-day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.	enables staff to practice in line with the policy. Where appropriate, policies should be coproduced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.
Area for improvement 10 – Peer support In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.	As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.
Area for improvement 11 – Care planning We found limited evidence that care planning arrangements were coproduced with VC and his family. Building on are of improvement, once the Trust has developed the family engagement offer, arrangements need to be put in place to ensure coproduction of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family	The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.
Area for improvement 12 – Joint clinical decision making We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.	The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.

1.3 Key Findings of the Independent Review

The independent review identified systemic failures in mental health service delivery, governance, and inter-agency collaboration, which contributed to VC's disengagement and subsequent events. The findings highlighted critical gaps in risk management, medication compliance, assertive outreach, and governance oversight, necessitating urgent system-wide reforms.

Key failings included:

Risk Management & Clinical Decision-Making Failures

- Static and ineffective risk assessments, failing to adapt to VC's changing circumstances.
- Missed opportunities for assertive interventions (e.g., Community Treatment Orders (CTOs), depot medication).
- Disjointed decision-making between inpatient and community teams, with no clear escalation for clinical disagreements.

Medication Adherence & Treatment Compliance

- Inconsistent medication adherence was not effectively addressed.
- Lack of structured interventions for non-concordance with treatment.
- VC's poor insight into his condition was not accounted for in treatment planning.

Discharge & Continuity of Care Issues

- VC was discharged without a face-to-face review, increasing his risk of disengagement.
- Poor information-sharing between mental health services and primary care post-discharge.
- Disengagement was accepted as a reason for discharge, despite clear risks.

Assertive Outreach & Engagement Gaps

- Limited resources restricted proactive re-engagement efforts.

- Disbandment of Assertive Outreach Teams (AOTs) reduced intensive community follow-up.
- High-risk individuals lacked structured intervention plans when disengaging.

Lack of Family Involvement & Support

- Repeated concerns from VC's family about his deterioration were not acted upon.
- Care planning did not include family input or scenario-based crisis planning.

Governance, Oversight & Cross-Agency Failures

- Weak governance structures failed to escalate patient risks.
- Limited inter-agency communication (mental health, police, primary care, education).
- No structured learning process from past safety incidents.

1.4 Key Recommendations from the Review

The review outlined clear, actionable recommendations to improve patient safety and governance at local, regional, and national levels:

1. Strengthening Risk Management

Implement dynamic risk assessments that adapt to changing patient circumstances.

Develop structured escalation mechanisms for community teams to highlight concerns.

2. Enhancing Assertive Outreach

Reinvest in Assertive Outreach Teams (AOTs) or ensure community mental health services have sufficient resources for proactive engagement.

Implement NHS England's 2024 Assertive Outreach guidance to support at-risk individuals.

3. Medication Compliance Improvements

Ensure early use of CTOs and depot medication for individuals with repeated non-adherence.

Strengthen community teams role in treatment planning for high-risk patients.

4. Family and Carer Involvement

Introduce structured family involvement in care planning and risk discussions.

Implement formal safety planning tools to engage families in crisis management.

5. Discharge and Transfer Processes

Implement mandatory post-discharge follow-up for high-risk patients.

Strengthen secondary-to-primary care communication to improve risk awareness.

6. Governance and Oversight Improvements

Establish structured multidisciplinary decision-making for high-risk cases.

Strengthen risk communication mechanisms between mental health services, police, and social care.

Enhance ICB and Trust oversight to ensure earlier identification of emerging risks.

Summary

Key Findings

- 1. Inadequate Risk Management:** Despite a history of psychosis-related violence, Calocane was discharged to his GP in September 2022 without sufficient risk mitigation. This decision was made even though evidence indicated a high likelihood of relapse into aggressive behavior without proper treatment.
- 2. Medication Non-Compliance:** Calocane frequently refused antipsychotic medication, citing a dislike of needles. Despite this, clinicians did not enforce treatment through depot injections or utilize legal powers under the Mental Health Act to ensure compliance.
- 3. Ignored Family Concerns:** Calocane's family repeatedly raised alarms about his deteriorating mental state, but their concerns were often disregarded by the trust. In December 2021, he requested that mental health staff cease contact with his family, further isolating him from support systems.
- 4. Overburdened Services and Poor Oversight:** The trust faced high demand, with instances of patients being discharged in a worse state than upon admission. Some patients lacked assigned care coordinators, leading to inadequate monitoring and support.
- 5. Cultural and Leadership Issues:** Staff reported a toxic work environment, including bullying and harassment by senior managers. This culture hindered effective care delivery and accountability.

Recommendations

Enhanced Risk Assessment Protocols: Implement regular reviews of treatment plans for individuals with schizophrenia, ensuring that risk assessments accurately reflect the severity of potential threats.

Family Engagement: Establish protocols to actively involve families in care decisions, especially when patients exhibit signs of non-compliance or deterioration.

Robust Discharge Policies: Develop and enforce comprehensive discharge procedures that consider the patient's history and potential risks, preventing premature release from care.

Workforce and Cultural Reforms: Address staffing shortages and cultivate a supportive work environment to improve service delivery and staff morale.

National Review of Community Services: Conduct a nationwide evaluation of community mental health services to identify and address systemic gaps in care and safety.

Suggested Cohorts	CMHT Caseload Management Insight report- Complexity View	Required Tasks
1	Complex and More complex Not seen for the past 12 months No appointments booked COMPLETED May 25	Clinically validate Update Diagnosis Establish Contact Review as soon as possible if required
2a	Complex and More Complex Not seen for the past 12 months Appointments booked Post June once 1 completed	Clinically validate Update Diagnosis Establish if appointment needs to be brought forward
2b	Complex and More complex Seen in the last 12 months No appointments booked	Clinically Validate Update Diagnosis Establish Contact and review based on need
3	Complex and More complex Seen in the last 12 months Appointments booked	Clinically validate Update Diagnosis Confirm if schedule of contact is adequate or more intensive support needed
Note	Complex and More Complex Not Clinically Validated as such	Decide review schedule Within CMHT or NMHT or GP
4	Less Complex Not seen for the past 12 months No appointment booked	Clinically validate Update Diagnosis Establish contact Review to be booked if required
5	Less Complex Seen for the past 12 months No appointment booked	Clinically validate Update diagnosis Review if appointment needs to be offered
6	Less Complex Not seen in the past 12 months Appointment booked	Clinically validate Update Diagnosis Establish if appointment needs to be brought forward
Note	Less Complex Clinically validated as Complex or More Complex	Establish Contact and decide schedule of review/CMHT input

Intensive and assertive Community Mental Health treatment:
ICB review outcome template



Review details - to be completed	
ICB Name	Birmingham and Solihull
Region	Midlands
Please list the providers in your area, which the review covers	Birmingham and Solihull NHS Foundation Trust (now including Forward Thinking Birmingham, formerly Birmingham Women's and Children's)
Name of SRO overseeing review	Fabola Adu
Operational lead responsible for completing review	Vanessa Devlin via BSMHFT Divisional Associate Directors
Please provide the email address for the operational lead responsible for completing the review	vma.10001@nhs.uk

Scope and purpose

The purpose of these local reviews is to ensure that appropriate, intensive, and assertive mental health care is available to meet the needs and support the wellbeing of people with severe mental illness who may struggle to engage with traditional services. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

National guidance is clear that this care does not necessarily need to be delivered through a standalone team. Instead, all community mental health teams should be equipped to provide intensive and assertive support to this group, wherever they present.

Key Features of the Intensive and Assertive Community Treatment Model

This model is a multidisciplinary, community-based approach designed to deliver flexible and person-centred care. Its core components include:

- Multidisciplinary, Skilled Workforce: Care should be delivered through an MDT. Each service user should have a named key worker within the team who provides personalised support, monitors early signs of relapse, and initiates appropriate interventions. Staff must be trained in engagement techniques, trauma-informed care, risk assessment, and the management of co-occurring conditions such as substance misuse.
- Community-Based, Person-Centred Care: Care is provided in the individual's environment – at home or community or the least restrictive setting. This enhances accessibility, supports recovery, and promotes continuity of care, including during periods of hospitalisation.
- Intensive Support with Low Caseloads: Key workers should maintain a small caseload, enabling intensive, personalised, and frequent contact. Daily or near-daily engagement is often required to maintain therapeutic relationships and proactively address emerging needs.
- 24/7 Continuity and Out-of-Hours Support: While full 24/7 services are not mandated, robust out-of-hours support is essential to ensure safety and responsiveness, especially during crises or transitions.
- Comprehensive, Integrated Care: Wraparound support needs to be available to meet the individual's mental and physical health, housing, and social care needs. Care plans must be co-produced whenever possible, reviewed at least every six months, and include detailed guidance for escalation.
- Collaborative, Multi-Agency Approach: Effective care involves coordinated working between multiple partner organisations including housing services, social care, primary care, and criminal justice agencies. Information-sharing protocols must support holistic decision-making and reduce duplication of effort across services.
- Active Involvement of Families and Carers: Where appropriate, families and carers must be engaged in care planning, treatment, risk/safety management, and care transitions, even where direct information sharing is limited. Their insight is key to sustaining recovery and managing risk collaboratively.
- Strong Governance and Safety Management: Governance structures at both ICB and provider level must support oversight of quality, safety, and risk. Proactive identification and management of risk is essential, underpinned by multi-agency partnership approach and shared governance structures.
- Demonstrable Impact: Services must monitor appropriate outcomes and use data to inform continuous improvement.

All ICBs are expected to complete the review by 3 September 2025 and submit the completed template to their regional team.

Intensive and assertive Community Mental Health treatment: ICB review outcome template



About this review

As set out in the 2024/25 Planning Guidance, NHS England directed all Integrated Care Boards (ICBs) to review their policies and practices across community mental health services. The objective was to ensure that local systems are equipped to meet the needs of individuals with Severe Mental Illness (SMI) who may struggle to engage with traditional services and require more intensive and assertive community-based support.

ICBs were specifically asked to work with local partners to evaluate existing provision, assess whether it meets the needs of this population, and identify areas for improvement. This national requirement was reinforced through guidance and a structured reporting template issued in July 2024, which asked systems to identify involved providers, examine key policies and practices, highlight service gaps, and set out improvement actions.

All 42 ICBs completed this initial review by September 2024. Submissions highlighted examples of good practice, opportunities to strengthen care pathways, and common challenges—particularly related to workforce capacity. Since then, systems have been working to implement action plans and enhance whole-system responses to ensure timely, coordinated, and effective care for this vulnerable group.

Following Claire Murdoch's February 2025 letter marking the publication of the Independent Mental Health Homicide Review, and as part of ongoing assurance, ICBs are required to review and update their action plans at both six and twelve months. This updated template has been developed to support the June 2025 review and is intended to assist ICBs in evaluating their progress in delivering improved assertive and intensive community treatment.

This work is also critical in supporting broader improvements to ensure that fewer people require this level of intervention. A key part of this includes the development of a new Personalised Care Framework, designed to ensure that all individuals with serious mental illness receive consistent, person-centred, and well-coordinated support across teams and settings. Due to be published in Summer 2025, the framework will offer further guidance to ICBs and mental health providers on how to improve the quality and continuity of care for this population group.

The review is designed to be light-touch and should be completed as a self-assessment in collaboration with local partners. The template uses a RAG (Red-Amber-Green) rating approach to help systems assess their current position, identify ongoing challenges, and outline next steps.

All ICBs are expected to complete the review by 3 September 2025 and submit the completed template to their regional team. These returns will help inform national policy development. NHS England will also publish a national summary report drawing on both the July 2024 and June 2025 reviews, including key findings and recommendations for system improvement.

Update on progress since summer 2024	
Reflecting on your initial review and the development of local action plans, it would be helpful to understand the progress made across the ICB since that point	
Reflecting on progress made, are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?	No – we have started to make progress in improving our intensive and assertive community care, however are still unable to provide full assurance that we can fully meet the need of this population group.
Are you on track to present, or have you already presented, your updated action plans at both Trust and ICB public board meetings by the 30 June 2025 deadline, as requested in the February 2025 letter from Claire Murdoch and Adrian James?	Partially – We plan to do this, but it will take place after the 30 June 2025 deadline.

Understanding the specific provision in place in line with the model of care	
The following questions are designed to gather information on the provision currently in place across your ICB footprint. We recognise that progress may vary across different areas; this exercise is intended to develop a national overview of where systems are concentrating their improvement efforts and to identify any gaps where additional national support may be required.	
Partnership working	ICB self-assessment
RAG key Red - There is no clear partnership working or governance structure in place for this patient group •No dedicated forums or partnership arrangements currently exist. •Roles and responsibilities across the system are unclear or undefined. •Little to no evidence of collaborative activity to support this group. •The ICB has not yet initiated any focused work in this area. Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing •There may be ad hoc or emerging forums for collaboration. •Governance structures are partially defined but not widely understood or embedded. •Some joint actions have been taken with system partners, but gaps remain in coordination and oversight. •Plans are in place to strengthen arrangements, but impact is not yet clear. Green - Strong and embedded partnership and governance arrangements are in place to support this patient group •Dedicated forums or formal partnership structures exist and are regularly used to monitor safety, quality, and outcomes. •Governance responsibilities are clearly defined, understood, and integrated across relevant organisations. •There is robust evidence of collaborative planning and delivery with measurable improvements for the target population.	Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing.
To what extent has your ICB taken action to strengthen partnership working and governance arrangements to support this patient group? Consider: • Whether dedicated forums or local partnership arrangements exist to oversee safety quality, and outcomes. • Clear governance structures, with defined responsibilities and accountability for this population are in place • Evidence of collaborative action taken with system partners to improve support and outcomes for the group.	
Reflecting on the Past Six Months: What progress has been made in strengthening your approach to partnership working? Please highlight any key achievements, as well as any ongoing challenges or barriers you have encountered.	Forums are being established within the provider space, with clearly defined Senior Responsible Officers (SROs) and maturing governance arrangements now in place. Strong links have been developed with AUEC colleagues through the AUEC Transformation Lead, Kevin Heffernan. Collaborative work is also progressing across localities to strengthen place-based approaches. All six localities now have established Local Delivery Partnerships representing all system partners this is most advanced in the East and continues to develop in other areas. This work has been developed through collaborative working with Birmingham Community Healthcare Care Trust, enabling a physical health and mental health aligned approach. Ongoing support from the Mental Health Provider Collaborative (MHPC) will be essential to ensure joint system ownership, full partner engagement, and effective oversight across all localities.
Looking Ahead: What are your plans over the next six months to strengthen and improve partnership working? Please outline any planned initiatives, priorities, or changes in approach.	MHPC are supporting in setting up engagement workshops with partners (GPs, VCFSE) to look to further strengthening forums wider than the providers and to link viable actions with leads back to the plan, ensuring for coproduction across system partners. Locality action plans are being finalised across of the Local Delivery Partnerships in readiness for Winter and the year ahead, these are due to be presented to governance forums during September 25.

Workforce	ICB self-assessment
RAG key Red - There are significant gaps in assurance processes relating to staffing for this patient group • No clear workforce planning specific to the needs of this population. • Training and competency frameworks are absent or not aligned with service needs. • Recruitment and retention challenges are unaddressed. • No routine mechanisms to monitor or assure safe staffing levels or skills. Amber - Some systems are in place, but they are incomplete, inconsistently applied, or under development •Workforce planning partially considers this population but lacks detail or implementation. •Relevant training is available but not consistently accessed or mandated. •Some recruitment or retention activity is underway, but gaps remain. •Assurance processes exist but lack robustness or regular review. Green - Robust systems are in place and embedded to ensure safe and competent staffing for this patient group •Workforce plans clearly address the specific care needs of this population. •Staff receive appropriate training and demonstrate required competencies. •Effective recruitment and retention strategies are in place and monitored. •Safe staffing is regularly reviewed through established assurance processes.	Green - Robust systems are in place and embedded to ensure safe and competent staffing for this patient group.
To what extent does your ICB have effective systems in place to provide assurance of safe staffing for the care and treatment of this patient group? Consider: • Whether workforce plans account for the specific needs of this population. • Availability and uptake of appropriate training and competency development. • Recruitment and retention strategies relevant to staff working with this group. • Robust mechanisms for the ongoing monitoring and assurance of safe staffing levels, skills, and competencies.	

Reflecting on the Past Six Months: What progress has been made in supporting the workforce that provides care and treatment for this patient group? Please include an overview of your workforce plans, efforts to recruit peer support workers, and any challenges or barriers you are currently experiencing.	Workforce plans have been developed across all directorates, supported by the Trust's Workforce Transformation Lead. Recruitment activity is aligned to these plans at team level, taking into account specific role requirements, such as Marlon posts. Directorate leadership teams oversee skill mix across the service and are supported by a centralised vacancy management process. All vacancies are closely monitored throughout the recruitment process, with oversight provided by Finance, Heads of Service, and the Associate Director. Vacancy plans are reviewed on a monthly basis to ensure alignment and triangulation across Transformation priorities, vacancy management, team skill requirements, and financial planning. Work has commenced with the Trust ACP Lead to review all Advanced Clinical Practitioner (ACP) and Advanced Nurse Practitioner (ANP) roles within Community Mental Health Teams (CMHTs). The aim is to establish a consistent baseline skill level across all CMHTs. In parallel, the Head of Nursing is leading a review of current roles, role profile, and development pathways for additional training for staff interested in progressing to ACP/ANP roles. This work will strengthen senior clinical oversight across CMHTs. Training provision across the Trust has been enhanced to align with recommended role-specific requirements. Compliance and monitoring are reviewed monthly through Directorate FPP meetings. Within ICCR, compliance with training requirements has improved from 90% to 98%, with some teams achieving between 86-100%. Compliance levels remain consistently high. All staff across the Trust receive automated reminders for upcoming training requirements, available training courses, and non-attendance notifications. Staff falling below 75% compliance are contacted directly, alongside their line managers, with non-attendance monitored monthly and reported by reception to Disrupted Training Teams for discussion during supervision. Allistair Service Training Needs Assessment has been completed, incorporating workforce retention considerations, and tailored training has been provided to individual service teams where required. Bank and agency usage is monitored monthly through divisional FPP meetings and is aggregated by the Trust People Committee. Usage continues to decline, supported by an increase in substantive recruitment. Within ICCR, over the last 12 months there have been more than 80 additional substantive whole-time equivalent posts recruited. During this period, sickness absence has reduced from 5.3% to 4%, requested bank and agency shifts have reduced by almost 50%, turnover has fallen from 6.1% to 5.4%, and the vacancy factor has decreased from 16.7% to 12.7%. Ongoing work is being undertaken with the Trust's dedicated Staff Leaving Lead to further strengthen workforce sustainability through robust use of e-Rostering, management of bank-only staff, and improved oversight of annual leave. Staff survey and engagement plans are in place across all divisions, supported by corporate teams. In addition, a 24/7 wellbeing helpline remains available for all staff.
Looking Ahead: What actions are planned over the next six months to strengthen the skills, training, and competencies of staff supporting this patient group? Please outline any specific initiatives, development programmes, or strategic priorities.	Further work is to be carried out around qualified staff and training in the community setting. Collaboration with local universities where there is a pathway for Band 5 non-qualified staff now seeking to work with the trust, this needs to convert however into Band 6 roles. All teams currently have students on placements 5-6 at a time, how this pulled through to vacancies needs to be strengthened as part of vacancy plans. Another area of focus

Community based care - access and oversight		
	RAO key	ICB self-assessment
	Red - There are no formal local policies or governance arrangements in place to support access to community services for individuals in this patient group • DNAs may still result in discharge without consideration of vulnerability. • Referral pathways, systems to effectively identify patients in this cohort, and transitions are unclear or inconsistently applied. • No oversight or assurance mechanisms in place to monitor these processes.	Amber - Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice
	Amber - Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice • Policies discourage discharge after DNAs but are not fully embedded or monitored. • Pathways exist but may vary between services to lack transparency. • There are limited systems in place to effectively identify patients in this cohort. • Transition processes are present but lack consistency or clear accountability. • Limited or ad hoc governance arrangements exist to oversee these areas.	
To what extent are local policies and governance arrangements in place to ensure equitable access and oversight of community-based care for individuals identified as needing intensive and assertive community treatment? • Whether local policies explicitly state that "Did Not Attend" (DNA) should not be used as a reason to discharge individuals. • The existence of governance arrangements that provide oversight and assurance of referral pathways into services, effective identification of patients requiring intensive and assertive treatment, and transition processes between services.	Green - Comprehensive, embedded, and routinely monitored policies and governance arrangements are in place to ensure access, support, and safe transitions for individuals in this patient group • Clear policy prohibits DNA-based discharge for this group, with staff training and oversight in place. • Referral pathways are standardised, transparent, and equitable. • There are clear systems in place to effectively identify individuals who require intensive and assertive treatment. • Transition processes are well-defined and supported by joint working. • Governance structures provide effective oversight, assurance, and continuous improvement.	Green - Comprehensive, embedded, and routinely monitored policies and governance arrangements are in place to ensure access, support, and safe transitions for individuals in this patient group

Reflecting on the Past Six Months: What progress has been made in identifying individuals within this patient group, ensuring they have appropriate access to services, and maintaining oversight of their care? If additional, please describe how you monitor and assure that relevant policies are being effectively translated into practice for this cohort, including any barriers or challenges you are currently facing.	All areas are in place other than having clear systems to effectively identify individuals who require intensive and assertive treatment. Caseload review: Caseload metrics have been reviewed to consider high acuity populations. Metrics have been applied to any cases currently held in the CMHT that hadn't been seen in the last 12 months to ensure from a risk management perspective all cases had been reviewed. Complex Cases Reviewed: 1,041 cases Most Complex Cases Reviewed: 106 cases Additional metrics have been applied through liaison with medics to include additional service users for completeness: 1. Currently receiving treatment/intervention by another service (e.g. OGA, HHT, Specialty Service). 2. Reviewed by another clinician under consultant supervision (e.g. another doctor, ANP). To ensure ongoing monitoring of the caseloads in addition to current metrics Business-as-Usual (BAU) Reporting has commenced as of 1st September, complex caseload data will be pulled against the original baseline and re-reviewed each one of the 12 CMHTs and complex caseloads will be reviewed by clinical leads across the 12 CMHTs. Audit scope for the data reviews will include: quality of care, recording standards (medication, risk, diagnosis, action plan), and follow-up timeliness. Audit outputs will be captured via the Trusts AMTS system. All exceptions will be escalated to teams for urgent MDT discussions and data taken to the divisions fortnightly KPI data meetings for oversight and escalation where needed with the Divisional Leadership Team. The above BAU process will allow monitoring of cases as we move for further align and review CMHT caseloads. Patients will be split into the following areas: - Step up to Secure Care (More Complex) - Step up to ADT (More Complex) - Step up to CMHT Assertive & Intensive Provision (More Complex & Links to Resource in Reach Out Business Case) - Step down to CMHT from CRT (More Complex/Complex) - Step down from secure care (More Complex/Complex) - Step down from CMHT Assertive & Intensive Provision (Complex/Less Complex) - Step down from ADT to CMHT (More Complex/Complex) - CMHT (More Complex/Complex/Less Complex) - NHHTs (Less Complex/Discharge ready) The above caseload profiling work has commenced and will require further refining, workshops with leads are planned for September to consider complexity pyramid and presentation of data. It also requires support from ICT and informatics colleagues to ensure the EPR system is functioning as needed and that the data can be pulled on an ongoing basis. Once the caseload profiling has been completed this will enable us to ensure caseloads of distributed
Looking Ahead: What steps do you plan to take over the next six months to improve the identification of individuals in this cohort, strengthen oversight of their care, and enhance their access to appropriate services?	

Key working arrangements and caseload management		
	RAG key	ICB self-assessment
To what extent are local governance structures in place to provide assurance that all individuals in this cohort have an allocated key worker, and that caseloads are appropriate to provide the level of support needed for individuals requiring intensive and assertive engagement? Consider: - Whether there are systems in place to monitor and ensure key worker allocation for every individual in scope. - Whether local governance structures provide oversight of caseload size and complexity. The extent to which caseloads enable key workers to deliver proactive, personalised, and sustained engagement.	Red – We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness. - Many individuals in the cohort may not have an identified key worker. - Caseloads are unmanaged or exceed safe levels, limiting the ability to provide intensive support. Amber – There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness. - Most individuals have a key worker, but allocation is not routinely tracked or assured. - Caseload sizes are monitored in some areas, but data is incomplete or actions are not always taken. Green – Robust and embedded oversight and monitoring systems are in place, providing clear oversight and assurance of key worker allocation and caseload management. - All individuals in the cohort have a named key worker. - Caseloads are regularly reviewed to ensure they are manageable and allow for assertive, personalised engagement.	Amber – There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness.

Reflecting on the Past Six Months: Please describe how you monitor and maintain oversight of key worker allocation and caseload management. Include any challenges or barriers you have encountered in ensuring appropriate staffing and workload balance.	The Trust's Care Management CPA Policy provides clear guidance on which service users are suitable for CPA, alongside defined timelines for allocation. This policy is accessible to all staff and forms the foundation for consistent practice across services. The Community Mental Health and Wellbeing Operational Framework outlines the processes for case allocation within Community Mental Health Teams (CMHTs). Clinical Leads in each CMHT are responsible for allocating cases for care coordination locally, ensuring that service users are matched appropriately to the most suitable Care Coordinator. Caseload Monitoring and Supervision Caseloads are reviewed and managed through regular clinical supervision and line management supervision. Compliance with both forms of supervision is monitored monthly, with the Trust achieving a compliance rate of 80%. Compliance data is reviewed at monthly FPP meetings. Where staff fall below compliance expectations, the Head of Nursing and Associate Director contact them directly to request a recovery plan, which must be completed within the same month. Ongoing Monitoring and Allocation Administrative leads from each CMHT provide the Associate Director, Head of Service, and Clinical Service Managers with a weekly report of cases awaiting allocation, in line with the Operational Framework. The same governance process applies to the Assertive Outreach Team (AOT) for Care Coordinator allocation. A clear contingency process is in place to ensure continuity of care where Care Coordinators are absent due to sickness or extended annual leave. This process is also set out within the Operational Framework. Current Position Care Support Caseloads: 614 More Complex and 4,282 Complex CPA Caseloads: 387 More Complex and 833 Complex (These cases will have Care Coordinators allocated)
Looking Ahead: What actions are planned over the next six months to improve oversight of key worker assignment and caseload management for this cohort? Please include any planned changes to processes, use of data or digital tools, or workforce development initiatives aimed at ensuring effective and equitable support.	The above caseload profiling work needs to be completed alongside the aforementioned workshops with leads that are planned for September to consider complexity pyramid and presentation criteria for each, it also requires support from ICT and informatic colleagues to ensure the EPR system is functioning as needed and that the data can be pulled on an ongoing basis. Once the caseload profiling has been completed this will enable us to ensure caseloads of distributed fairly and a mix of complexity and also understand the training needs of the teams. Immediate plans regarding the caseload focus on the implementation of Patient Initiated Follow Up (PIFU) this will focus on the less complex service users
Out of hours provision	
To what extent are local arrangements in place to support effective multi-agency coordination outside of core hours for individuals in this cohort? Consider: • Whether there are established pathways or protocols for coordination between key agencies (e.g. police, crisis services, social care, ambulance services) outside of 9-5 working hours. • The clarity of roles, responsibilities, and escalation routes during evenings, weekends, and public holidays. • The extent to which these arrangements are used in practice to support timely, safe and appropriate responses.	RAG key Red - There are no formal arrangements in place for multi-agency coordination outside of core hours • Agencies operate in isolation during evenings, weekends, and public holidays. • There are no agreed pathways, protocols, or escalation procedures in place. • Responses are reactive and inconsistent, and there is no specific out-of-hours provision in place for this group. Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement • Certain agencies coordinate out-of-hours, but this is reliant on individual relationships or ad hoc solutions. • Pathways and escalation routes are partially defined but not consistently used. • There is access to a crisis line for individuals who require out-of-hours provision. Green - Clear, formalised, and embedded arrangements are in place to enable effective multi-agency coordination outside of core hours • All relevant partners (e.g. police, crisis services, social care, ambulance) are engaged in agreed protocols • Roles, responsibilities, and escalation procedures are clearly defined and routinely used • There is a full 24 hour access to support for individuals who require out-of-hours provision ICB self-assessment Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement
Reflecting on the Past Six Months: Please provide an overview of the out-of-hours provision currently in place for this cohort. Include any challenges or barriers you have encountered in delivering consistent and effective support outside of core service hours.	The roll-out of the CMHT PLT alert has now been completed and the PLT link worker is in place to support this function. The alert notifies CMHT teams presenting a known service user presents at A&E and is seen by the PLT prompting follow-up contact. The alert will also prompt the CMHTs if the service users has been seen by the PDU. The PLT link worker is now offering case review slots to the PLT following a service user who is known to the CMHT presenting in A&E. Ongoing considerations include links with the Health & Justice Vulnerability Service, high-volume service users, and integration with 111/Call Before You Convey initiatives. There is also a focus on Midland Met high-volume users, with discussions about the Urgent Care Pathway scheduled for September.
Looking Ahead: What specific actions are planned over the next six months to strengthen out-of-hours support for individuals within this patient group? Please include any proposed service developments, workforce initiatives, or partnership approaches aimed at improving access and continuity of care outside standard	For circumstances where police are attending, the police are tasked with contacting Call Before Convey through a dedicated number and the call handler Work is due to take place with MHPC colleagues to carry out workshops with further system partners to support the development of the plan and to ensure a fully collaborative plan. Once workshops have been completed all actions will be integrated. Work to strengthen the connection with the police healthcare provider, who are 24/7 and provided by MITIE Whilst processes exist between AUEC and CMHTs these need to be formalised in an agreed standardised process
Care delivery	
To what extent is there appropriate oversight in place to ensure that individuals in this cohort have a care plan, and that their clinical, social, and psychological needs are effectively assessed and addressed? Consider: • The extent to which care plans are co-produced, person-centred, and regularly reviewed. • Whether oversight mechanisms ensure that care planning includes a comprehensive assessment of clinical, social, and psychological needs. • Evidence of multidisciplinary involvement and coordinated action to meet identified needs. • There is joint discharge planning arrangements in place between inpatient and community teams to support transitions in care.	RAG key Red - There is no consistent oversight to ensure that individuals in this cohort have care plans or that their needs are comprehensively assessed • Care plans are often missing, incomplete, or outdated. • Assessments of clinical, social, and psychological needs are not routinely undertaken. • No formal governance structures or quality assurance mechanisms are in place to monitor care planning or needs assessment. • Joint discharge planning arrangements are not in place between inpatient and community teams following a period of hospital admission. Amber - Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services • Most individuals have care plans, but quality and consistency vary. • Holistic needs assessments are undertaken in some cases but not systematically or across all domains. • Oversight processes are present but lack regular review or do not drive improvement. • There is some evidence of joint discharge planning arrangements between inpatient and community teams but these are not formalised or regularly monitored. Green - Robust and embedded oversight arrangements are in place to ensure care plans are in place and holistic needs are assessed and addressed • All individuals in the cohort have co-produced, care plans that are regularly reviewed. • Clinical, social, and psychological needs are systematically assessed and reflected in care planning. • Strong governance mechanisms ensure quality assurance and continuous improvement across the system. • There is clear joint discharge planning arrangements in place between inpatient and community teams following a period of hospital admission. ICB self-assessment Amber - Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services
Reflecting on the Past Six Months: Please provide details on how you maintain oversight of care plans and assessments for individuals within this patient group. In particular, describe how concerns or red flags are identified, how responsive actions are coordinated across services, and any barriers you have encountered in ensuring timely and effective intervention.	Dialog+ care plans are now in place which focus on patient centric factors, care plans are reviewed through regular contact depending on care level or when there are significant changes. Dialog+ care plans taking into account impact of social and economic issues, this will be enhanced with the revised Safety Plan and Log, the roll out is being overseen by the DMD for Quality and Safety and will take place over the next 6 months. The care plans are reviewed through the patient journey and professionals involved in the service users care will update the plan at key points, these updates will take place across all areas of interactions - Community Teams and AUEC Teams. MDTs are in place across all CMHTs.
Looking Ahead: What specific actions are planned over the next six months to enhance oversight of the care provided to individuals within this patient cohort? Please include any initiatives aimed at improving monitoring, quality assurance, or inter-service coordination.	Targeted work needs to take place with AUEC colleagues around joint discharge planning processes and how this can be operationalised. Safety Plan and Safety Log roll out needs to be commenced and supported by appropriate staff comms. Continue working with Matrons to review the quality of the Dialog+ care plans, previously quantitative information was captured about care plan completion however from August 2025 the audit encompasses quality aspects such as whether the information is personalised, relevant and useful to others and the inclusion of family/carers within the care plan (CPA Patients only).
Information sharing	
	RAG key ICB self-assessment

To what extent are clear and effective information sharing protocols in place between relevant partner organisations and agencies to support safe, coordinated care for this cohort? Consider: • Whether formal information sharing agreements or protocols exist and are aligned with legal and professional standards. • The consistency and timeliness of information sharing across health, social care, police, education, and voluntary sector partners. • Whether staff are aware of and trained in appropriate information governance practices. • Evidence of information sharing supporting joint decision-making, risk management, and continuity of care.	Red - There are no formal information sharing protocols in place, or existing protocols are not used in practice • Significant barriers to information flow between agencies. • Staff are unclear on when and how to share information appropriately. • Lack of information sharing impacts coordination, safety, and continuity of care. Amber - Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners • Information is shared in some cases, but processes may be informal, fragmented, or delayed. • Staff awareness and training on information governance is variable. • Systems do not reliably support timely or secure information exchange across sectors. Green - Clear, formalised, and consistently applied information sharing protocols are in place across all relevant partner organisations • Information sharing arrangements are aligned with legal and professional standards. • Staff are trained and confident in using them appropriately. • Systems support timely, secure, and purposeful information flow to enable coordinated care, joint risk management, and continuity across services.	Amber - Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners.
Reflecting on the past six months: Please outline the progress you have made in developing information sharing protocols and agreements, and/or describe any barriers you have encountered in implementing them.	Information sharing mechanisms are in place across BSOL through shared care. Work has commenced to look how this information can be strengthened in particular when looking at how these cohorts of Complex and More Complex service users can be tracked. Work is underway to look at the data from BQHC looking at the frequent user info which feeds into the INT and Locality Hubs. The locality work is maturing and the Case Management Tool is due to be released in August/September, this will allow for more robust data oversight and information sharing across, Health and Social Care, ICCR AD attending system Joint Strategic Operational Group to ensure input towards collaborative system working across community teams.	
Looking ahead: What specific actions are planned over the next six months to enhance multi-agency information sharing and collaboration?	Further work needs to take place to consider how the shared care systems can be enabled for VCSFE and the police, links via Kevin Haffeman are to be explored to consider this is can be taken forward.	

Family and carer involvement		
	RAG key	ICB self-assessment
To what extent are there governance arrangements and processes in place to monitor, respond to, and act on feedback from families and carers of individuals in this cohort? Consider: • Whether the ICB is aware of, and has oversight of, local mechanisms for collecting and monitoring family and carer feedback. • Whether there are clear processes in place at provider and/or system level to respond to feedback and make improvements. • How feedback from families and carers informs service development, quality assurance, and personalised care planning. • Evidence of regular engagement with families and carers in shaping services.	Red - There are no formal mechanisms in place to gather, monitor, or respond to family and carer feedback • The ICB has limited or no awareness of local processes for involving families or carers. • Feedback is not routinely collected or used to inform care or service improvement. • Families and carers report feeling excluded or unheard. Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance • The ICB is aware of some local processes but does not have consistent oversight. • Feedback mechanisms are present but may be limited in reach or impact. • Responses to feedback are variable, and changes made are not always communicated or evidenced. Green - Clear, embedded arrangements and processes are in place to routinely capture and respond to family and carer feedback • The ICB has full oversight of local processes and ensures feedback is used to inform service development and care planning. • Families and carers are regularly engaged, and their input is valued and acted upon. • There is evidence of feedback driving measurable service improvement, with clear communication back to families and carers.	Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance
Reflecting on the last six months: Please outline the progress made in improving your approach to involving families and carers in the care of this patient group. Your response should include how staff respond to concerns raised by families, the mechanisms in place to support meaningful engagement, and any current barriers to effective involvement.	The Trust has a dedicated Expert by Experience (EBE) and Co-Production Lead, who has collaboratively developed a governance structure that embeds the voices of families, service users, and carers in all areas of improvement. Service users are actively involved in project and steering groups, with direct links to the wider Trust Participation Team. In addition, national leads at IMROC have been commissioned to support further development of our co-production and peer support offer. A Peer Support Worker (PSW) Hub is currently being established, with PSWs joining operational teams to share their lived experience, strengthen the design of frontline services, and ensure our approaches remain consistently patient-centred.	
Looking ahead: What specific actions are planned over the next six months to strengthen the involvement of families and carers in care planning, service reviews, and service design?	Continued working with IMROC to embed learning and links with wider communities, continue work relating to certain communities and health inequalities and continue to roll out the peer support hub provision. Continue to develop assurance and governance to give MHPC/ICB full oversight of the work.	

Demonstrating Impact		
	RAG key	ICB self-assessment
To what extent are processes in place to measure, monitor, and demonstrate the effectiveness and impact of local services supporting this cohort? Consider: • Whether the ICB is aware of and has oversight of performance indicators, outcome measures, and quality metrics for relevant services. • The extent to which data is regularly collected, analysed, and used to inform service improvements. • How impact measurement incorporates patient outcomes, experience, and system-wide benefits. • How lived experience helps inform service design and delivery. • Whether there is transparency and accountability in reporting service effectiveness.	Red - There are no formal processes to measure or monitor the effectiveness of local services • The ICB lacks awareness of any outcome measures or performance data. • Data collection is absent or inconsistent, with no systematic analysis. • Service design and delivery is not co-produced with people with lived experience. • Service impact is not evaluated, limiting opportunities for improvement or accountability. Amber - Some processes exist but are inconsistent, incomplete, or lack full integration across services • The ICB has partial oversight of some performance indicators or outcome measures. • Data is collected irregularly or not routinely analysed to inform decisions. • There is limited input from people with lived experience to support the design and delivery of services. • Impact measurement focuses on limited aspects and does not fully incorporate patient outcomes or experience. Green - Comprehensive and embedded processes are in place to systematically measure, monitor, and demonstrate service effectiveness • The ICB has full oversight of relevant metrics, including PROMs and family specific outcome measures. • Data is regularly collected, analysed, and used to drive continuous service improvement. • Services are co-designed with people with lived experience. • Reporting is transparent, and findings inform commissioning and accountability frameworks.	Amber - Some processes exist but are inconsistent, incomplete, or lack full integration across services
Reflecting on the last six months: Please describe the improvements made in monitoring service quality and tracking outcomes for this patient group, including any challenges or barriers faced.	Data is regularly collected through reporting cycle and links back impact operational and quality/safety decisions, lived experience workforce are in place and are continued to be recruited to as part of the peer support hub. EBE's form a fundamental part of our entire governance structure and inform and direct the changes that are made. Reporting is via a clear governance structure internally and informs decisions that are made. PROMs are regularly collected and DIALOG+ is being rolled out across services. In addition, the Data Dashboard for BSMMHT modelled on the Nottingham TTrust 'Safe Now' Data set is in development with a deadline of October for a	
Looking ahead: What actions are planned to evaluate and gain deeper insight into the impact of services on this patient group?	Continue to refine the model linking in the work that is underway with IMROC to look at Coproduction and the developing Peer Support Hub, along with the trusts patient participation team and the wider MHPC team particularly when considering commissioning impacts.	

Closing questions	
Thank you for taking the time to support this review. Please return the completed template to your regional NHSE team.	
Are there any particular are of best practice you can share?	EBE, Coproduction and health inequalities across the AWA community teams in well established Our work with the VCSFE is also established and continues to mature allowing access to partner offers across the system to holistically support service users Roll out of DIALOG+ and the work with its developer Stefan Pribe Roll out of PIFU and the move towards changes in the CMHT caseload management Implementation of the complexity metrics
What additional support is required from NHSE to meet the needs of the individuals in scope?	Peer Discussion with other trusts in the area to consider their plans of action would be beneficial

Committee Escalation and Assurance Report

Name of Committee	People Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	16 September 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 • Staff Survey Planning • Medical Directorate 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 impact of CYP on some of the workforce metrics was raised as a concern, particularly in relation to the percentage of agency spend that had transferred into the organisation. It was noted that the transfer had led to increased pressures on existing people function capacity and resources. The Committee would continue to monitor this closely. • The three sub-groups (Transforming our Culture and Staff Experience, Shaping our Future Workforce and Multi-Professional Education and Training) all raised concerns in relation to quoracy and lack of representation from Medical and Pharmacy colleagues. This was having a negative impact on business cycles and key work progress. Reviews would be undertaken on meeting frequency, membership and business items to improve governance processes.
Assure:	• The Committee noted that 97% of doctors had completed their annual appraisals. • Positive assurance had been received on the planning for this year's Staff Survey, with a focus on engagement with key hotspot areas. • The Committee noted continued reduced sickness levels, with the Trust reporting the second lowest sickness rates across the system.
Advise:	The People Committee highlighted some discrepancy in reporting of key workforce metric data in different reports and requested that the same data points were used consistently for monthly reporting. The Trust was currently utilising 40% of its apprenticeship levy, with a continued underspend. This was being monitored within the Learning and Development and Finance teams to optimise usage.



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	Report of the Extraordinary Finance, Performance and Productivity Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	18 September 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 • Developing the 2026/27 Plan • Winter Plan, inc Board Assurance Statements • Committee Effectiveness Self-Assessment
Alert:	• The Month 5 position was a reported deficit of £1.9m, which was £3.6m adverse to plan. This was an improvement of £0.2m compared to July, with a significant reduction in non-Trust bed expenditure in August partly offset by an increase in bank spend. • A financial recovery plan had been developed with a trajectory to recover year-to-date overspend and meet the original plan surplus of £4.2m. This plan was reliant on non-Trust bed expenditure and temporary staffing expenditure reductions to meet original plan levels. • The 2025/26 savings target was £36m. To date, the savings achieved was £11m, which was £3.8m adverse to plan. It was forecast that the target would be achieved through non-recurrent means, and the target would rollover for 2026/27; it was noted (and agreed) that this approach was not sustainable. The recovery plan for 25/26 remained very high risk in terms of the Trust's ability to assure the Committee on long-term financial sustainability. • The Committee highlighted the importance of embedding a culture of continuous improvement and delivering services in a more transformative way, which would enable stronger recurrent financial, organisational and qualitative benefits. Clear alignment and accountability between strategy, the Trust's cost reduction plans, quality improvement and Digital was needed to ensure long-term sustainable efficiency. This was a key consideration when developing the Trust's financial plans for 26/27 and the five-year outlook. The Committee would continue to seek assurance against this as planning phases began.



	- The Committee noted the review of the go-to-green plans for Talking Therapy services, as the current plans were not having the desired impact. - The Committee also noted the high level of Bank spend (11% of total pay spend), despite the ongoing action plans to reduce spend.	
Assure:	Continued improvements were reported, with positive performance on spot bed purchasing and placements noted. There was also improvement seen in clinically ready for discharge processes. The Committee acknowledged the progress being made, in particular the Trust's very positive position at M5 with spot bed purchases and inappropriate out-of-area placements. The Committee received and noted the Winter Plan and endorsed the Board Assurance Statement.	
Advise:	The Committee would continue to seek assurance through the Trust's ability to deliver the 2025/26 financial position and to establish a recurrent financial plan for 2026/27 and beyond, supporting long-term financial sustainability. The potential for a digitally-focused sub-group or committee was discussed, with further exploration required to determine whether this would be feasible. This aligns with the point made in the Alert section around developing a culture of continuous improvement.	
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



Committee Escalation and Assurance Report

Name of Committee	Report of the Extraordinary Finance, Performance and Productivity Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	19 August 2025
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Finance Report • National Oversight Framework
Alert:	• The Month 4 position was reported deficit of £2.3m, which was £3.7m adverse to plan. A surplus had been seen in July, however this was mostly driven by non-recurrent benefits. • A projected £16m overspend was forecast, driven by significant savings shortfall across the Trust, and ongoing financial pressure particularly related to acute and older adults inpatients. A monthly financial trajectory report had been requested by NHSE to assess progress. • The Committee reviewed the National Oversight Framework, its metrics, segmentation process and the anticipated impact on the Trust's public profile, internal communications and performance management. The Committee's position was unchanged from July in seeking urgent assurance on the Trust's ability to remediate the financial plan for this year, as well as providing assurance on long term financial sustainability.
Assure:	The Committee received assurance on improvements in the use of non-contracted beds and discharge processes. This would continue to be monitored closely to ensure sustainable processes were in place to continue to meet trajectory.
Advise:	The CYP transfer had been reflected in the Trust's financial position from Month 4, and was reported breakeven. Any underlying budgetary pressures were being discussed and resolutions sought. The Committee sought assurance on the achievability of the 2025/26 savings plan, including identification of business as usual and innovative savings, and to clarify the expected timeline to identify these savings.
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



compassionate



inclusive



committed

	Failure to deliver optimal outcomes with available resources	
	New risks identified: The Committee reflected on the reputational risks associated with the National Oversight Framework and the need for clear narrative ownership, and the role of committees and the Board of Directors in providing clear messaging.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	Minutes available from: Kat Cleverley, Company Secretary

Report to Board of Directors						
Agenda item:	15					
Date	1 October 2025					
Title	Month 5 2025/26 Finance Report					
Author/Presenter	Emma Ellis, Head of Finance & Contracts / Richard Sollars, Deputy Director of Finance					
Executive Director	David Tomlinson, Executive Director of Finance	Approved	Y	✓	N	
Purpose of Report		Tick all that apply ✓				
To provide assurance	✓	To obtain approval				
Regulatory requirement		To highlight an emerging risk or issue		✓		
To canvas opinion		For information		✓		
To provide advice		To highlight patient or staff experience				
Summary of Report						
Alert	✓	Advise		Assure		
Purpose To provide an overview of the Group month 5 year to date financial position. Introduction The 2025/26 consolidated Group month 5 year to date position is a deficit of £1.9m which is £3.6m adverse to plan. The August position is an improvement of £0.2m compared to July. A significant reduction in non-Trust bed expenditure in August is partly offset by an increase in bank spend. The draft month 5 BSOL ICS financial position is a £38m deficit (£23m adverse to plan). Key Issues and Risks Alert: The Committee is asked to note and discuss the following key financial alerts: Deficit position and financial recovery plan – The month 5 year to date position is a deficit of £1.9m, compared to a planned surplus of £1.7m, this is a £3.6m adverse variance. A financial recovery plan, as shared with the executive team, has been developed with a trajectory to recover year to date overspend and meet the original plan surplus of £4.2m. It is reliant upon non-trust bed expenditure and temporary staffing expenditure being reduced to meet original plan levels alongside other non-recurrent mitigations including technical adjustments. This was shared with NHSE on 8.9.25 and discussed at a meeting with NHSE regional finance on 11.9.25. Savings – The 2025/26 savings target is £36m. The month 5 year to date savings achieved is £11m, this is £3.8m adverse to plan. It is forecast that the full year savings target will be achieved but £15m will be via non-recurrent means. As such this will rollover as a savings target for 2026/27.						

- **Group Underlying position** - As at month 5, the underlying position is assessed as £25m deficit. This comprises £15m roll forward savings target, £5m underlying deficit in the Mental Health provider collaborative related to packages of care volume and inflation increases and £2m underlying deficit in Reach Out provider collaborative related to growth in secure inpatient beds usage. In addition to this, Children and Young People's (CYP) services which transferred to BSMHFT on 1.7.25 from Birmingham Women's and Children's Foundation Trust (BWCH) is currently showing a £3.5m to £4m recurrent deficit, discussions continue between CFOs from BSMHFT and BWCH to address this.
- **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 month 5 year to date spend of £14.7m is £2.6m adverse including local savings targets. The financial recovery plan is reliant on temporary staffing spend reducing in line with original plan.
 - **Bank:** There has been a £0.5m increase in temporary staffing run rate in month 5 driven by increased bank spend trust wide. The Executive Director of Nursing is leading the Bank Reduction Gold project to progress actions to meet required expenditure reduction.
 - **Agency:** There has been a significant reduction in non-CYP agency spend in recent months, in particular medical agency spend in ICCR and Specialties. This improvement has been offset by CYP agency spend which totals £0.6m for July and August and equates to nearly one third of the total year to date agency spend.

Advise:

- **Financial planning** – on 8.9.25, NHSE published the planning framework. It outlines the shift from annual planning to rolling five-year integrated plans, with the aim of securing medium-term financial sustainability while enabling service transformation. We await further guidance and notification of allocations but we will be required to develop plans during October to December 2025, with plan submissions due December 2025 and review by NHSE regional teams during quarter 4.

Capital position:

The month 5 year to date 2025/26 Group capital expenditure is £1.6m, this is £5.2m adverse to plan and £90k behind the revised forecast. The capital plan was phased equally across the year.

Cash position:

The Group cash position at the end of month 5 was £98m, including £33m Trust cash balance.

Recommendation

The Board is asked to review the month 5 year to date financial position and discuss the key alerts noted.

Enclosures

Month 5 2025/26 finance report

Finance Report

Financial Performance:
1st April 2025 to 31st August 2025

Group financial position

£1.9m deficit YTD

Group Summary	Annual Budget	0.68% Pay Award Funding	CYP Transfer	Revised Plan	YTD Position		
					Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
Patient Care Activities	706,067	4,638	401	711,106	296,152	288,456	(7,696)
Other Income	24,081	-	8,343	32,424	11,888	14,620	2,732
Total Income	730,148	4,638	8,744	743,530	308,040	303,076	(4,964)
Expenditure							
Pay	(319,512)	(2,750)	(24,460)	(346,722)	(139,647)	(138,833)	814
Other Non Pay Expenditure	(369,431)	(1,888)	18,112	(353,207)	(150,683)	(149,361)	1,322
Drugs	(6,058)	-	(1,320)	(7,378)	(2,817)	(3,763)	(946)
Clinical Supplies	(684)	-	(23)	(707)	(290)	(342)	(52)
PFI	(13,896)	-	-	(13,896)	(5,790)	(5,836)	(46)
EBITDA	20,566	-	1,053	21,619	8,812	4,940	(3,872)
Capital Financing							
Depreciation	(10,033)	-	(795)	(10,828)	(4,357)	(4,350)	7
PDC Dividend	(500)	-	-	(500)	(208)	(208)	(0)
Finance Lease	(6,939)	-	-	(6,939)	(4,438)	(4,466)	(28)
Loan Interest Payable	(882)	-	(258)	(1,140)	(425)	(437)	(13)
Loan Interest Receivable	3,376	-	-	3,376	1,407	1,718	312
Surplus / (Deficit) before taxation	5,588	-	-	5,588	790	(2,804)	(3,594)
Taxation	(380)	-	-	(380)	(158)	(163)	(4)
Surplus / (Deficit)	5,208	-	-	5,208	632	(2,967)	(3,598)
Adjusted Financial Performance:							
Remove capital							
donations/grants/peppercorn lease I&E	5	-	-	5	2	2	-
Adjust PFI revenue costs to UK GAAP	(1,013)	-	-	(1,013)	1,111	1,111	-
Adjusted financial performance Surplus / (Deficit)	4,200	-	-	4,200	1,745	(1,853)	(3,598)

Month 5 2025/26 Group Financial Position

The 2025/26 consolidated Group month 5 year to date position is a deficit of £1.9m (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 of £1.1m). The August position is a surplus of £0.4m which is an improvement of £0.2m compared to July. A significant reduction in non-Trust bed expenditure in August is partly offset by an increase in bank spend.

The year to date position is £3.6m adverse to plan. There is £3.8m slippage on savings year to date (page 6). Non-Trust bed expenditure is £1.1m above plan year to date but there has been a £0.6m reduction in spend in August (page 7). Temporary staffing expenditure has increased by £0.5m in August compared to July, mainly driven by increased bank spend (pages 8 to 10).

The Group position is driven by a deficit of £1.9m in the Trust, £3k surplus for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £104k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Financial Recovery Plan

A financial recovery plan has been developed and reported to NHSE, this includes a trajectory to recover year to date overspend and meet the original plan surplus of £4.2m. It is reliant upon non-trust bed expenditure and temporary staffing expenditure being reduced to meet original plan levels alongside other non-recurrent mitigations including technical adjustments (see appendix 1).

Draft System position Month 5 YTD

The draft month 5 year to date financial position for Birmingham and Solihull Integrated Care System (BSOL ICS) is a deficit of £38m which is £23m adverse to plan.

Total Performance	YTD			FOT			Prior Month variance £000s	YTD	
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plan £000s	FOT £000s	Variance £000s		Income / Allocation £000s	Deficit as % of turnover
BSOL ICB	-2,967	-2,058	909	0	0	0	1,178	1,786,868	-0.12%
BSMHT	1,737	-1,861	-3,598	4,200	4,200	0	-3,675	303,076	-0.61%
BCHC	312	-1,116	-1,428	0	0	0	-1,547	162,528	-0.69%
BWC	0	-4,700	-4,700	0	0	0	-4,631	309,000	-1.52%
ROH	-803	-671	132	35	35	0	352	58,816	-1.14%
UHB	-12,716	-27,441	-14,725	-4,200	-4,200	0	-9,483	1,102,787	-2.49%
Total	-14,437	-37,847	-23,410	35	35	0	-17,806	3,723,074	

Total Actual Surplus/(Deficit)	Trend					YTD £000s
	M1 £000s	M2 £000s	M3 £000s	M4 £000s	M5 £000s	
BSOL ICB	-627	-555	-679	608	-805	-2,058
BSMHT	-1,086	-1,496	77	220	425	-1,861
BCHC	-604	-585	-294	141	226	-1,116
BWC	-1,081	-698	-1,222	-1,630	-69	-4,700
ROH	-377	403	-242	-164	-291	-671
UHB	-11,221	-2,753	-4,833	-2,666	-5,968	-27,441
Total	-14,997	-5,685	-7,193	-3,490	-6,482	-37,847

Total Variance	Trend					YTD £000s
	M1 £000s	M2 £000s	M3 £000s	M4 £000s	M5 £000s	
BSOL ICB	0	78	-52	1,152	-269	909
BSMHT	-1,433	-1,843	-270	-128	77	-3,598
BCHC	-496	-688	-402	39	119	-1,428
BWC	-1,081	-698	-1,222	-1,630	-69	-4,700
ROH	-96	629	-71	-110	-220	132
UHB	-7,268	654	-1,822	-1,047	-5,242	-14,725
Total	-10,375	-1,869	-3,839	-1,723	-5,604	-23,410

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	172,654	-	68,781	197,799	(150,778)	288,456
Other Income	14,386	11,854	-	-	(11,620)	14,620
Total Income	187,040	11,854	68,781	197,799	(162,398)	303,076
Expenditure						
Pay	(130,681)	(5,629)	(1,172)	(1,489)	138	(138,833)
Other Non Pay Expenditure	(42,687)	(2,765)	(67,991)	(196,892)	160,974	(149,361)
Drugs	(3,932)	(960)	-	-	1,128	(3,763)
Clinical Supplies	(342)	-	-	-	-	(342)
PFI	(5,836)	-	-	-	-	(5,836)
EBITDA	3,560	2,500	(382)	(582)	(157)	4,940
Capital Financing						
Depreciation	(2,905)	(1,362)	-	-	(83)	(4,350)
PDC Dividend	(208)	-	-	-	-	(208)
Finance Lease	(4,460)	(148)	-	-	143	(4,466)
Loan Interest Payable	(437)	(845)	-	-	845	(437)
Loan Interest Receivable	1,474	21	487	582	(845)	1,718
Surplus / (Deficit) before Taxation	(2,977)	165	104	0	(97)	(2,804)
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(163)	-	-	-	(163)
Surplus / (Deficit)	(2,977)	3	104	0	(97)	(2,967)
Add back all I&E impairments/(reversals)	-	-	-	-	-	-
Surplus / (Deficit) before impairments	(2,977)	3	104	0	(97)	(2,967)
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	2	-	-	-	-	2
Adjust PFI revenue costs to UK GAAP basis	1,111	-	-	-	-	1,111
Medical equipment grant	-	-	-	-	-	-
Adjusted financial performance Surplus / (Deficit)	(1,863)	3	104	0	(97)	(1,853)

Trust Month 5 YTD

£3.6m overspend

	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m
Acute and Urgent Care Services	30.4	33.7	(3.2)
Healthcare Income	(173.7)	(171.1)	(2.6)
Specialties Services	21.3	23.2	(1.8)
Trustwide	(1.1)	(1.1)	(0.0)
ICCR	32.1	31.1	1.0
Secure Services & Offender Health	30.9	30.5	0.4
Corporate Services	46.5	43.9	2.6
CYP*	12.9	12.9	0.0
Adjust PFI revenue costs to UK GAAP basis	(1.1)	(1.1)	0.0
(Surplus) / Deficit - Trust	(1.7)	1.9	(3.6)

Annual Budget	Projected spend	Variance
£m	£m	£m
73.1	78.8	(5.7)
(440.3)	(434.8)	(5.5)
51.2	55.2	(4.0)
(6.5)	(1.4)	(2.2)
77.1	76.0	1.1
74.2	73.8	0.4
107.9	103.5	4.4
58.1	55.3	(0.0)
1.0	1.0	0.0
(4.2)	7.3	(11.5)

Projected spend as at month 5 gives a forecast £12m variance to plan, a financial recovery plan has been developed to mitigate against this, see Appendix 1.

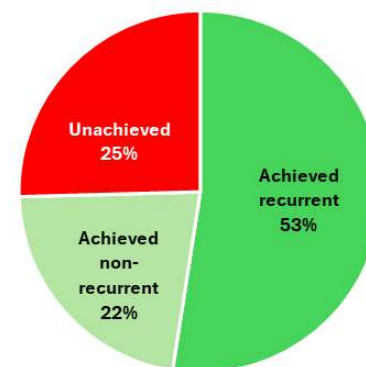
Group Underlying position

As at month 5, the underlying position is assessed as £25m deficit. This comprises £15m savings target (forecast to deliver non-recurrently in 2025/26, see page 6), £5m underlying deficit in the Mental Health provider collaborative related to packages of care volume and inflation increases and £2m underlying deficit in Reach Out provider collaborative related to growth in secure inpatient beds usage. In addition to this, CYP services are currently forecast as break even for 2025/26, but discussions continue between CFOs from BSMHFT and BWCH around the underlying position which is currently showing a £3.5m to £4m recurrent deficit.

	Year to date			Annual		
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Forecast £'000	Variance £'000
Non-Recurrent	2,306	3,264	958	5,529	14,773	9,244
Recurrent	12,453	7,742	(4,711)	30,879	21,635	(9,244)
Grand Total	14,759	11,006	(3,753)	36,408	36,408	0

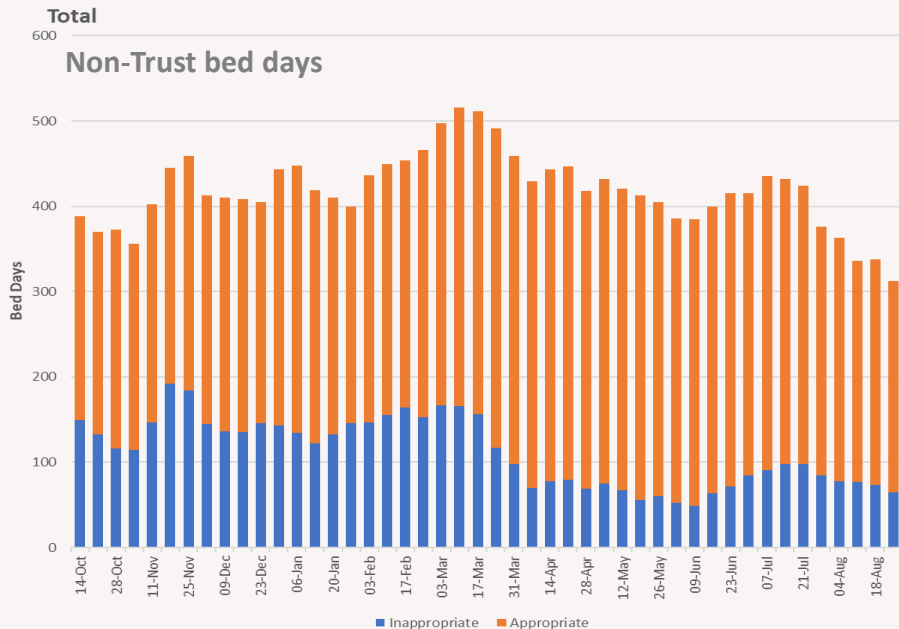
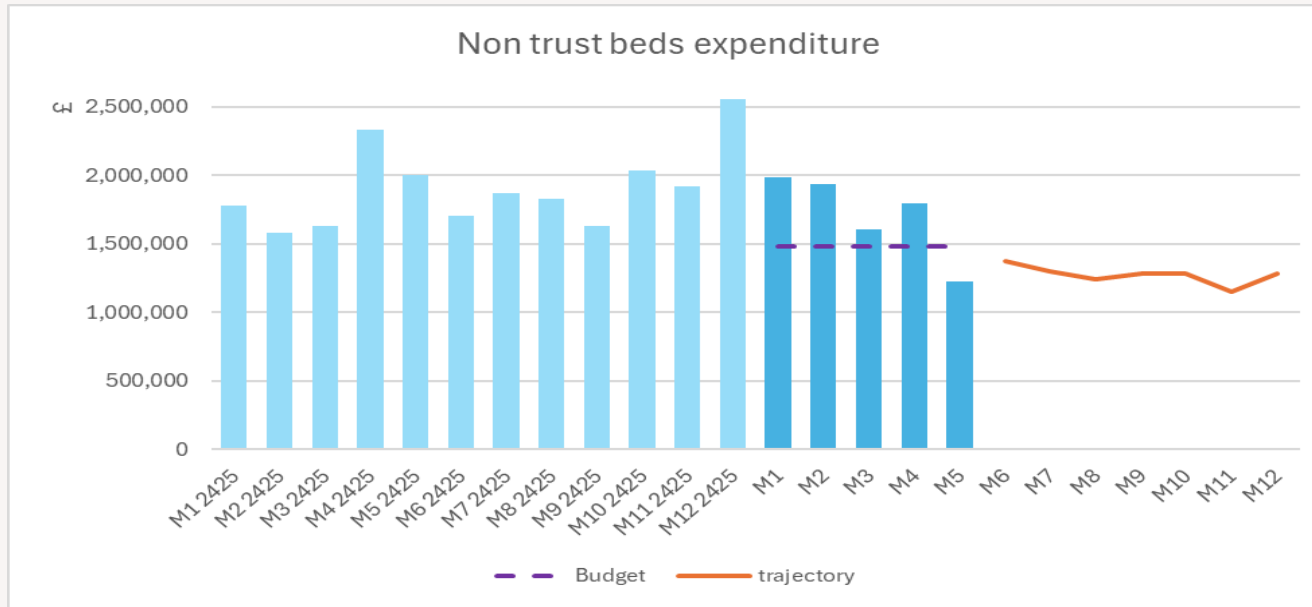
- The 2025/26 efficiency target is £36.4m. This comprises £30.9m recurrent and £5.5m non recurrent targets.
- The month 5 year to date savings achieved is £11m, this is £3.8m adverse to plan.
- Local forecasts suggest a £7.5m shortfall on delivery, non recurrent mitigations have been determined via financial recovery plan (appendix 1).
- It is currently forecast that £15m savings will be achieved non-recurrently, meaning that this £15m savings target will roll forward to 2026/27.

YTD savings achievement v plan



	Year to date			Annual			Comments - forecast variance
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Forecast £'000	Variance £'000	
Trustwide	6,014	4,553	(1,461)	15,429	11,339	(4,090)	£2.5m decommissioning, £1.7m provider collaborative income, £0.5m corporate benchmarking, part offset by £0.7m B/S flex release
Acute & Urgent Care	3,767	2,103	(1,664)	9,039	7,600	(1,439)	slippage on 2% savings schemes (£1m bank reduction, £0.3m vacancy factor)
Specialties	531	75	(456)	1,282	367	(915)	slippage on 2% savings schemes (£0.4m bank reduction, £0.3m vacancy factor)
Corporate	529	352	(177)	1,258	725	(533)	slippage on 2% savings schemes (£0.4m SW licence reduction)
ICCR	820	825	5	1,966	1,453	(513)	slippage on 2% savings schemes (£0.4m ICRT income)
Secure & Offender Health	598	598	0	1,434	1,434	-	
Provider Collaboratives	2,500	2,500	-	6,000	6,000	-	
Grand Total	14,759	11,006	(3,753)	36,408	28,917	(7,491)	

Non-Trust Beds overspend



- The 2025/26 non-Trust bed budget is £17.8m.
- The month 5 year to date spend of £8.5m is an overspend of £1.1m.
- There has been a significant reduction in August, with spend being £0.6m below the year to date average. This is predominantly driven by spot placements being reduced (from 7 at the start of the month) to zero. There has also been a net reduction in contracted placement usage of 3.
- The current forecast in the financial recovery plan is total expenditure of £18m (in line with original plan).



compassionate

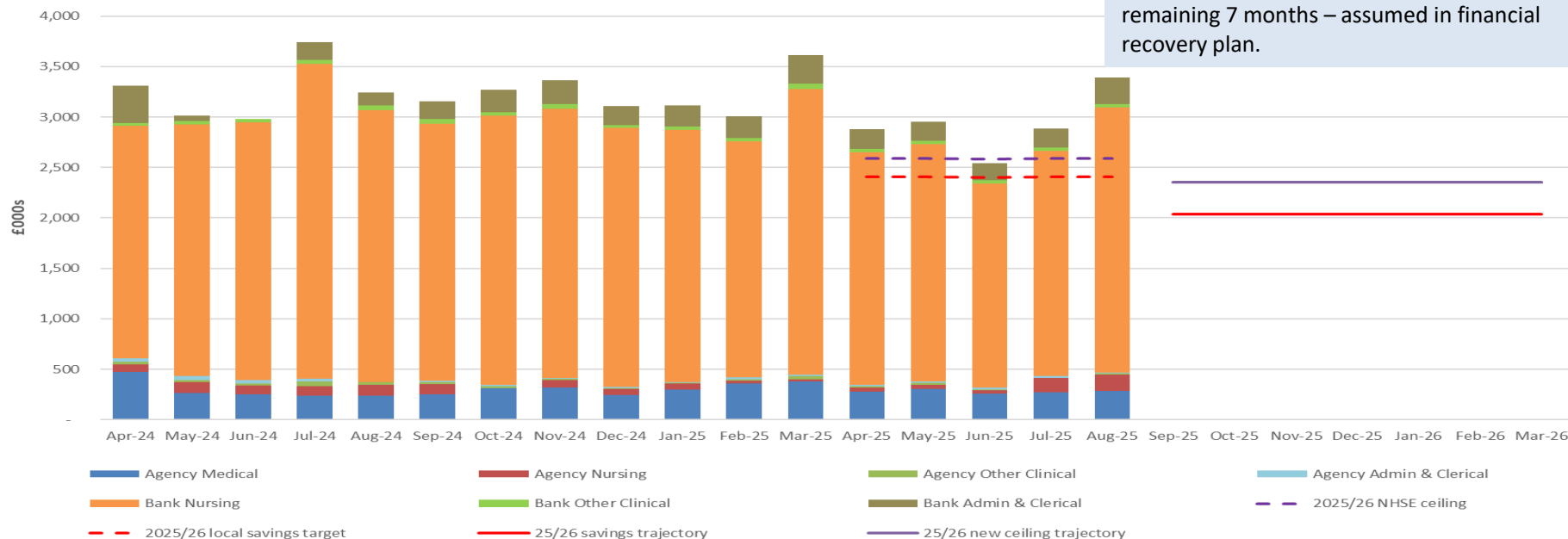


inclusive



committed

Agency & Bank Spend by Type



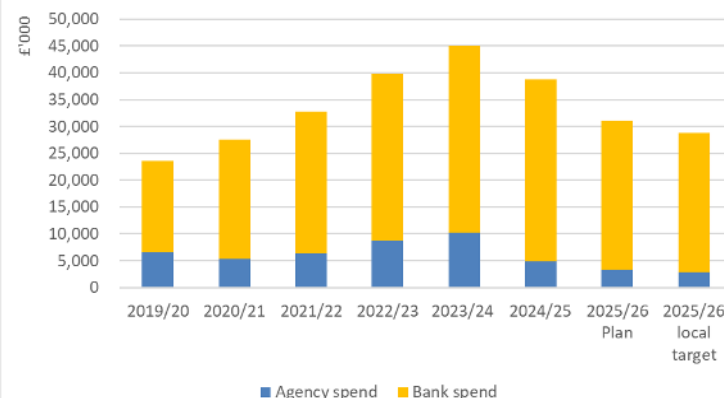
The 2025/26 temporary staffing plan of £31m has been set in line with the NHSE ceiling (reduction of 30% agency and 15% bank spend compared to November 2024 forecast). Additionally, local savings targets of £0.5m for agency and £1.7m for bank expenditure have been set.

The month 5 year to date spend of £14.7m is £1.7m above the NHSE ceiling plan and £2.6m adverse including local savings targets. Spend in August is £501k higher than July, with £464k relating to bank spend. For total spend to be within the NHSE ceiling and meet local savings targets, monthly spend will need to reduce by £1.4m per month from September onwards,

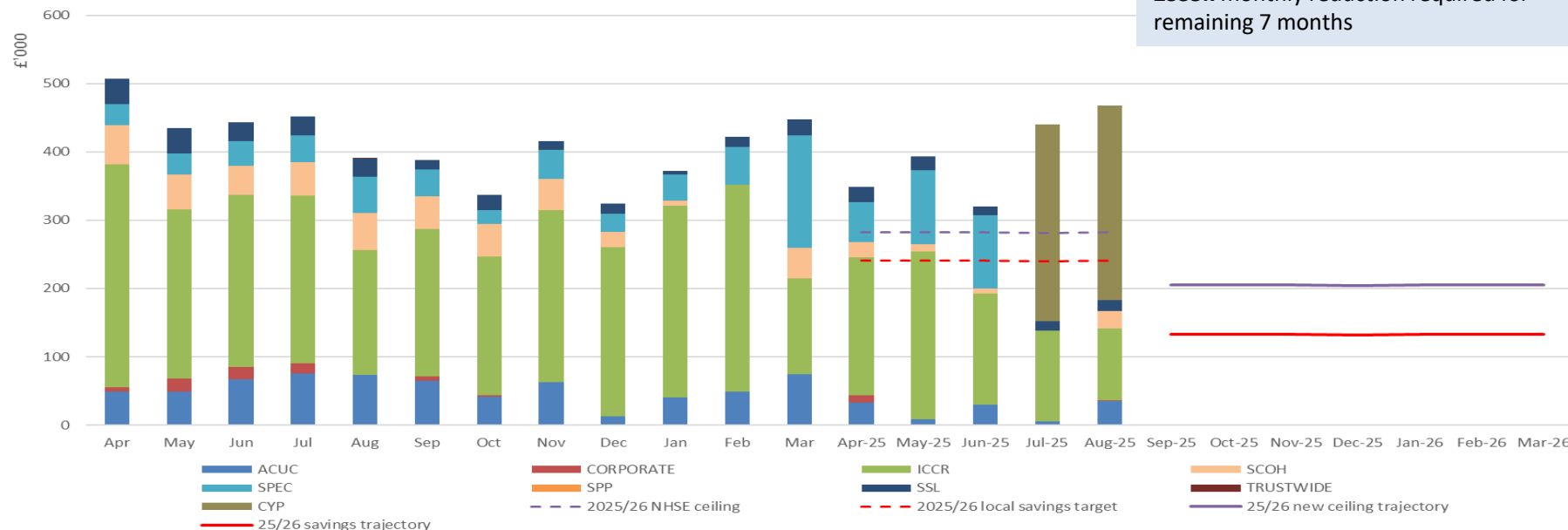
Bank expenditure £12.7m (86%) – the majority of bank expenditure relates to nursing bank shifts - £11.5m

Agency expenditure £1.95m (14%) – the majority of agency expenditure relates to medical agency - £1.4m.

Total temporary staffing spend



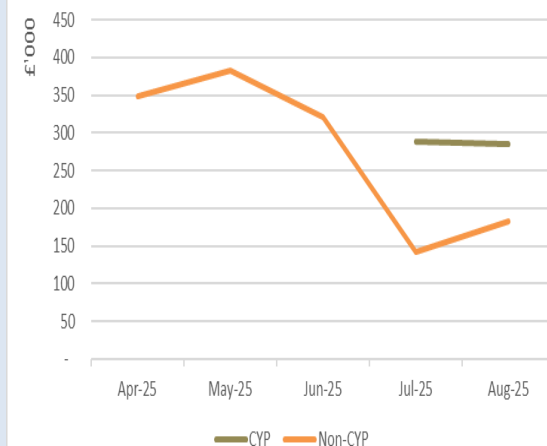
Agency Spend by Service Area



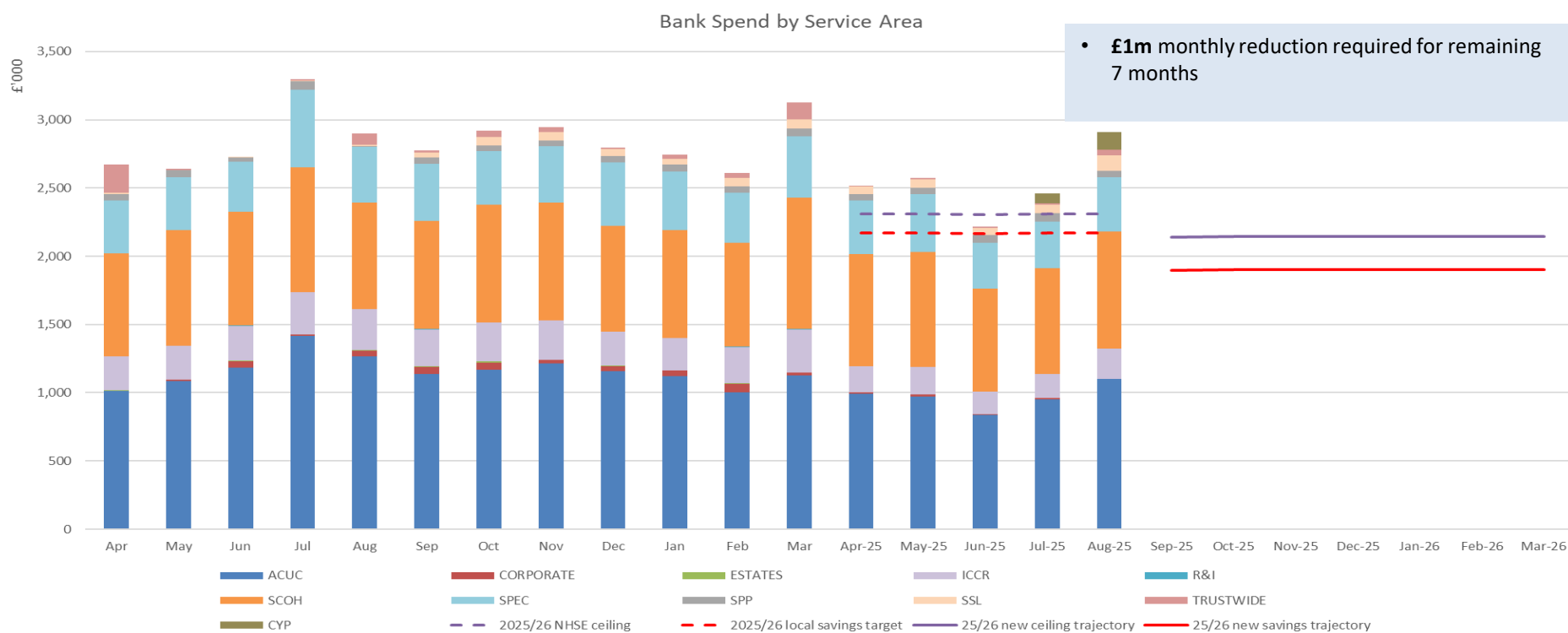
Agency expenditure

- The month 5 year to date agency expenditure is £1.95m which is £539k adverse to the NHSE ceiling (set as 30% reduction from November 2024 forecast) and £748k adverse including local savings targets.
- August agency expenditure is £37k higher than in July.
- There has been a considerable reduction in non-CYP agency since June, with the month 4 and 5 average spend being £188k less than the quarter 1 average (ICCR £84k and Specialities £94k). As of August, medical agency has been eradicated within Specialities.
- The transfer of CYP to BSMHFT from 1 July 2025 has lead to a significant increase in agency spend that has offset the non-CYP reductions. CYP expenditure is £574k for July and August (this equates to 29% of total agency spend)
- For total spend to be within the NHSE ceiling and meet local savings targets, reduction of £335k per month from August onwards is required. We are working with BWCH to understand the agency ceiling that was assumed in their original financial plan for CYP.

Agency run rate

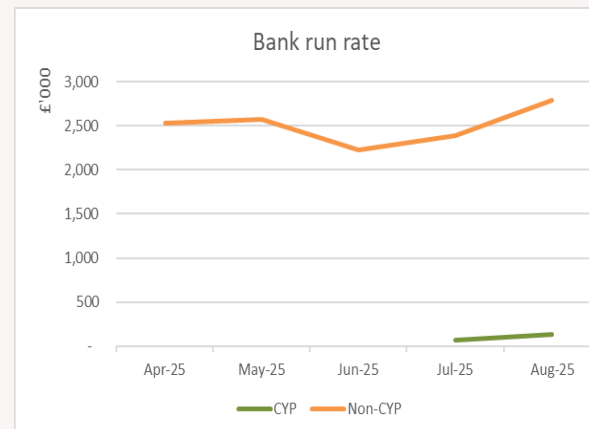


Bank expenditure



Bank expenditure

- The month 5 year to date bank expenditure is £12.7m which is £1.2m adverse to the NHSE ceiling (set as 15% reduction from November 2024 forecast) and £1.9m adverse including local savings targets.
- £464k increase in spend in August compared to July. £149k increase in Acute and Urgent Care due to increased levels of PICU specialising and summer holiday cover. Other increases: Secure Care & Offender Health £83k, CYP £62k, SSL £54k, Specialties £58k
- August 2025 bank spend of £2.9m is consistent with August 2024.
- For annual spend to be within the NHSE ceiling and meet local savings targets, a reduction of £1m per month (35%) from the August level is required from September onwards.



Consolidated Statement of Financial Position (Balance Sheet)

SOFP Highlights

The Group cash position at the end of August 2025 is £97.9m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 12 to 13.

Current Assets & Current Liabilities

Ratios

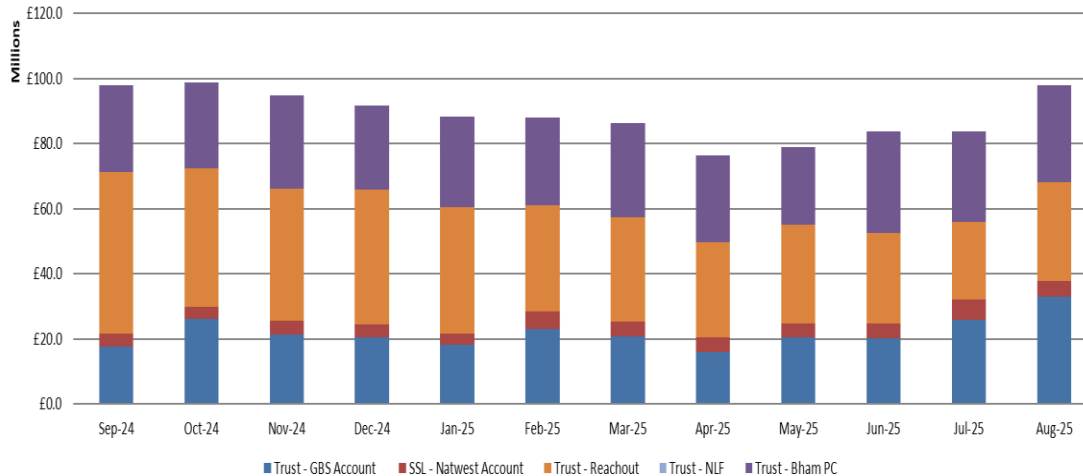
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	£m's
Current Assets	117.1
Current Liabilities	-134.0
Ratio	0.9

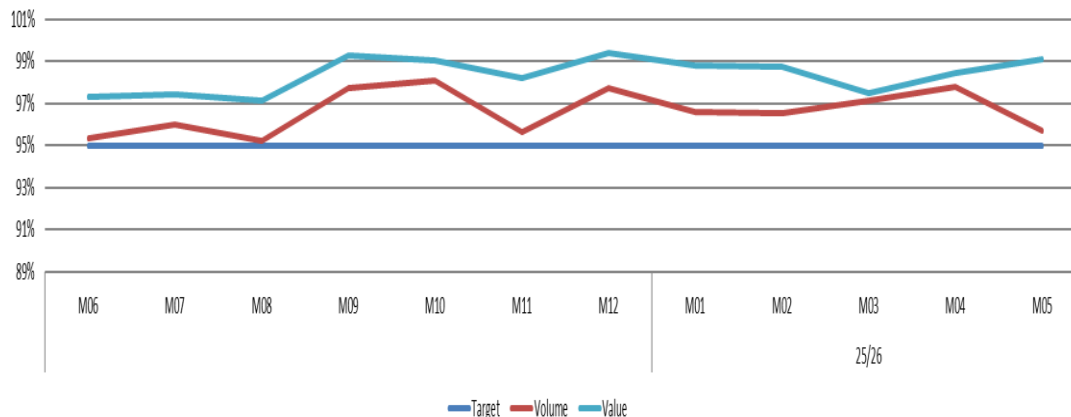
Current Assets to Current Liabilities cover is 0.9:1 this shows the number of times short-term liabilities are covered.

Statement of Financial Position - Consolidated	EOY - 'Audited' 31-Mar-25 £m's	NHSI Plan YTD 31-Aug-25 £m's	Actual YTD 31-Aug-25 £m's	NHSI Plan Forecast 31-Mar-26 £m's
Non-Current Assets				
Property, plant and equipment	221.1	223.8	218.6	227.5
Prepayments PFI	1.2	1.2	2.2	1.2
Finance Lease Receivable	0.0	-	(0.0)	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	222.4	225.0	220.7	228.8
Current assets				
Inventories	0.6	0.6	0.6	0.6
Trade and Other Receivables	31.0	31.0	18.6	31.0
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	86.4	85.0	97.9	83.0
Total Current Assets	117.9	116.6	117.1	114.6
Current liabilities				
Trade and other payables	(86.2)	(86.4)	(74.1)	(86.2)
Tax payable	(6.7)	(6.7)	(9.6)	(6.7)
Loan and Borrowings	(2.6)	(2.6)	(2.5)	(2.6)
Finance Lease, current	(1.3)	(1.3)	(1.3)	(1.3)
Provisions	(1.3)	(1.3)	(1.0)	(1.3)
Deferred income	(35.6)	(35.6)	(45.5)	(35.6)
Total Current Liabilities	(133.7)	(133.9)	(134.0)	(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)	(80.7)	(80.7)	(78.9)
Finance Lease, non current	(4.8)	(4.5)	(4.7)	(4.1)
Provisions	(2.4)	(2.4)	(2.4)	(2.4)
Total non-current liabilities	(107.1)	(107.1)	(107.2)	(103.8)
Total assets employed	99.6	100.7	96.6	105.9
Financed by (taxpayers' equity)				
Public Dividend Capital	117.9	118.4	117.9	119.1
Revaluation reserve	49.1	49.1	49.1	49.1
Income and expenditure reserve	(67.5)	(66.9)	(70.4)	(62.3)
Total taxpayers' equity	99.6	100.7	96.6	105.9

Group Cash Holding



Public Sector Pay Policy



Cash

The Group cash position at the end of August 2025 is £97.9m. This comprises of Trust £32.8m, SSL £4.9m, Reach Out Provider Collaborative 30.5m and Mental Health Provider Collaborative £29.7m.

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

Better Payments

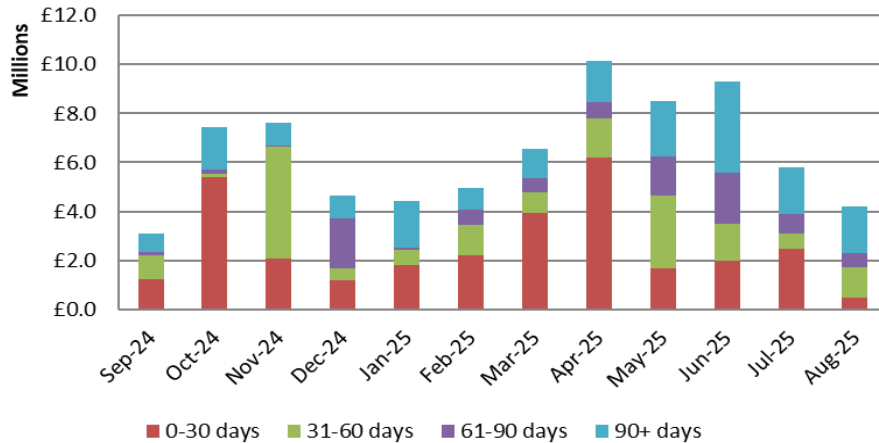
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

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

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	98%	✓	98%	✓
Non - NHS Creditors within 30 Days	96%	✓	98%	✓

Ageing of Trade Receivables



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 :

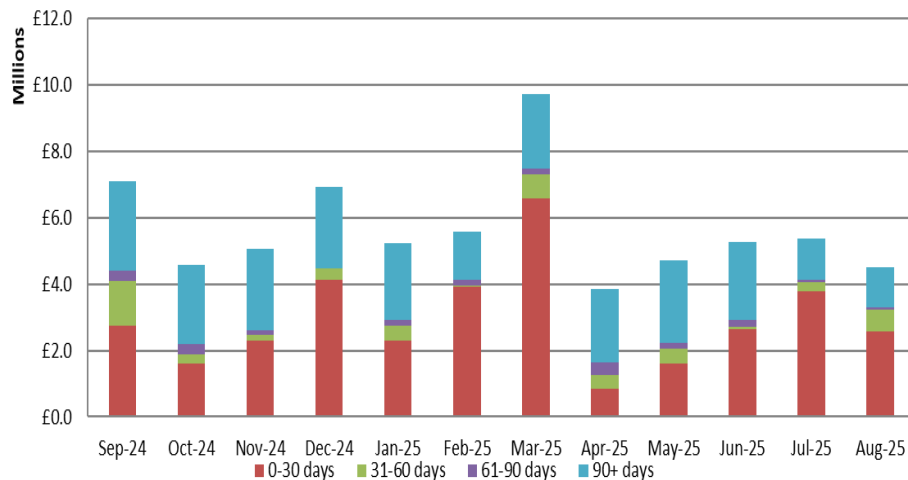
- **0-30 days-** Overall Balance £480k- decrease in balance. Several debts have been settled, awaiting approval/payment. Balance consists of monthly/daily ad hoc invoices waiting to be advised if approved or in query.
- **31-60 days-** Overall Balance £1.2m - increase in balance. *Paid:* £635k Sept 25. *Awaiting authorisation:* £650k. Remaining balance mainly staff overpayments (on payment plans).
- **61-90 days-** Overall Balance £635k- decrease in balance. *Awaiting authorisation:* £27k, *In query:* BWC - £44k, UHB-£561k, SDSmy HC -£3.5k. Remaining balance mainly staff overpayments (on payment plans).
- **Over 90+ days-** Overall Balance £1.9m—decrease in balance. *Awaiting authorisation:* BWC £955k, UHB - £229k, Black Country HC - £24, NHS Commissioning - £5.2k, BSOLMHPC - £46k, ReachOut - £223k, UofB - £94.6k, Comm Care HG PCn - £7.6k, ATW - £22.2k, Parexel Inc Ltd - £29.5k, SDSmy HC - £14.1k, Anthony Nolan - £57.6k. Remaining balance mainly staff overpayments (on payment plans).

Trade Payables-Over 90 days:

NHS Suppliers £145k: UHB £35k in query (working directly with UHB to resolve accordingly), CNWL £55k in query, Nottinghamshire £52k in query.

Non-NHS Suppliers (48+) £1.0m: 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 September 2025.

Ageing of Payables



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:							
AUC/Others - Anti-Barricade Alarmed Doorsets	0.4	0.4	(0.4)	0.0	0.0	0.0	0.0
Refurbishment for FIRST Team and Recovery College	1.0	1.0		1.0	0.1	0.0	0.1
ACUC Bathrooms	0.2	0.2		0.2	0.0	0.0	0.0
SSBM Works	2.1	2.1		2.1	0.2	0.4	(0.2)
Medical Devices	0.1	0.1		0.1	0.0	0.0	0.0
Lease Vehicles	0.3	0.3	0.5	0.8	0.8	0.5	0.3
Recognition of IFRS 16 Leases	0.3	0.3		0.3	0.0	0.0	0.0
ICT	0.1	0.1	0.4	0.5	0.3	0.2	0.0
Minor Works	4.0	4.0	(0.6)	3.4	0.2	0.3	(0.1)
2025/26 Estates Safety	1.1	1.1		1.1	0.0	0.0	0.0
24/7	3.2	3.2		3.2	0.0	0.0	0.0
Total	12.6	12.6	0.0	12.6	1.6	1.5	0.1
Highcroft New Build	6.1	6.1		6.1	0.2	0.1	0.1
Total	18.8	18.8	0.0	18.8	1.8	1.6	0.2

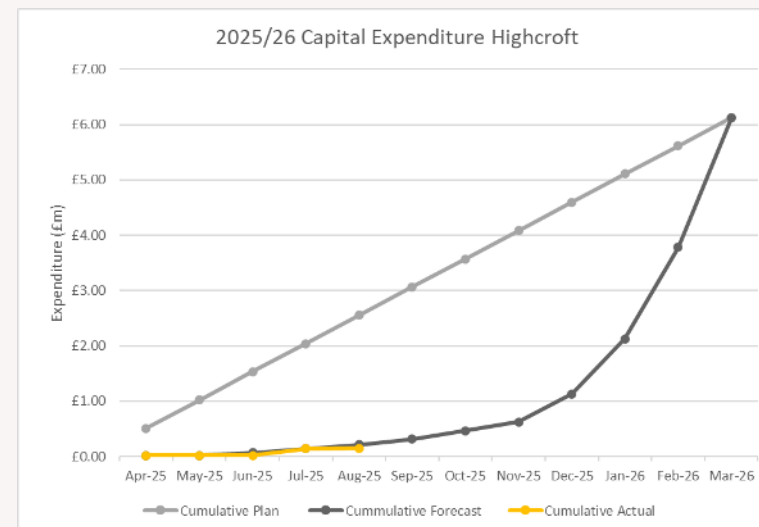
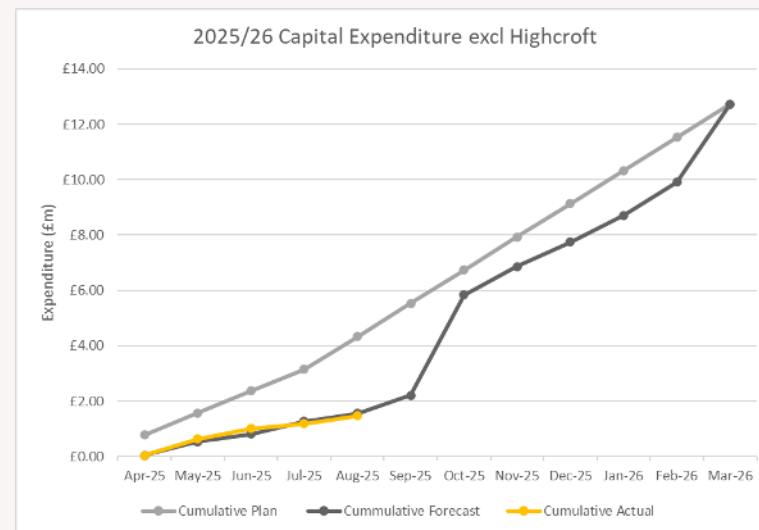
Group Capital Expenditure

The total revised planned capital for 25/26 is £18.86m, this reflects an additional ICT capital of £90k that has been awarded for the Cyber Improvement Programme.

Capital Excl. Highcroft - As per the table above, there has been 1.47m year to date spend against a capital forecast of £1.56m in month 5, £90k behind year to date forecast spend. The variance to original plan is £5.2m year to date (capital plan phased equally across the year).

Highcroft Project – Year to date spend £148k against a forecast spend of £215k, £70k behind forecast.

Approximately £5m is forecast to be spent in quarter 4.



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Committee Escalation and Assurance Report

Name of Committee	Audit Committee
Report presented at	Board of Directors
Date of meeting	1 October 2025
Date(s) of Committee Meeting(s) reported	24 September 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 • Local Counter Fraud Specialist Progress Report • External Audit Report 2024/25 • Standing Financial Instructions • Terms of Reference Review • Anti-Fraud Bribery and Corruption Policy
Alert:	The Committee wished to alert the Board of Directors to the impact of external risk for oversight and triangulation, particularly in relation to social disruption, industrial action, supplier organisation failures, inflation and cyber security. The Committee also discussed the pace of change needed on the refresh of the Trust strategy that would link to the delivery and sustainability of financial and quality plans.
Assure:	The Committee was assured on the following areas: • The Committee was assured by the internal audit progress and action tracking reports, noting the continued proactive work. • The Committee received the external audit report for 2024/25 and was assured by the unqualified audit opinion that had been received.
Advise:	The Committee endorsed the revised Standing Financial Instructions, which had been updated to include new procurement legislation. The Committee endorsed the Anti-Fraud Bribery and Corruption Policy. A comprehensive update on internal audit job planning management actions was received, with some assurance received on progress.



Board Assurance Framework	The Committee reviewed the Board Assurance Framework and was satisfied with the progress made so far, noting that the BAF provided greater clarity and strategic oversight and would continue to mature. The Corporate Risk Register was received, and the Committee was encouraged by the progress made and by the process for reviewing and escalating risks through the Risk Management Group. The Committee discussed the need for a more forward-looking approach to risk, with future reports to include emerging risk themes for committees to monitor. The Committee received the Commissioning BAF and was satisfied with the significant improvements and notable progress made. Positive assurance was received on the SSL Risk Summary.	
	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:	17					
Date	1 October 2025					
Title	NHSE Provider Capability Assessment Update Report					
Author/Presenter	David Tita – AD of 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 (<i>executive summary, key risks</i>)						
Alert		Advise		Assure		✓
1. Purpose: As part of the NHS Oversight and Assessment Framework, NHSE will assess NHS providers` capability, and using the intelligence gathered alongside providers` NOF segmentations will judge and decide on what actions or support the provider may need. This is an evidence-based piece of work grounded in the evidence which Providers will present. NHSE expects boards to assess their organisation`s capability against the following six oversight domains set out in `The Insightful Provider Board` guidance: - • Strategy, leadership and planning • Quality of Care • People and culture • Access and delivery of services • Productivity and value for money • Financial performance and oversight Deadline for submission for completing and submitting this piece of work on Assessing provider capability (i.e. Board Self-assessment template and Board Self-certification) to the NHSE Regional team is 22nd October 2025. NHSE has assigned a `relationship lead` to our Trust so they could support us through the process and they have also arranged a virtual training session for `nominated leads` on <i>Friday 26th September 10.00-11.00</i> with the aim to facilitate completion of the Assessing provider capability and answering any questions which Providers may have. 2. Introduction: Assessing Provider capability comprises 2 distinct but complementary steps: • Completing an evidence-based Self-assessment template. • Completing the Board Self-certification. Key dates to save: - • A presentation on Assessing provider capability has been delivered to Execs and the members of the Senior Leadership Team. • The six broad domains articulated in `The Insightful Provider Board` guidance` around which the self-						

assessment template has been framed, have been aligned to Exec portfolios with staff completing at pace as the deadline is set for **Friday 26th September**. As of the time of writing this report, over **75% of the template has been completed** on the Teams channel.

- The ET meeting will receive an update on Monday 29th September, prior to receiving the full completed self-assessment template and Board Self-Certification as well as evidence on **Tuesday 7th October** for scrutiny and recommendation to Board Committees and the Board.
- Two extraordinary meetings have been arranged to review and approve the self-assessment and Board self-certification prior to submission to NHSE; -
 - ❖ A Joint FPP/PC and QPES Committee meeting for **Wednesday, 8th October 2025**.
 - ❖ A Board meeting on **Friday 10th October**.

From the pace with which colleagues are completing the self-assessment, there is reasonable assurance that this piece of work will be completed timely. We intend to submit our package on Assessing provider capability to the NHSE Regional team on **Monday, 20th October 2025**.

3. Key issues and risks:

There are two key risks worth recognising: -

- Potential risk that staff may not adequately showcase the great work they are doing in evidencing and demonstrating compliance with the key lines of inquiry which underpin the six broad domains.
- Potential failure to provide robust and compelling evidence.

In terms of mitigations in place, Kat and I are providing tailored and targeted support to colleagues who contact us whilst I am encouraging colleagues to read through the narrative provided by their teams (*First Line of Defence*), then I will also read through the narrative and evidence (*Second Line of Defence*), prior to submitting to Execs for further scrutiny and completion of the Board Self-certification.

Strategic Priorities

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

Recommendation

The Board is requested to:

1. **NOTE** the content of this report.
2. **GAIN ASSURANCE** that the Trust will timely complete and submit the piece of work on Assessing provider capability.

Enclosures

Appendix 1: Assessing provider capability – Presentation (reading pack)

Appendix 2: Assessing provider capability guidance (reading pack)

Report to Board of Directors						
Agenda item:	18					
Date	1 October 2025					
Title	Risk Appetite 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 <i>(executive summary, key risks)</i>						
Alert		Advise		Assure	✓	

1. Purpose:

As a follow up to the discussion on the Risk Appetite Framework (RAF) at the strategic board development session and completion of the Risk Appetite Framework SurveyMonkey by all 13 members of the Board of Directors, this report will present the outcome of the survey with emphasis on members' preferred risk appetite category for each type of risk.

The Board of Directors is expected to review, scrutinise and approve the enclosed RAF for inclusion in the updated Risk Management Policy and wider application across the Trust.

2. Introduction:

This report notes that although members of the Board were very clear on most types of risk as to their preferred risk appetite category, there were two risks where this wasn't the case as the Board was inconclusive on their preferred risk appetite categories.

i.

Inconclusive Risk Appetite categories – no specific board preference				
Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board's preferred risk appetite category
Reputational	Appetite for risk taking limited to those events where there is little chance of any significant repercussion for organisation.	Cautious 42.86% (6)	6-8	
	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Open 42.86% (6)	9-10	

ii.



Inconclusive Risk Appetite categories – no specific board preference

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board's preferred risk appetite
Digital Improvement	Systems / technology developments considered to enable improved delivery, maximisation of patient care and avoidance of harm. Agile principles may be followed.	Open 35.71% (5)	9 – 10	
	New technologies viewed as a key enabler of operational delivery. Maximisation of patient care and avoidance of harm. Agile principles are embraced.	Eager 35.71% (5)	12	

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The Board is expected to debate, discuss and identify their preferred risk appetite category for the above two risk types (*i.e. Reputational and Digital Improvement*).

3. Key issues and risks:

There are two main issues worth recognising here: -

- The need to disseminate the approved new Risk Appetite Framework as part of the updated Risk Management Policy.
- The need to encourage staff to regularly consult and use the RAF in setting the target risk scores for their risks.

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:**

- REVIEW** and **SCRUTINISE** the content of the enclosed Risk Appetite Framework.
- IDENTIFY** their preferred risk appetite categories for the inconclusive two risk types.
- RATIFY** the enclosed Risk Appetite Framework.
- GAIN ASSURANCE** that the design of the Trust's Risk Appetite Framework aligns with best practice.

Enclosures

Appendix 1. The new Trust Risk Appetite Framework

Appendix 1. The new Trust Risk Appetite Framework

Risk Appetite Framework

RISK APPETITE FRAMEWORK (RAF)

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

- Supporting informed decision-making.
- Reducing uncertainty.
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement.
- Focusing on priority areas within an organisation.
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board's preferred risk appetite
Quality & Safety	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.	Cautious	6 - 8	Cautious
Reputational	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Open	9-10	
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Open	9 – 10	Open
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	9 – 10	Open
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	6 – 8	Cautious

Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open	9 - 10	Open
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Open	9 – 10	Open
Data and Information Management	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Cautious	6 - 8	Cautious
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	Cautious	6 – 8	Cautious
Digital Improvement	New technologies viewed as a key enabler of operational delivery. Maximisation of patient care and avoidance of harm. Agile principles are embraced.	Eager	12	
Cyber Security	Consideration given to adoption of established /mature systems and good cyber security architecture and awareness of cyber security threats. Agile principles are considered.	Cautious	9 - 10	Cautious
Transformation/ Projects and Quality Improvement	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.	Open	9 – 10	Open
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	Minimal	2 - 4	Minimal
Property	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Open	9 - 10	Open

Environment	Requirement to adopt a range of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Cautious	12	Cautious
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open	9 – 10	Open
Partnerships & Provider Collaboratives	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.	Open	9 -10	Open

N.B: BSMHFT's Risk Appetite Framework is aligned to target risk scores!

Report to Board of Directors						
Agenda item:	19					
Date	1 October 2025					
Title	Risk Management Policy					
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 (<i>executive summary, key risks</i>)						
Alert		Advise		Assure	✓	
1. Purpose: This report presents the updated Trust's Risk Management Policy to the Board of Directors for review, scrutiny, strategic oversight, assurance and ratification following its approval and recommendation by the Risk Management Group and Audit Committee. BSMHFT Risk Management Policy sets out the Trust's risk management approach, process and procedure for identifying, assessing, monitoring, reviewing, managing and mitigating potential risks to the achievement of its operational and strategic objectives/priorities while ensuring and prioritising the provision of high-quality safe care. 2. Introduction: BSMHFT Risk Management Policy thus provides a structured and comprehensive framework for supporting the proactive mitigation and management of both the threats and opportunities which obtain in the Trust's risk management space and for promoting a culture of risk awareness and informed decision-making. Reviewing the Trust's Risk Management Policy every year enables the Trust to ensure its Risk Management Policy remains relevant, effective, adheres to best practice and aligns to its current strategic priorities and operational context. Key changes to this updated version of the Trust's Risk Management Policy include: - • Strengthening of the rationale for having a Risk Management Policy. • Clarification on type of controls and how they can lead to a reduction of the likelihood and/or impact of risk scores. • Inclusion of the Head of Health and Safety and Regulatory Compliance as the lead for the responsibilities which had previously been assigned to the AD of Clinical Governance. • Inclusion of <i>Caring Minds</i> as a Board Committee while setting out its oversight responsibilities for the effective mitigation and management of risks within its remit.						

- The updated Risk Appetite Framework (RAF) has been included pending approval from the Board of Directors today.

Further changes to the Trust's Risk Management Policy are highlighted in orange.

3. Key issues and risks:

There are two main issues worth recognising here: -

- The need to disseminate the updated Risk Management Policy to staff and services across the Trust.
- The need to encourage staff to regularly consult and use the Policy as an aide-memoire.

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** and **SCRUTINISE** the content of the attached updated Risk Management Policy.
2. **RATIFY** the attached updated Risk Management Policy.
3. **GAIN ASSURANCE** that the attached Risk Management Policy has been appropriately updated in line with best practice.

Enclosures

Appendix 1. Updated Risk Management Policy

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	RS 01	Risk & Safety
VERSION NO & DATE	18.2	October 2025
RATIFYING COMMITTEE	Board of Directors	
DATE RATIFIED	October 2025	
NEXT REVIEW DATE	1 year after ratification	
EXECUTIVE DIRECTOR	Executive Director of Finance	
POLICY LEAD	Associate Director of Corporate Governance	
POLICY AUTHOR <i>(if different from above)</i>	As above	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	Yes	

Previously Reviewed:	June 2023	Sept 2024	Oct 2025						
Changes Made: Yes/No:	Yes	Yes	Yes						

POLICY REQUIREMENT

This Policy applies to all staff - including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, agency staff, TSS/Bank staff, trainees, contractors, Trade Union colleagues, students and persons engaged in doing business or providing services on behalf of the Trust. **It would be reviewed annually as there is a requirement for the Trust Board of Directors to agree on and approve the organisation's risk appetite framework every year.**

- All staff members are responsible for:
 - ensuring that risks are identified, assessed, **mitigated** and **appropriately** managed.
 - highlighting identified risks to their manager where they are unable to manage them as part of their legitimate role/responsibilities.
- All operational service areas and Executive Directors should systematically review risks on their risk registers, in a timely, dynamic and proportional way, **with** those scored 15 or more, on a monthly basis as a minimum while those scored 12 or less quarterly as a minimum, identify controls for mitigation and **actions to implement to attain target risk score as well as** evaluate their effectiveness.
- The Risk Management Group (RMG) will ensure **effective risk management arrangements including** controls are in place to proactively manage the escalation of risks. Risk moderation will take place at the RMG to determine appropriateness of risk scores, approve risks for escalation and ensure operational risks do not compromise the delivery of the Trust's operational objectives and business plan.
- All risks which could significantly compromise the Trust's ability to deliver its operational and strategic objectives will be reviewed on a monthly basis as a minimum via the Corporate Risk Register and Board Assurance Framework respectively, by the Quality, Patient Experience and Safety Committee, People Committee, and the Finance, Performance and Productivity Committee, as a tool for driving their **meeting** agendas, discussions, debates **and deliberations**.
- The Audit Committee will **independently review, assure and advise the Board of Directors on the effectiveness of the Trust's systems of internal control including its risk management arrangements and that these are effectively working in ensuring the achievement of organisational operational and strategic objectives/priorities.**

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1 Introduction

1.1 Rationale

The development and implementation of this Policy will be underpinned by the Trust's values of compassionate, inclusive and committed.

Risk is the **uncertainty** chance that something may happen which may have adverse **(threats)** or positive impacts **(opportunities)** on the achievement of the Trust's **operational and strategic** aims and objectives. It is measured by multiplying the likelihood (frequency or probability of the risk occurring) by the severity/consequence (impact or magnitude of the effect of the risk occurring)

(Adapted from ISO 31000:2018)

Risks will always be present in the things that we do. Effective risk management will foster the Trust's culture of safety, improve decision making and enhance the quality of patient care while ensuring robust and sustainable use of resources. The aim of this policy is to ensure that all staff are confident and empowered to actively understand risk, recognise hazards which could develop into risks, and know how to effectively identify risks, assess, report, review, mitigate and manage them risks to support in achieving the overall aims of the organisation. This means that we look at all staff are expected to effectively mitigate and manage risks at all levels; ranging from the risks to delivery of our strategic priorities/aims, through to the day-to-day operational delivery of team-based objectives which in turn contribute to the bigger picture.

This is demonstrated in the pictorial diagram below: -

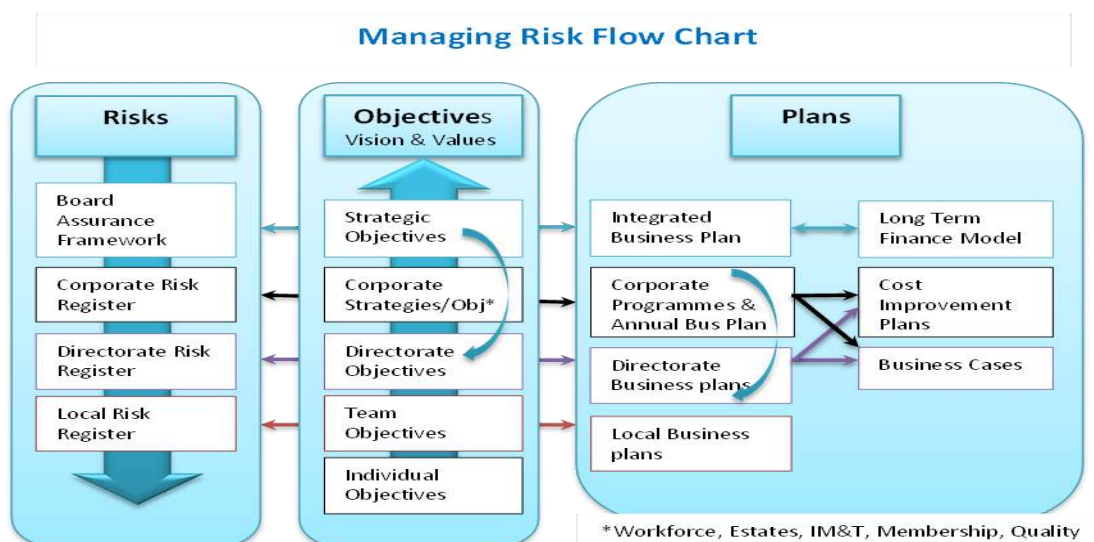


Figure 1 – Managing risks flow chart.

Good risk management is at the heart of everything we do in the Trust. We need to be open, honest, transparent and aware of the risks we are facing on a day-to-day basis level as well as strategically. BSMHFT is committed to implementing an agile, dynamic, integrated, Trust-wide, proportionate and proactive approach

to risk management – i.e. to identifying, assessing and managing potential risks/threats to the delivery of its operational objectives and strategic priorities.

In large complex organisations, managing risk could seem a daunting task. Risks are, however, inherent in everything that we do as the provision of healthcare entails some uncertainty, ~~hence, that uncertainty brings~~ which could create new opportunities and risks. How we manage existing and emerging risks is important in helping us meet our objectives, improve service delivery, achieve value for money as well as reduce unwarranted variations, fire-fighting and unwelcome surprises.

This Risk Management Policy provides a structured and comprehensive framework for the effective, proactive and timely mitigation and management of risks. ~~Sound recording and escalation mechanisms are described for departmental risks, wider locality service area risks and Trust wide risks.~~ This will be underpinned by clearly established systems and processes for Services, Directorates and Divisions to identify, assess, prioritise and treat risks well as regularly monitor, review and escalate those they wish to get support with mitigating and managing.

This policy also sets out the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks. Transparency, openness and accountability including effective management and governance review, scrutiny and oversight, are hallmarks of BSMHFT's risk management arrangements.

1.2 Scope

This Policy applies to all staff, including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, Agency, TSS/Bank staff, agency staff, trainees, contractors, Trade Union colleagues, and students and persons engaged in doing business or providing services on behalf of the Trust. Effective risk management like good governance is everyone's responsibility from the shopfloor to the Board.

The Trust works in partnership with Birmingham Community Healthcare and other partners within the system to ensure individuals with learning disabilities have full and equal access to the full range of mental health services. Therefore, all aspects of this policy will equally apply to service provision within related learning disabilities.

1.3 Principles

The Trust's approach recognises:

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The implementation of the risk management arrangements must be proportionate, timely, dynamic, aligned to the delivery of the Trust's goals, comprehensive and embedded into business as usual as well as responsive to changes within the Trust's business environment.

- There is need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create opportunities for staff to explore a risk-based approach in tackling 'wicked issues' which could undermine the delivery of high-quality safety care. Some risks will always exist as they will never be completely eliminated; hence, staff must understand the nature of risk while accepting responsibility and accountability for their effective mitigation and management.
- The Trust explores an integrated approach to risk management that combines a top-down strategic view with a complementary bottom-up operational process.

2 Policy

All staff members are responsible for ensuring that risks are identified, assessed and managed.

All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.

The consequence and likelihood of risk occurrence will be assessed against the Trust wide risk scoring matrix (see appendix 1 for details). Risks will be recorded on risk registers via the Eclipse electronic risk management system.

All local service areas, managers and Executive Directors should systematically review risks on their risk registers or within their portfolios on a quarterly basis as a minimum. Risks scored 15 and above, should be reviewed monthly as a minimum while those scored 12 or less should be reviewed quarterly. Regular review, presentation and discussion of risks irrespective of their scores at Local Clinical Governance Committees is a marker of good governance as it provides assurance that risks are thoroughly and appropriately managed and mitigated in related Service, Directorate or Division. However, Local service areas, Directorates and corporate support teams are expected to escalate any risks with a score of 15 or more that have been approved at their local governance meeting, signed off at the Directorate level and by the relevant Executive Director. Such risks will then be presented at the RMG for consideration and approval for inclusion onto the CRR, please see section 5 for more details on risk escalation.

Risks which could significantly compromise the delivery of the Trust's corporate objectives/business plan, once approved by the RMG, will be added onto the Corporate Risk Register (CRR). Relevant extracts of the Corporate Risk Register will be presented to the Quality Patient Experience and Safety Committee, People Committee and Finance, Productivity and Performance each time the BAF is received to ensure both the CRR and BAF complement, inform and each feed off other.

Whilst management is responsible for operationalising risk management across the Trust, Board Committees, the Board and related governance arrangements are responsible for providing scrutiny, constructive challenge and oversight. The entire CRR will be presented to the Audit Committee and Board each time they receive the BAF.

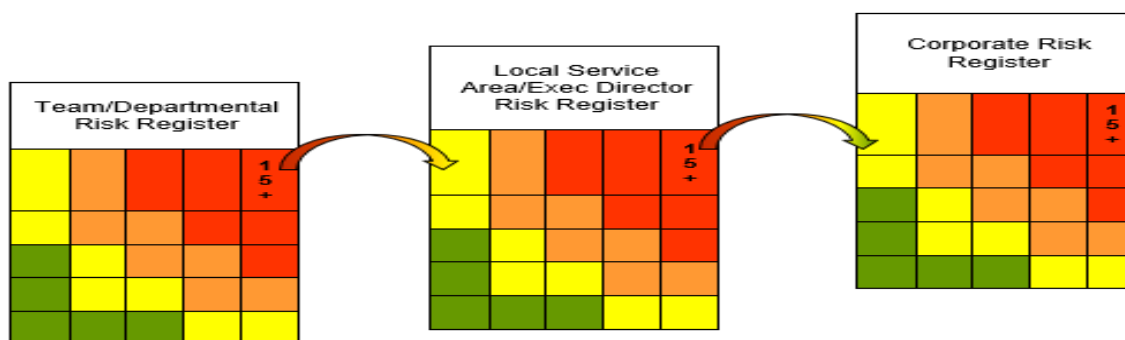


Figure 2 - Escalation in the Risk Register Hierarchy

BSMHFT's Risk Management Policy provides a comprehensive framework to underpin how staff in all Services and Directorates across the Trust should timely and proactively identify, assess, manage and mitigate any potential risks that could compromise the achievement of their local operational objectives/goals. It thus seeks to foster standardisation, engagement, consistency and galvanise leadership in fostering effective risk management and risk escalation from 'Ward to Board'.

3 Procedure

3.1. The Trust's overall approach to risk management is underpinned by the following 5 key distinct but interrelated and complementary steps: -

- Establish the Context
 - Risk Identification
 - Risk Analysis
 - Risk Evaluation
 - Risk Control/Treatment
- } Risk assessment



Figure 3: BSMHFT's approach to risk management - Five steps

3.1.1. Step 1: Establish the context

As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priorities in order to clearly identify risks and opportunities which may impact on their achievement. It is also important to consider the internal and external contexts.

3.1.2. Step 2: Risk identification

The identification of risk needs to be dynamic process, should involve all staff and ensure that appropriate action is taken before incidents/actual loss or harm have occurred. Risks may be clinical or non-clinical, including financial and reputational and may be identified from many sources, such as but not limited to:



Figure 4 - Sources of Risk Identification

Any change process implemented in the Trust should be risk assessed before, during and after it has occurred. Significant projects should be managed through the Project Management Office so that risk & issue logs including Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams.

For risks which arise in the Trust’s Emergency Preparedness, Resilience and Response (EPRR) space, BSMHFT’s Emergency Preparedness & Business Continuity (BC) Management Policy clearly sets out a strategic framework for their effective management, including emergency planning and business continuity for the Trust as this applies to all staff (both temporary and permanent). The Emergency Preparedness and Major Incident plans, as well as a range of other associated documents, are designed to ensure the resilience of the Trust in a range of scenarios that would limit its operating capacity.

Major Incident plans should be tested on a regular basis, and risks identified from any learning communicated back to the relevant groups to ensure processes are refined. All risks relating to EPRR and BC should be captured on the Trust risk

management information system (Eclipse), reviewed monthly as a minimum for those scored 15 or more and quarterly as a minimum for those scored 12 or less, as well as reported to the Business Continuity & Emergency Preparedness Committee which has responsibility for scrutinising, communicating and escalating such risks through the relevant Trust governance channels.

Staff should adhere to the Trust's structured approach for describing risks also referred to 'Cause and Effect Analysis' or the 'Bow-tie' model. This model clearly identifies the event, the cause and the effect. It is helpful to frame the description of a risk into three parts by starting with these phrases:

- **There is a risk of/that/if...**(this relates to not achieving an objective as intended).
- **This may be caused by...**
- **This may lead to an impact/effect on ...**

Risk description must be clear and use concise appropriate language e.g.

- *"There is a risk that patients may not be discharged promptly from the Community Hospital.*

This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Hence the description of a risk must clearly outline the event or objective that relates to or might not be achieved if the risk were to crystallise, what could be the cause(s) and what could be some potential impacts and/or opportunities.

3.1.3. Step 3: Risk analysis

Determine the cause and effect and analyse what could happen, where, when, why and decide who might be harmed and how. Also determine the existing controls, the likelihood and consequences as well as estimate the level of risk. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

3.1.4. Step 4: Risk Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and if the risk were to be realised (likelihood). The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix (see appendix 3 for details) in assessing and scoring the risk. Decide on the most appropriate risk response option. The following three risk scores will have to be identified during a risk assessment process: -

- **Inherent** – this refers to the uncontrolled level of risk i.e. the initial or gross risk before any controls and actions are put into place.
- **Current** – this is the residual risk after controls and action have been put into place.
- **Target** – this is the threshold at which the risk would be sufficiently mitigated such that it could be tolerated or accepted as actions have

been completed and controls internalised into BAU. The target risk score is linked to the Risk Appetite Framework (see appendix 6 for details).

3.1.5. Step 5: Risk Treatment & Prioritisation

Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to reduce the risk and then identify further actions, which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan or risk treatment plan and decide on how best to manage it.

Hence, a decision should be made as to whether the Trust should avoid, reduce, eliminate, accept/retain or transfer the risk.

- **Avoid:** Whether a particular task can be undertaken a different way so that the risk does not occur.
- **Reduce:** Whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure.
- **Eliminate:** Whether definitive action can be taken to eliminate the risk exposure.
- **Accept/Retain:** Whether the level of risk is acceptable as no further mitigating actions can be taken, or the extent of actions to be taken outweighs the consequence of the risk occurring. Risks that are accepted will continue to form part of our review and reporting processes.
- **Transfer:** Whether the risk can be transferred to another organisation

Where further actions are required to avoid, eliminate or reduce a risk in order to attain its target score, such actions must be entered onto the risk register alongside their completion dates and owner responsible for their delivery.

3.2. Risk Review and Monitoring

Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales: -

- Risks scored 15 or more should be reviewed monthly as a minimum.
- Risks scored 12 or less should be reviewed at least quarterly as a minimum.

The resources deployed to mitigate and manage a risk must be proportionate to the perceived potential impact of the risk were it to crystallise. All risks must be captured on, mitigated and managed via Eclipse - the Trust's electronic risk management information system as managing risks on papers/spreadsheets is highly discouraged by the Trust.

3.3. Types of control: Risk control techniques

Controls are measures or interventions that are implemented in order to reduce either the likelihood and/or impact of a risk were it to materialise. The following types of control are frequently used in mitigating and reducing risks: -

- a. **Preventive controls** - these controls are designed to limit the possibility of a risk crystallising e.g. regular maintenance of electrical equipment.
- b. **Corrective or Response controls** – These controls are designed to correct or in response to undesirable outcomes which have already been realised e.g. contingency planning.
- c. **Detective controls** – these controls are designed to detect a risk before it occurs e.g. Medication reconciliation to identify potential risk of medication error or accounts reconciliation to identify potential fraud.
- d. **Directive controls** – these are controls that we implement because we are directed by guidelines, regulation or legislation e.g. Requiring new staff to shadow before being allowed to work alone.

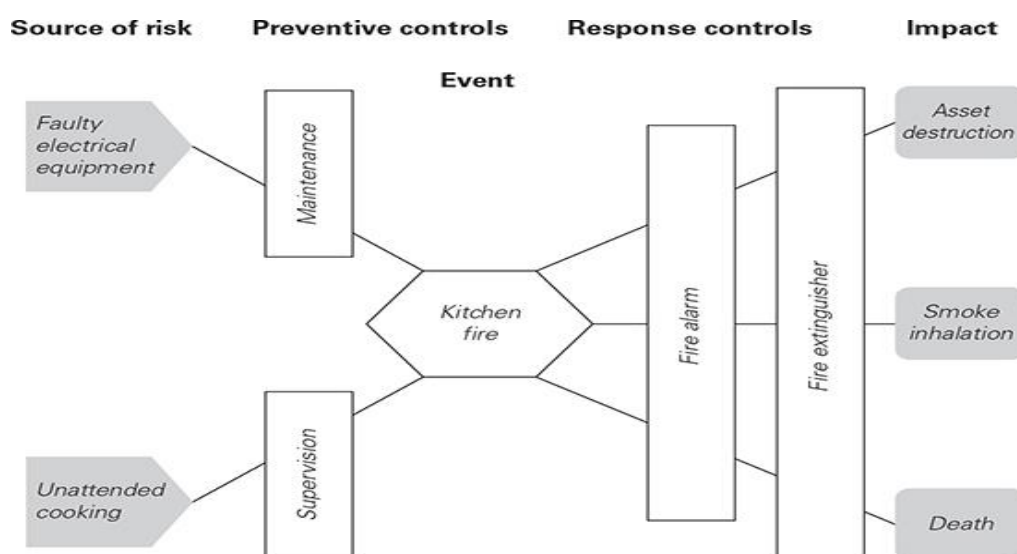


Figure 5. Types of control

While **preventive controls** help in reducing the **likelihood** of the risk crystallising, **response controls** reduce the **impact** or **consequence** once the risk has already occurred. Although risk owners as part of the risk review process often reduce the likelihood to demonstrate progress in mitigating and managing the risk, it is worth noting that in some rare instances, where response controls have been put in place, (e.g. installation of sprinklers in high-rise buildings), the **impact** or **consequence** could also be reduced to align with progress. Risk owners should often seek to ensure and provide assurance on the effectiveness of controls and the management of risks through relevant management and governance meetings.

3.4. Criteria for escalating risks onto the Corporate Risk Register (CRR):

- The risk must be scored 15 or more and must be approved for escalation by the Service/Directorate/Divisional local clinical governance (LCGC) meeting and/or management team and supported by the relevant senior management team and/or Exec Director.
- The risk must be appropriately assessed, and all fields completed prior to presentation for escalation.

- Once a risk has been approved for escalation by the LCGC and/or management team, the risk Manager should be notified so they could liaise with the Service and/or Directorate to ensure the risk is appropriately captured on the CRR template and included onto the agenda for the RMG. Please see appendix 2b for details of the Trust's risk escalation flow chart.

3.5. Risk Escalation:

- Timely and dynamic escalation of risks is important for effectively risk management; hence this policy identifies two pathways through which risk could be escalated to the RMG: -
- **Via Governance route:** through appropriate governance meetings as described above.
- **Via management route:** This implies expedited escalation, hence, in the case where the local governance meeting isn't due to be held for a few weeks or months. Once management at the local service/Directorate/Divisional level have reviewed the risk and are satisfied that it has been appropriately described and scored, it should be presented to the Clinical Director (CD) (or the appropriate Senior Manager) for support and shared with the relevant Executive Director for signed-off and either: -
 - a. Presented to the RMG for approval and/or
 - b. Direct inclusion onto the CRR via Chair's action, in the case where the RMG isn't due to hold soon. This will ensure timely and dynamic escalation of risks; however, such a risk will need to be presented at the earliest RMG for review, scrutiny, noting, learning and minuting.
- If in doubt, services/Directorates/Divisions are encouraged to contact the Risk Manager for support and clarifications.

A manager from the Service/Directorate/Division escalating the risk and/or the CD supporting its escalation should be invited to attend the RMG to present the risk. However, if a risk isn't approved at the RMG following escalation, the RMG will provide advice through the colleague who presented the risk and request that it be de-escalated and held in the relevant service for appropriate mitigation and management or for review, amendments, and re-escalation if that is deemed appropriate.

3.6. Board Assurance Framework (BAF)

- The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Trust and co-ordinating them to best effect, hence, it helps in driving strategic oversight.
- The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Trust's strategic goals have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance.

- It thus provides a structure and process through which the Trust could focus on those principal risks which may undermine the achievement of its strategic goals as defined in the Level 1 priorities in its updated Strategy.
- Executive Directors and their ADs are responsible for ensuring that risks within their portfolio captured on the CRR and BAF are timely and regularly updated prior to presentation at the relevant Board Committees.

3.7. Linking the CRR to the BAF

- BSMHFT's BAF and CRR are maintained distinctively separate, however, both **assurance** toolkits complement each other and are symbiotically linked; inform, shape and feed-off each other. Both documents are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks to the delivery of the Trust's strategic priorities are appropriately mitigated and managed in **line with best practice** and this Risk Management Policy.

3.8. Collaborative and shared Risk Management

- BSMHFT recognises that there will be instances where the effective management of a risk will require inputs from other colleagues and stakeholders who may not necessarily be part of the service/Directorate in which the risk has been identified. For example, a service may identify a risk, which requires inputs from subject experts from say Informatics, Finance, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively mitigate and manage it. However, **when involving colleagues in the collaborative management of risks, it is important to recognise** that responsibility **and accountability for ownership**, mitigation and **effective** management of the risk lies with the local service where it has been identified.
- In such a situation, Services/Directorates should ensure that all key stakeholders who **need** contribute to the effective management of the risk are involved in the discussions on how best to reduce and manage it. **It is worth recognising that** in other instances, collaborative management of a risk many involve external stakeholders such as the Local Authority; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately mitigating and managing such risks.

3.9. Risk Management Training:

- BSMHFT recognises that developing staff capacity, capability **and organisational resilience** in risk management is critical for fostering

engagement and embedding its culture of safety and effective risk management.

- The Risk Manager with the support of the relevant AD, Senior Professional Lead or Exec will design and deliver bespoke risk management training that will be available to all staff and managers as well as to contractors delivering services on behalf of BSMHFT. Staff will be regularly signposted to log onto the learning zone to book onto the Trust's risk management training programme i.e The Fundamentals of Risk Management.

3.10 Risk Management Annual Improvement Plan:

- BSMHFT is committed to continuously learning and improving its risk management arrangements, hence, it has adopted a QI approach to improving its risk management landscape through the implementation of a risk management annual improvement plan.
- The plan will be monitored at the RMG on a quarterly basis and assurance provided to ET.

4. Responsibilities

Staff/Groups	Responsibilities	Ref
All Staff	All staff should be aware of risk assessment findings and risk management measures, which could affect their practice and professional needs. They must inform their line managers of risks deemed to be unacceptable and/or outside of their ability to manage. In addition, all staff (permanent and temporary) must • Report incidents/accidents and near misses in a timely manner and in accordance with incident reporting policies via Eclipse. • Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business. • Comply with all Trust policies and procedures and any other instructions/guidelines to protect the health, safety, and welfare of anyone affected by the Trust's business. • All staff including Trade Unions colleagues, contractors and partners who provide services for and on behalf of BSMHFT are responsible for effectively mitigating and managing risks to the delivery of the Trust's operational and strategic objectives/priorities. In short, risk management is everyone's responsibility.	

Executive Directors & Trust Board	The Chief Executive maintains overall accountability for risk management within the Trust and will however, delegate responsibility to nominated Executive Directors of the Trust Board. The Director of Finance (on behalf of the Chief Executive) is the Executive Director responsible for risk management and for co-ordinating the implementation and operationalisation of the Risk Management Policy across the Trust. The Executive Director of Finance shall ensure the provision of effective risk management including risk governance structures and robust systems which assure implementation of the Trust's risk and risk governance objectives through the proactive identification and prioritisation of key organisational and risks from service areas, through to Directorates and ultimately the Board. The Executive Director of Finance shall ensure the development of systems, control process and risk management arrangements that comply with internal and external risk governance and best practice requirements and ensure continuous improvement of the quality of risk information, particularly in the areas of key controls. The Executive Director of Finance shall be responsible for designing, developing, coordinating and reporting on the Corporate Risk Register to the Trust Clinical Governance Committee, Board and Board Committees as well as for the implementation of the Annual Risk Management Improvement Plan and the Annual RMG Self-assessment while ensuring there are effective risk management systems and processes in place. They are also responsible for ensuring that there is a bespoke risk management training programme in place to support developing staff capacity and capability and organisational resilience in risk management. The Executive Director of Finance has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). The Executive Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and for the effective management of risks within their portfolios.	

	The Executive Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning. The Executive Director of Strategy, People and Partnerships has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships.	
Clinical Directors	Clinical Directors are responsible for ensuring that there are robust systems and processes in their Directorates to support the effective identification, assessment, mitigation, monitoring and management of risks. They are responsible for ensuring that risk management and especially high-level operational risks in their directorates are periodically reviewed and scrutinised at their Directorate Clinical Governance Meetings. Clinical Directors will be responsible for timely reviewing and approving high operational risks scoring 15 and above from their directorates being put forward for escalation to the RMG prior to their presentation at the RMG.	
Head of Health and Safety and Regulatory Compliance/ Associate Director of Corporate Governance	The Head of Health and Safety and Regulatory Compliance will be responsible for ensuring all clinical and patient safety related risk are appropriately added onto the Trust risk management information system. They will be responsible for embedding a culture of risk awareness, risk maturity and risk compliance in the Nursing Directorate, Services and Directorates. They will liaise with the Risk Manager in ensuring Services and Directorates escalating risks to the RMG for consideration, approval and inclusion onto the corporate risk register are appropriately supported. The Associate Director of Corporate Governance has overall responsibility for the designing and regularly refreshing Risk Management Policy and through the Company Secretary for the management of the Board Assurance Framework. They shall also work closely with ADs, Non-Executive Directors, Executive Directorates and the Company Secretary in designing, regularly refreshing and implementing the BAF. The AD of Corporate Governance shall with the support of the Company Secretary be responsible for presenting the BAF twice a year at the TCGC, at least bi-monthly ~~quarterly~~ at the RMG, bi-monthly at Board Committees and ~~twice yearly~~ at the Board.	

Associate Directors / Corporate Senior Professional Leads	All Associate Directors and Corporate Senior Professional Leads have delegated responsibility for the effective management of risks within their portfolios and for ensuring that significant risks to the achievement of their local operational objectives are escalated in line with this Policy. ADs and Corporate Senior Professional Leads are responsible on behalf of their Executive Directors, for BAF and CRR risks that are assigned to their portfolio, ensuring these are regularly reviewed and updated as well as all related actions appropriately implemented and evidenced.	
Senior Leaders and Managers (including Senior Directorate Teams).	• Implementing Trust policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility. • Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. • Overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register. • It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.	
Risk Manager	• They are responsible for ensuring the Trust has effective risk management arrangements in place, populating the Trust's risk management policy, raising the profile, visibility and supporting Services and Directorates across the Trust to embed risk management into business as usual.	

	• Creating space for a risk aware-culture to flourish across the Trust and the provision of risk management-related assurance to the Board and its sub-committees. • Act as an adviser to the Trust on all aspects of risk management and lead on the development of a dynamic, comprehensive, proactive, agile, sustainable Trust-wide risk management infrastructure. • Support local services and Directorates in reviewing and keeping their local risk registers up-to-date and in pulling risk registers for local governance meetings if requested including servicing the RMG. • Designing and delivering the Trust's risk management training. • Provide admin support to the RMG including, servicing, minuting and ensuring all reports and papers are collated and timely circulated.	
Trust Board	Responsible for: - • overall risk oversight, scrutiny, gaining assurance, setting the tone and culture that underpins the Trust's risk management approach. • ratifying the Trust's Risk Management Policy including the Risk Appetite Statement. • reviewing the Board Assurance Framework and the Corporate Risk Register.	
Audit Committee	Responsible for: - • reviewing the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management. • making recommendations to the Board as appropriate regarding its risk management arrangements.	
Quality, Patient Experience and Safety Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect quality, safety, and patient experience risks and that there are effective controls, assurance and mitigation to manage these.	
Finance, Performance and Productivity Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect performance, sustainability, financial and governance risks and that there are effective controls, assurance, and mitigation to manage these.	

People Committee	Responsible for reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect workforce related risks and that there are effective controls, assurance, and mitigation to manage these.	
Caring Minds	Responsible for - reviewing related Board Assurance Framework and the Corporate Risk Register risks which could negatively impact on its operations, finances, and reputation. - It will seek assurance that there are robust risk management arrangements in place including risk mitigation plans, and regular monitoring of risks in the space of the Trust's charity work.	
Risk Management Group	Responsible for: - - seeking assurance on the effectiveness of the Trust's risk management systems. - developing and overseeing the implementation of the Risk Management Policy. - reviewing and approving risks escalated to it and ensuring that those rated 15 or above are properly recorded in the Corporate Risk Register. - Considering evidence and approving the closure of risks on the Corporate Risk Register. - Supporting the Board with the development and maintenance of the Risk Appetite Statement and the CRR. - Receive, review the BAF twice a year and offer advice and recommendations to the Board via relevant Board Committees.	
Strategy and Transformation Board / Sustainability Board	Responsible for: - - Strategy and Transformation Board for providing scrutiny, assurance, governance and oversight, of all risks and impact assessments relating to change programmes and projects. - Sustainability Board for providing scrutiny, assurance, governance and oversight of finance-related risks.	
Local management and assurance groups	Responsible for: - maintaining risk registers relating to their area of responsibility.	

	• systematically reviewing relevant risks, seeking and providing assurance that they are being managed through their local governance arrangements. • escalating risks with a score of 15 or above through their Directorate meetings to the Risk Management Group.	

5. Development and consultation process

Consultation summary	
Date policy issued for consultation	July 2025
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Staff and reps from Services/ Directorates - Workshops	July/August 2025
Policy Development Management Group (PDMG – for noting)	August 2025
Local Governance Committees	August 2025
ET	--- August 2025
Risk Management Group	21 st August 2025
Audit Committee	24 th September 2025
Board	1 st October 2025

6. Reference documents

Australian/New Zealand Standard AS/NZS 4360:

7. Bibliography

None

8. Glossary

None

9. Audit, assurance & monitoring implementation.

The policies, systems, framework and processes covered by the Risk Management Policy and Strategy and the Board Assurance Framework will be regularly, systematically and independently audited as required by the Audit Committee.

Monitoring implementation of this Risk Management Policy

- BSMHFT will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of

its risk management culture using key performance indicators (KPIs – please see appendix 2a for details) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 10 risks randomly selected from each Directorate risk registers and 5-10 from the Corporate Risk Register in measuring the following KPIs as set out on the table below: -

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
1. Compliance	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.
2. Maturity	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.
3. Data Quality	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.

10. Appendices

- 1 Equality Impact Assessment
- 2a. Definitions of KPIs for monitoring implementation of this Risk Management Policy
- 2b. Risk Management Flow Chart
3. Risk Scoring
4. Risk Thresholds/Risk Level Monitoring
5. Key definitions
6. Risk Appetite Framework

Appendix 1: Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect

<http://connect/corporate/humanresources/managementsupport/Pages/default.aspx>

Title of Proposal	Risk Management Policy		
Person Completing this proposal	David Tita	Role or title	AD Corporate Governance
Directorate	Finance	Service Area	Corporate Governance Team
Date Started	July 2025	Date completed	July 2025
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Quality, Sustainability, People and Clinical Services			
Who will benefit from the proposal?			
The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.			
Does the policy affect service users, employees or the wider community? <i>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</i>			
The Policy may directly affect service users as its effective implementation may have positive impacts the Trust's safety culture and enhance the delivery of high-quality patient-centred safe care.			
Does the policy significantly affect service delivery, business processes or policy? <i>How will these reduce inequality?</i>			
N/A			
Does it involve a significant commitment of resources? <i>How will these reduce inequality?</i>			

N/A				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
N/A				
Impacts on different Personal Protected Characteristics – Helpful Questions:				
<i>Does this proposal promote equality of opportunity?</i> <i>Eliminate discrimination?</i> <i>Eliminate harassment?</i> <i>Eliminate victimisation?</i>			<i>Promote good community relations?</i> <i>Promote positive attitudes towards disabled people?</i> <i>Consider more favourable treatment of disabled people?</i> <i>Promote involvement and consultation?</i> <i>Protect and promote human rights?</i>	
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	No/Minimal 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	✓			It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their age.
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	✓			It is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of any disclosed disability. The Trust 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. This is dependent if the individual

				feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues. The current WDES is showing the Trust is ranked in the top 10% nationally in Recruitment and Reporting of harassment, bullying and abuse.
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	✓			It is anticipated that gender will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. Currently gender is collated and there is a disparity around gender pay gap overall with an increase from 6.99% to 11.17%. The Trust has now set up a Women's Network and Men's Network who meet 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	✓			It is anticipated that marriage or civil partnership will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy 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	✓			It is anticipated that pregnancy and maternity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide

				necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. This is dependent on staff feeling comfortable about being open about their or their partners pregnancy, including miscarriage. 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	✓			The Trust is working towards a Anti Racist organisation and will be launching the Anti Racist Framework. It is anticipated that Race or Ethnicity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. We also have the Race Equity Network and Anti Racist Campaign to support those who are facing racial discrimination.
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	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. The Trust will provide necessary support and reasonable adjustment for employees, and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy 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 religion or belief.
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	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. 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 the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. The Trust has also launched the LGBTQ+ campaign to support staff and training.
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	✓			Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, 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. The Trust is currently offering Trans Awareness training to support staff.
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	✓			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
				✓
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?				
Discussions took place with colleagues in the development of this policy. EDI Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns.				
How will any impact or planned actions be monitored and reviewed?				

Via the Directorate CGCs, RMG, Board and Board Committees. Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates.
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.
This is not relevant. The policy is applicable to all members of the Trust regardless of their personal protected characteristics.
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 Directorate or Service planning and monitored on a regular basis.

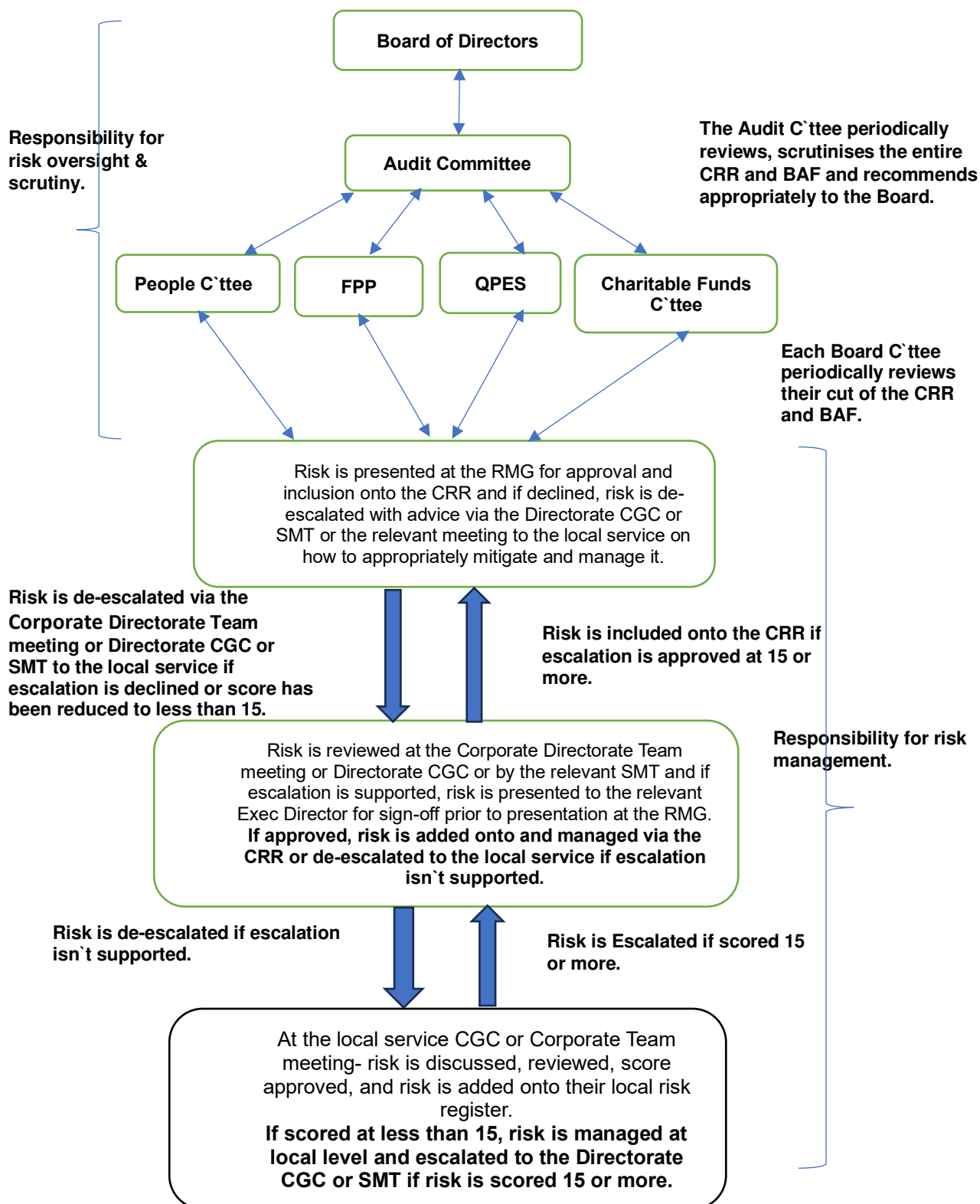
Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive impact in highlighting risks to equality and support specific approaches to close the gaps where these are identified.

Appendix 2a: Definitions of KPIs for monitoring implementation of this Risk Management Policy

- **Compliance:** This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components: -
% of risks which are in date and/or out of date;
Evidence that services escalating risks in line with this Risk Management Policy.
- **Maturity:** This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: -
% of risks appropriately completed.
- **Data Quality:** This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -
% of risks which have been appropriately described.

Appendix 2b: Risk Management Flow Chart

BSMHFT Risk Management flow chart - Escalation and de-escalation of risks.



NB: Responsibility for mitigating and managing risks on the CRR lies with the local service which owns the risk as escalation doesn't exonerate them from this responsibility.

Appendix 3: Risk Scoring

RISK SCORING

The prioritisation and allocation of risk

To ensure that meaningful decisions on the prioritisation and treatment of risks can be made, the Trust will grade all risks using the same tool.

- **The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) will be used to assign risk priority.**

It is essential to have one system for prioritising and rating risks, and this will be used to prioritise risks on the Assurance Framework and Risk Registers, and for rating incidents, complaints, and claims. Risk analysis uses descriptive scales to describe the magnitude of potential consequences and the likelihood that those consequences occur.

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

	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.	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
				Mismanagement of patient care with long term effects.	
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) 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	Non-compliance with national standards with significant risk to patients if not resolved. Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if findings not acted on 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 breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breaches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breaches 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	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable.	National media coverage with >3days service well below reasonable public expectation. MP

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
		expectation not being met.		public expectation.	concerned (questions in the House) Total loss of public confidence
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 Minor 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.

	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 attack 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 counselling – no time off work required	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 Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	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, fracture, blow to the head Loss of limb Post-traumatic stress disorder	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 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						

Appendix 4: Risk Thresholds/Risk Level Monitoring

RISK THRESHOLDS / RISK LEVEL MONITORING

Level of Risk	Risk Scores	Determination of Level, monitoring of Action Plans and acceptability of risk to the Trust	Monitoring Process
Red	All risks rated ≥ 15 (post moderation) Unacceptable level of risk exposure which requires immediate corrective action to be taken. Risk should be considered for escalation.	Unacceptable risk Approved by the RMG if escalated. Risk treatment plan approved by relevant Executive Director and RMG.	Oversight by Risk Management Group QPES, FPP and People Committee if risk has been escalated onto the CRR. QPES, FPP and People Committee to advise Board on ways of managing high risks that cannot be addressed within existing resources.
Amber	All risks rated 12. Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	Unacceptable risk Risk scores approved by local Service and Directorate clinical governance Committees. Level determined by Executive Director. Risk treatment plan managed by senior managers. Progress updates via Directorate Leads.	Included on the Risk Register and reported to local Service and Directorate Clinical Governance Committee. Risk treatment plan monitored by Executive Director.
Yellow	All risks rated 4- 10	Level determined by the Service Manager. Risk treatment plan managed locally by named managers on behalf of the Director.	Risk treatment plan monitored by Directors Management team.
Green	All risks rated 1 - 4		

Appendix 5: Key definitions

KEY DEFINITIONS

Risk Description		There are 3 main components will need to be considered when articulating the risk description (cause, event and effect):
		- There is a risk of...if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Rating	Inherent	This is the score of a risk without taking into consideration any controls which may be in place to mitigate it. This is also referred to as gross risk, initial risk, uncontrolled risk or absolute risk.
	Current	This is the score of the risk taking into consideration the controls and mitigation measures in place. This is also referred to as net risk, residual risk, current risk, or managed level of risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is 'rare' which denotes it will probably never happen, with a 5 being 'almost certain' which indicates that it will undoubtedly or possibly happen.
Risk Score		Risk score is derived by multiplying the Impact by Likelihood.
Risk Appetite	Definition	Is defined as the amount and level of risk that the Trust is willing to pursue or accept in order to achieve its priorities.
Controls or risk mitigations	Definition	These are measures/interventions implemented by the Trust to reduce either the likelihood of a risk and/or the impact were it to be realised. Controls could include strategies, policies, procedures, systems, SOPs, Checklists etc being implemented to reduce either the likelihood and/or impact of the risk were it to crystallise. A control is also a measure that maintains and/or modifies risk (ISO 31000:2018(en)).
Three Lines of Defence Model	1 st Line of Defence	The first Line of defence refers to the service or function that owns, mitigates and manages the risk on a day-to-day basis.
	2 nd Line of Defence	This refers to other functions in the in the Trust which oversee compliance or risk management e.g. HR, Risk Management team etc.
	3 rd Line of Defence	This refers to functions in the trust which provide objective and independent assurance and may include Internal Audits, External Audits etc.

Appendix 6: Risk Appetite Statement

RISK APPETITE STATEMENT

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

- Supporting informed decision-making.
- Reducing uncertainty.
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement.
- Focusing on priority areas within an organisation.
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

Risk Appetite Framework

RISK APPETITE FRAMEWORK (RAF)

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

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- Reducing uncertainty.
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement.
- Focusing on priority areas within an organisation.
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board's preferred risk appetite
Quality & Safety	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.	Cautious	6 - 8	Cautious
Reputational	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Open	9-10	
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Open	9 – 10	Open
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	9 – 10	Open
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	6 – 8	Cautious
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open	9 - 10	Open
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Open	9 – 10	Open
Data and Information Management	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Cautious	6 - 8	Cautious
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	Cautious	6 – 8	Cautious

Digital Improvement	New technologies viewed as a key enabler of operational delivery. Maximisation of patient care and avoidance of harm. Agile principles are embraced.	Eager	12	
Cyber Security	Consideration given to adoption of established /mature systems and good cyber security architecture and awareness of cyber security threats. Agile principles are considered.	Cautious	9 - 10	Cautious
Transformation/ Projects and Quality Improvement	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.	Open	9 – 10	Open
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	Minimal	2 - 4	Minimal
Property	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Open	9 - 10	Open
Environment	Requirement to adopt a range of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	Cautious	12	Cautious
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open	9 – 10	Open
Partnerships & Provider Collaboratives	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.	Open	9 -10	Open

N.B: BSMHFT's Risk Appetite Framework is aligned to target risk scores!

Report to Board of Directors						
Agenda item:	20					
Date	1 October 2025					
Title	Audit Committee Terms of Reference					
Author/Presenter	David Tita – AD of 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 (<i>executive summary, key risks</i>)						
Alert		Advise		Assure		✓
1. Purpose: A Board Committee's terms of reference once regularly reviewed and updated to ensure relevance and alignment with organisational strategy, must be approved by the Board of Directors. The ToR should thus set out the committee's role, objectives, scope, authority, responsibilities and membership. This paper sets out amendments that have been made to the Audit Committee's terms of reference as these were reviewed, scrutinised, approved and recommended to the Board for ratification by the AC at its last meeting on 24th September 2025. 2. Introduction: An annual review of the terms of reference of a Board Committee offers an opportunity for the committee to ensure its ToR remains fit for purpose and aligns with its statutory and delegated responsibilities from the Board while ensuring its effectiveness and added value to the organisation's success. It is best practice for committees to review their terms of reference annually against external best practices, model ToR and standards, with a view to fostering continuous learning and improvement. This review of the Audit Committee ToR has drawn inspiration from the <i>NHS audit committee handbook (2024)</i> and <i>Model Audit Committee Terms of Reference (CGI – 2022)</i> in making the following changes. • Better clarification of the authority of the Audit Committee as having no executive powers, other than those specifically delegated to it by the Board as per its terms of reference and the authority to seek outside legal or other independent professional advice as it may deem necessary. • Better clarification of its powers to seek information (assurance) it may require from any member of staff, with the expectation for them to co-operate with any such request made by the Committee. • And within its remit of risk management oversight; confirmation of the Audit Committee's responsibility for the review and scrutiny of the CRR from the Commissioning Arm as well as high scoring operational risks from SSL in addition to their BAFs and the Trust BAF. • Better clarification and alignment of management of conflicts during meetings with relevant section in the Trust's Declaration of Interest Policy.						

3. Key issues and risks:

Once ratified by the Board, the key issue will be the need to populate this updated ToR to all members of the Audit Committee while ensuring effective implementation. This will be mitigated through sufficient publicity and sharing of the final version with all members of the Committee for their records and private reading.

Strategic Priorities

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

Recommendation

The Board is requested to:

1. **NOTE** the content of this report.
2. **REVIEW, SCRUTINISE and RATIFY** the updated Terms of reference of the Audit Committee (please see appendix 1 for details).

Enclosures

Appendix 1: Update Audit Committee Terms of Reference

Appendix 1: Update Audit Committee Terms of Reference

AUDIT COMMITTEE TERMS OF REFERENCE

1. VALUES

1.1 The Committee will role model the Trust values:

Compassionate

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

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve, and grow together.

2. AUTHORITY

2.1 The Audit Committee is constituted as a Standing Committee of the Board. **The Committee is a non-executive committee and has no executive powers, other than those specifically delegated in these terms of reference.** Its constitution and terms of reference shall be as set out below, subject to amendment **and approval** by the Board. This will include the responsibilities of the Trust in being a provider and commissioner of services.

2.2 The Committee is authorised by the Board to request the attendance of individuals and authorities from within or outside the Trust with relevant experience and expertise if it considers this necessary. **The Committee is also authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.**

2.3 The Committee is a Non-Executive Committee of the Board of Directors, with no executive powers, other than those specifically delegated in the Terms of Reference.

2.4 The Audit Committee is responsible for oversight of processes and systems for commissioning, and interfaces with the Commissioning Committee (“**CoCo**” – Board in Committee) for this responsibility.

2.4 The Committee is responsible for providing assurance to the Trust Board and the Commissioning Committee on the adequacy of the audit arrangements (internal control) for the Provider and Commissioning arms of the Trust and on the effectiveness of their risk management systems by means of independent and objective review of the financial, corporate governance, and risk management arrangements, including compliance with the law, corporate governance codes, guidance, best practice and regulations governing the NHS.

- 2.6 The Audit Committee's remit across both provider and commissioner responsibilities.

3. PURPOSE

- 3.1 The Committee is authorised by Board to carry out any function within its terms of reference.
- 3.2 The Committee shall request and review reports and positive assurances from directors and managers, on the overall arrangements for governance, risk management and internal control and will provide assurance on these to the Board. **It thus is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit Committee.**
- 3.3 The Committee is delegated and authorised by the Board to:
- Investigate any activity within its terms of reference.
 - Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
 - Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
 - Recommend the consolidated "group" Annual Accounts and Report (including the Quality Account and Charitable Funds Account) to the Board for approval. These will incorporate the SSL Accounts, and both provider and commissioner Trust Accounts.
- 3.4 The Committee may also request specific reports from individual functions within the organisation as it may deem appropriate to provide assurance on overall governance arrangements.
- 3.5 The Committee will review all matters relevant to both the commissioning and provider functions within the overall group.

4. DUTIES

- 4.1 Governance, Risk Management, and Internal Control
- 4.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical, and provider and commissioner) that supports the achievement of the organisation's objectives.
- 4.1.2 The Audit Committee will scrutinise the provider arm's Board Assurance Framework ("BAF") to provide the Board with assurance that the BAF is valid and suitable for the Trust's requirements. Specifically, the Audit Committee will:
- Ensure that there is an appropriate spread of strategic risks. This should be done once a year.
 - Assure itself that the process undertaken by management to populate the BAF is appropriate. This could be carried out on the Committee's behalf by the Internal Auditors to terms of reference agreed by the Committee.
 - Monitor the implementation of action plans that have been drawn up to cover gaps in controls, assurances, and reports to management.

- Consider the audit needs of the organisation in terms of sources of assurance, and that there is a plan for these assurances to be received.
 - Review the results of assurances and the implications these have on the achievement of the Trust's strategic objectives.
- 4.1.3 The Audit Committee will scrutinise the commissioning arm's Board Assurance Framework to provide the CoCo with assurance that the BAF is valid and suitable for the Trust's requirements. The Audit Committee will discharge the same functions as described in 4.1.2 above, but with a particular focus on the Trust's management of strategic risks associated with Lead Provider and partnership activities **as well as review and scrutinise the commissioning arm's Corporate Risk register (CRR).**
- 4.1.4 The Committee will review the adequacy of:
- All risks and controls related to disclosure statements (in particular the declarations of compliance with the CQC regulations and requirements for the Annual Report and Accounts and the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to approval by the Board
 - The policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements
 - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the NHSE Counter Fraud Authority.
- 4.1.5 The Committee will ensure and assure on behalf of the Board that:
- The Trust has an appropriate and up-to-date Risk Policy.
 - The Risk Policy is being adhered to, in that risks are being identified, described, scored, managed, and addressed appropriately.
 - There is a transparent and effective method for the escalation of risks upwards within the Trust.
 - The higher scoring risks as collated into a single Corporate Risk Register, which is visible to the Board.
 - **High operational risks within SSL are appropriately mitigated and managed.**
 - The Board Assurance Frameworks are live documents that reflect the controls and assurances needed to ensure and assure management of the risks associated with delivery of the Trust's Strategy and its responsibilities as a Lead Provider.
- 4.1.6 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions.
- 4.1.7 The Committee will review the establishment and maintenance of effective systems of governance, risk management and internal control for the Provider and Commissioning arms of the Trust.

- 4.1.8 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions.
- 4.1.9 The Committee will have delegated authority from the Board to receive and recommend for approval changes to the Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers ("**Scheme of Delegation**"). It will also consider any breaches of these arrangements.

4.2 Financial Reporting

- 4.2.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal instructions by the Regulator regarding financial performance.
- 4.2.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review both as to the completeness, accuracy, and fitness for purpose of the information and with regard to the effectiveness of the Board's consideration of this information.
- 4.2.3 The Committee will review the consolidated annual reports and accounts of the Trust before their submission to the Board, focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
 - Changes in, and compliance with, accounting policies, practices and estimation techniques;
 - Unadjusted misstatements in the financial statements;
 - Significant judgments in preparation of the financial statements;
 - Significant adjustments resulting from the audit;
 - Letter of representation; and
 - Qualitative aspects of financial reporting.

4.3 Internal Audit

- 4.3.1 The Committee shall ensure that there is an effective internal audit function appointed in line with the scheme of delegation and that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation dismissal; as well as agreeing the adequacy of the procurement process.
 - Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation including those identified in the Assurance Framework
 - Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
 - Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
 - Annual review of the effectiveness of internal audit.

4.4 Counter Fraud

- 4.4.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

4.5 External Audit

- 4.5.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:
- Consideration of the appointment and performance of the External Auditor in order for a recommendation to go to the Council of Governors, whose role it is to appoint the External Auditors.
 - Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
 - Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
 - Review of all External Audit reports, including receipt of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
 - Consideration of any non-audit work to ensure external audit retain independence.

4.6 Other Assurance Functions

- 4.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arms-length Bodies or appropriate regulators/inspectors.
- 4.6.2 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee, and any Risk Management committees that are established, as well as receiving or seeking assurances as appropriate, from the other board sub committees.
- 4.6.3 In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

5. **MEMBERSHIP AND ATTENDANCE**

- 5.1 All members of the Committee will be independent Non-Executive Directors. At least one member will have a formally recognised accountancy qualification.
- 5.2 The membership of the Committee will be:
- Chair – Non-Executive Director
 - Deputy Chair – Non-Executive Director & Chair of FPP.
 - The Chair of QPES

- The Chair of the People Committee
- The Chair of the Caring Minds Committee
- Another Non-Executive Director

The membership will comprise representation (Member or Chair) from the Trust committees leading on quality, finance, and people as outlined above. The Chair of the FPP shall act as the Deputy Chair of the Committee.

5.3 The following will be standing attendees of the Committee:

- Executive Director of Finance
- Company Secretary.

5.4 Invitations for attendance of others will be issued by the Chair of the Committee in line with the requirements of the agenda.

5.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. Other Non-Executive Directors who are not members of the Committee may attend with the agreement of the Chair of the Committee. The Chair of the Board will not be a member of the Committee but may be in attendance at the discretion of the Committee Chair.

5.6 All members will have one vote. In the event of votes being equal the Chair of the Committee (or the Deputy Chair if presiding) will have the casting vote.

5.7 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. Hence, the head of internal audit and external audit lead partner will be invited to attend meetings of the committee on a regular basis and other individuals may be invited to attend all or part of any meeting as and when appropriate. At least once a year the Committee should meet privately with the External and Internal Auditors.

6. QUORACY

6.1 A quorum shall be at least three Non-Executive Directors of the Committee, one of whom must either be the Chair or Deputy Chair.

7. DECLARATION OF INTERESTS

7.1 All members and attending officers must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. The Chair will decide if any Member must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur. Hence, the Chair shall adopt a sensible and pragmatic approach in managing conflict during the meeting as they may permit the conflicted member to participate and contribute to the debate and discussions on the item (so as to inform better decision-making) but abstain or recuse themselves from any related voting. (Check section 3.12 – Managing conflict of interests during meetings in the Trust's Declaration of Interest Policy for more details).

8. MEETINGS

8.1 Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may ask the Committee Chair for a meeting if they consider that one is necessary and the Chair can also convene an extraordinary meeting if need arises.

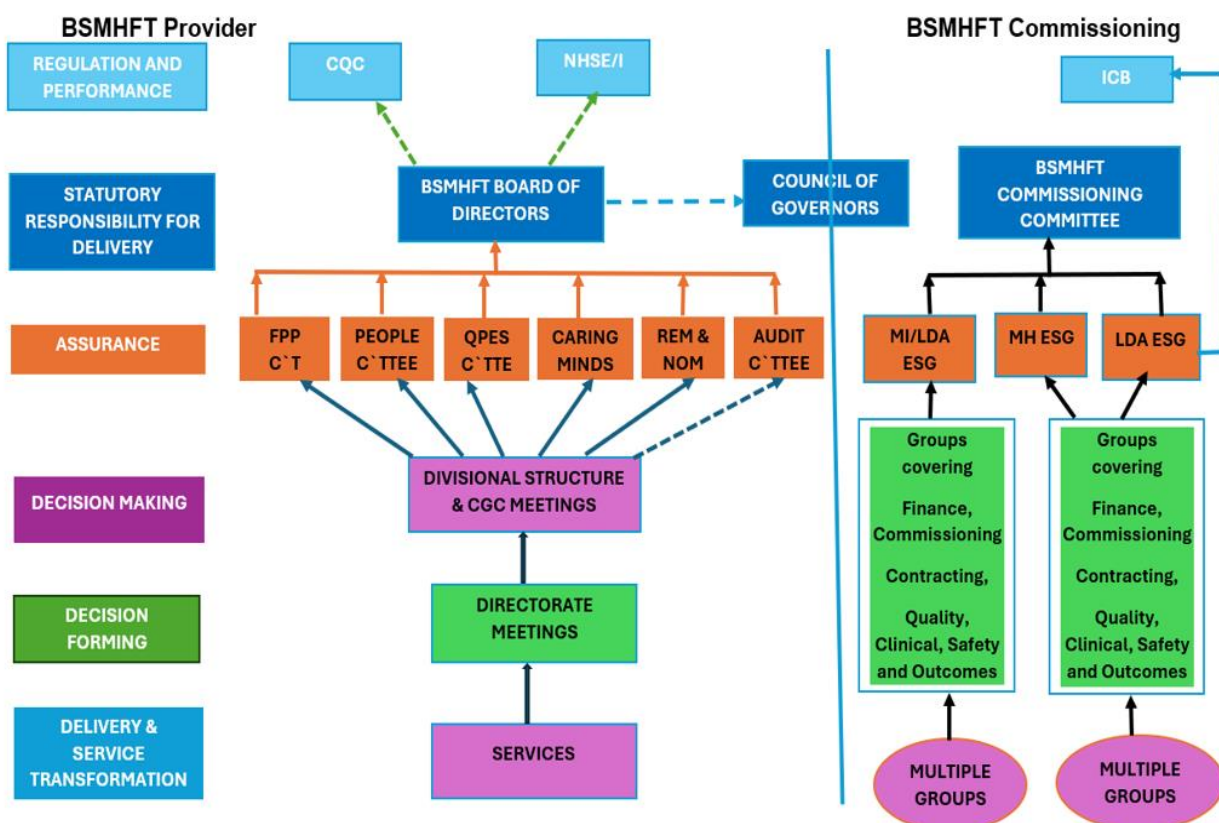
- 8.2 Meeting dates will be agreed annually in advance by the members of the Committee.
- 8.3 To include as a standing item on every agenda the Committee should review how effectively it has discharged its business.

9. ADMINISTRATION

- 9.1 The meeting will be closed and not open to the public.
- 9.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.
- 9.3 An Action List and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.
- 9.4 Any issues with the Action List or minutes will be raised within 7 calendar days of issue.
- 9.5 The Company Secretary will agree a draft agenda with the Committee Chair, and it will be circulated 7 calendar days (5 working days) before the meeting.
- 9.6 Any issues with the agenda must be raised with the Committee Chair within 4 working days.
- 9.7 All final Committee reports must be submitted 7 calendar days before the meeting.
- 9.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings.

10. Governance Structure

10.1 BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

- 11.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board and the CoCo when required. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.
- 11.2 The Committee will review its effectiveness on an annual basis, reporting the outcome of the review to the Board of Directors.
- 11.3 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee.

Approved: 24th September 2025

Renewal: September 2026

Amended: September 2025 (To strengthen and provide clarity on its powers, review of SSL high operational risks, the commissioning arm's CRR, their related BAFs and clarity on management of conflicts during meetings).

Date ratified by the Board of Directors: 2nd October 2025

Version: 3.3

Report to Board of Directors						
Agenda item:	21					
Date	1 October 2025					
Title	Board of Directors Effectiveness Annual Self-assessment					
Author/Presenter	David Tita – AD of 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 <i>(executive summary, key risks)</i>						
Alert		Advise		Assure	✓	
1. Purpose: An annual self-assessment will give the Board an opportunity to evaluate its effectiveness, gain assurance and identify areas within the remits of its statutory responsibilities and strategic oversight functions, including its operationalisation, that are below standards and need improving and strengthening. The purpose of this report is twofold: - i. to enable the Board to adopt an improvement mindset in evaluating its effectiveness or how well it is equipped to deliver its statutory responsibilities and strategic oversight functions within the context of driving continuous learning, innovation and identifying areas for improvement. ii. to provide a simple and quick tool (SurveyMonkey) for members of the Board to use in evaluating and assessing its effectiveness. 2. Introduction: The Financial Reporting Council (FRC) states that an annual review of a board effectiveness is a formal assessment of how well a board is performing their statutory responsibilities, operating, and contributing to the organisation's strategic success. This process involves evaluating aspects like governance, strategic oversight, decision-making, and board composition, with the goal of identifying strengths and weaknesses to create an improvement plan. Similarly, the UK Corporate Governance Code (2024) stipulates that there should be a formal and rigorous annual evaluation of the performance of the Board, its committees, the chair and individual directors. This report notes that an efficient and effective board is a key requirement of good corporate governance. The board should be able to set the overall strategy of the Trust, including its vision, shape its culture and hold the Executive Directors to account implementing the strategy while fostering the long-term sustainable success of the organisation. A board which ceases to continuously self-assess its effectiveness against stretching but challenging targets and objectives risks becoming irrelevant. This report explores a SurveyMonkey as a tool for members of the board to explore in evaluating and assessing its effectiveness and how well it is equipped to deliver its statutory responsibilities and strategic oversight functions. This report proposes a SurveyMonkey comprising 18 questions grouped under 5 broad themes that reflect the						



core responsibilities of the Board of Directors as defined by its Terms of Reference and best practice. Questions 19 and 20 on the other hand will give respondents the opportunity to provide further qualitative input which will be triangulated in establishing a comprehensive and better understanding of the 'health status' of the Board's effectiveness.

This self-assessment tool is structured into the following 5 broad themes with the first section focused on establishing the capacity in which the respondent is completing the questionnaire. i.e. Are they a member of the Board or a regular attendee?

1. Board composition, establishment and role
2. Board Assurance Framework, Risk management and Assurance
3. Board visibility and Stakeholder engagement
4. Strategy, Performance & holding to account.
5. Leadership and shaping organisational culture.

3. Key issues and risks:

There are two key issues and risks worth considering: -

1. Potential lower response rate.
2. Potential lack of qualitative comments to enable triangulation and enrich data analysis.

The key mitigations here will be good publicity and engagement, adopt a user-friendly mode of administration as preferred by members and encourage them to provide qualitative assessments.

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. **RECOMMEND** their preferred mode of implementation of the SurveyMonkey i.e. either paper-based system or web-based system).
3. **REVIEW, SCRUTINISE and APPROVE** the content and structure of the proposed SurveyMonkey tool for implementation in assessing its effectiveness.

Enclosures

Appendix 1: Board Effectiveness Annual Self-assessment Survey (please see appendix 1 below for details of the survey).



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Board of Directors Effectiveness - Annual Self-Assessment Tool for 2024/25

Instructions: Please read through each statement set out below and tick the `dot` against the answer which best reflects your assessment of the situation articulated in the statement. You could change your response by clicking on the `dot` against the one you wish to select, and your previous choice will automatically be unselected: -

Respondent's Membership status

1. In what capacity are you completing the survey?

- ☐ Non-Executive Director
- ☐ Executive Director
- ☐ A regular attendee at the Board of Directors.

1. Board composition, establishment and role.

2. The Board of Directors has sufficient membership and authority to perform its statutory roles effectively.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

3. You are satisfied that the Board delegates responsibilities effectively and appropriately to its members and committees.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

4. Members of the Board have the right balance of experience, knowledge and skills to fulfil its roles effectively.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

5. You are satisfied that the Board has clearly set out the roles and responsibilities of



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its committees and often receives chair's assurance reports from them?

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

6. You are satisfied the Board is effectively performing its triple role of setting strategy, holding to Execs to account for implementing it and shaping the Trust's culture?

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

2. Board Assurance Framework, Risk management and Assurance

7. You are satisfied the Board regularly receives, reviews and scrutinises the Board Assurance Framework (BAF) and uses it in driving its agendas.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

8. The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

9. You are satisfied the Board receives sufficient assurance and good quality information from the reports it receives.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree



- ☐ Disagree
- ☐ Strongly disagree

3. Board visibility and Stakeholder engagement

10. The Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

11. The Board ensures that relevant officers attend its meetings to enable it to understand the information it receives.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

12. The Board is visible, sufficiently and appropriately engaged with key internal stakeholders and system partners.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

13. You are satisfied with the broad range of staff and patient stories presented at the Board which enable it to listen to both comfortable and uncomfortable stories?

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

4. Strategy, Performance & holding to account.

14. You are satisfied the Board provide sufficient scrutiny, constructive challenge

and hold the Trust to account for performance and delivery of the strategy.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

15. The Board has a credible strategy to provide high quality, sustainable services to patients?

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

16. There are clearly defined processes in place for timely escalation of risks and issues aligned to underperformance to the attention of the Board.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

5. Leadership and shaping organisational culture.

17. You are satisfied the Board support a culture of continuous learning and improvement across the Trust.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

18. The Board is committed to shaping and fostering an open, transparent and quality-focused culture.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

19. You are satisfied the Board has the skills, capacity, capability and experience to lead the Trust.

- ☐ Strongly agree
- ☐ Agree
- ☐ Slightly agree
- ☐ Slightly disagree
- ☐ Disagree
- ☐ Strongly disagree

20. Provide further comments on the overall effectiveness of the Board of Directors.

a. what's working well (Please Make completion of this free text box mandatory as respondent shouldn't be able to submit without completing it).

20b. Areas the Board needs to improve or strengthen. (Please Make completion of this free text box mandatory as respondent shouldn't be able to submit without completing it).